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MINISTRY OF HEALTH OF THE REPUBLIC OF UZBEKISTAN
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BIOETHICS

TEXTBOOK FOR MEDICAL STUDENTS

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The textbook is devoted to the basics of bioethics as a new interdisciplinary direction. The authors of the textbook, a philosopher, a doctor and a lawyer, were triune in their desire to reflect the key problems of the theoretical foundations and practical applications of bioethical knowledge, to accompany them with international regulatory documents and laws, decrees, and legislative acts adopted in the Republic of Uzbekistan. The tests and cases included in the textbook will help to understand the features of bioethics and apply the knowledge gained in practice. The textbook contains a glossary of basic bioethical terms and personalities from this field of science and everyday bioethical practice.

The book is intended for students of higher educational institutions studying in medical and natural science areas and specialties, teachers, practicing doctors and nurses, healthcare organizers, as well as everyone who is interested in the ethical problems of modern medicine.

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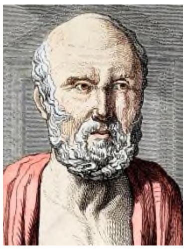
INTRODICTION

The first bioethical research institute, Hastings Center, was established in June 1969 in New York. In 1971, Georgetown University in Washington established Joseph and Rose Kennedy Institute of Ethics, which in turn, created the Center for Bioethics and published the first “Encyclopedia of Bioethics” of 4 volumes in 1978 (the last edition appeared in 2005). These were the first steps towards the institutionalization of bioethics, which can be compared with its state in the 21st century, when the total number of bioethical organizations around the world has long exceeded more than one hundred (the largest centers of bioethical research are located in Australia, Great Britain, Canada and the United States of America). As an academic discipline, bioethics has entered the international educational standard in philosophical and medical universities. The priority in the philosophical education of medical students is the formation of their creative thinking and scientific outlook in order to become a free and responsible person, able to work constructively in problem situations, combining professional competence with civic responsibility. Currently, Uzbekistan pays special attention to creating conditions for further improving the quality of medical services in all regions of the republic. For implementation of this task, the formation of a bioethical culture of future doctors is relevant. Tasks arising from the resolution of the President of the Republic of Uzbekistan Sh.M. Mirziyoyev dated April 20, 2017, № PD-2909 “On measures for the further development of higher education system” and others № 3151, 2956, 5274 provide for the widespread introduction of programs and teaching materials based on international educational standards into the educational process, which with good reason refers to the course of bioethics. The central issues in the course of bioethics are topics related to the presentation of modern worldview guidelines and humane values of culture, associated with delicate problems that have arisen as a result of a breakthrough in biomedical technologies: problems of life and death, ethical problems of biomedical research on humans, medical genetics and genomic medicine, etc. The discipline "Bioethics" refers to the social and humanitarian cycle, for which it is necessary to master as a previous knowledge in the field: philosophy, history of medicine, religious studies, history of Uzbekistan, jurisprudence, public health and healthcare, clinical genetics and others. Modern biomedical ethics is based on a rich tradition of systematic moral thinking, both philosophical and religious.

Today, in the 21st century, the interaction and synthesis of natural and humanitarian disciplines is of paramount importance in the system of medical and biological education. One of the ways to solve this problem is the development of the basics of biomedical ethics by future specialists.

The development and study of bioethics will help to formulate new ethical postulates, put them forward to the medical and scientific community, and better understand the moral dilemmas that doctors, medical staff and researchers face not only in their daily work, but also in mastering the latest biomedical technologies. It is physicians who first of all face the problems of biomedical technologies and their consequences. The presence of these problems and their solution is directly related to the physical, mental, social and spiritual health of people, the solution of problems is being carried out today and provided for in the priority areas of the Action Strategy for 2017-2021. The search for new value bases of biomedical ethics, such as mercy, charity, consent, solidarity, continues the ancient traditions of the spiritual basis left by the Arabic-speaking scientists of the East and Central Asia.

CHAPTER I. PHILOSOPHICAL FOUNDATIONS OF ETHICS AND BIOETHICS. FROM THE HISTORY OF MEDICAL ETHICS. MAIN MODELS OF DOCTOR AND PATIENT RELATIONSHIPS



“... the doctor-philosopher is equal to God...
everything that is sought for wisdom,
All this is in medicine, namely:
contempt for money, conscientiousness, determination,
knowledge of everything that is useful and necessary for life,
denial of superstitious fear of the gods,
divine superiority."
Hippocrates

“If, after all, there are “two cultures” - *science and the humanities, which seem to be incapable of dialogue. And if this statement is one of the reasons why the future is suspect, then perhaps through this new discipline (bioethics) we will be able to build a bridge that would unite these two cultures* - *a "bridge to the future."*
Potter W.R. Bioethics: a bridge to the future

Key words: *bioethics, soulless, clinical bioethics, Ethical and legal relations "doctor-patient", bioethics appear.*

Today, it is necessary to speak about bioethics as a reality of three types: research direction, a practice of ethical committees, and an academic discipline. The origins of bioethics go back to medicine and biology (the achievements of these areas of scientific knowledge have consequences that go beyond these sciences). Man “creates” not only the world of nature, but also himself, i.e., more and more goes beyond natural processes. Lagging moral principles here is unacceptable and dangerous. A moral assessment and a philosophical reflexive analysis of the consequences of human activity are required. Representatives of various specialties should be capable of it; therefore, bioethics unites physicians, biologists, philosophers, ecologists, jurists, theologians, etc. Essentially, it is clear how great is the role of the ideological, psychological and practical readiness of future specialists in the field of medicine to be included in the process of solving urgent social and medical problems.

BIOETHICS – a necessity of the times in which there is no alternative to the moral attitude to life in general and to a human life itself as the highest value. Today it is known that for medicine and health care good decisions are those based on an ethical imperative. A good medical decision will be tantamount to a good moral one. In this context, the field of bioethical knowledge has emerged as a vital area.

1. Classical sources, examples of medical ethics

Inspired by the ancient heritage of Hippocrates in the field of medical ethics, Ishaq ibn Al-Rukhavi, Ar-Razi, Ibn-Sina, Maymonid created an open system of moral values -Adab al-Tabib. Unlike European neo-hippocratism, the value system of Adab al-Tabib is flexible and multifunctional. It can adapt ancient knowledge to bioethics of the 21st century.

Back in the 9th century, a physician Ishak bin Al-Ruhawi wrote the first treatise on medical ethics, Adab al-Tabib. In this treatise, Ruhavi refers to doctors as "guardians of the soul and body", here he observes and analyzes the deeds and actions of a Muslim doctor. Al-Rukhavi, in his work did a lot for "humanization" of medicine, considering the problems of relationships with patients. He believes that the goal of a doctor is to bring good to humanity: people in general, friends, relatives, and even our enemies. God has taken an oath on doctors not to invent poisons. Al-Ruhawi quotes Aristotle, Socrates, Galen, Hippocrates and supports their ideals, but Adab al-Tabib, first, is a text built on Muslim traditions and beliefs. Adab al-Tabib is not only a guide to professional ethics, but contains important information about personal hygiene, the patient doctor, clarifies the relationship between profession and society.

Medicine is a complex system of natural-scientific and social-humanitarian knowledge about a person and his body, personality, and individuality. This knowledge makes it possible to competently intervene in the psycho-physiological processes of people in order to fight and protect against diseases.

Modern civilization is experiencing an unprecedented anthropological crisis that threatens the existence of life on Earth. This is due to the confrontation and opposition of fundamental universal moral values and the values of science. The "danger of knowledge" possessed by a modern person (biomedical, biochemical, military-industrial, agricultural technologies, etc.) lies in the fact that they allow one to interfere with foundations of life on earth, and the latest computer, television and video technologies change a habitual lifestyle and a way of thinking of a person.

Man is part of the biosphere and a biological being in its origin, but at the same time they are also above a biological being. The biological life of people is more and more subject to social, political, cultural, moral, spiritual needs and interests. STP, a new stage in the development of which is associated with biology, made it possible to study the nature of man in depth, to penetrate the secrets of his life and death. New methods of human reproduction (artificial insemination), prolongation and maintenance of life (artificial heart, kidney) were discovered, it became possible to “repair” the human body by replacing a diseased organ with a donor one (transplantology), etc. Already today, geneticists say, it is technically possible to plan the abilities of an unborn child with the help of biotechnology. This takes the Homo sapiens species out of the tight control of nature. We no longer need natural selection (death) as a factor of adaptation. However, the path of development of modern super industrial civilization has become the path of slow physical and chemical destruction of nature, genetic degeneration of living species, including humanity. Modern society turned out to be intellectually and morally unprepared for the latest discoveries in the field of biology, medicine, genetic engineering, etc. This gave rise to a global anthropological, social and spiritual crisis of mankind. A paradox has arisen, modern science has helped man to achieve unprecedented power in the development of nature, but at the same time, has led to a sharp increase in negative natural factors affecting human life, health and well-being. Society faced questions about the ways of human survival as a biological species and the preservation of the Earth's biosphere.

Today we are forced to adapt to new conditions generated by the global crisis of civilization, in particular the ecological crisis. Biotechnologies come to the rescue, with their help, scientists -

- grow disease-resistant plants, which makes it possible not to use chemical means of protection that are harmful to humans and nature;
- solve the problem of bioprocessing of household waste with the help of microorganisms;

- use special microorganisms, that are able to purify the waters of the oceans from petrochemical products;
- develop cheap protein meals to fight hunger in poor countries;
- develop new technologies for food processing and storage.

Biotechnologies open brilliant prospects in maintaining human health and treating various diseases:

1. Obtaining plant, animal and human proteins necessary to produce a wide range of drugs (insulin, somatotropin, interferon, various vaccines, hybridoma, monoclonal antibodies and many biologically active substances). These medicines are used for selective and highly sensitive diagnostics, prevention and treatment of diseases such as hepatitis B, poliomyelitis, etc.

2. Targeted transport of drugs in the human body. Pharmacologists are striving to develop new ways of introducing drugs into the human body that affect only the affected areas.

3. Diagnosis and subsequent treatment of several hereditary diseases: myopathy, mental disorders, allergic diathesis, blood diseases, severe immunodeficiencies, etc. Gene technology makes it possible to map the human genome and carry out diagnostics using gene probes already in embryos. This allows you to identify more than a dozen serious diseases and accurately determine the nature of the mutation of the corresponding gene. According to doctors, prenatal diagnosis of hereditary diseases is the second cornerstone of preventive activities.

All this makes it possible to expand the adaptive capabilities of a person in the conditions of an ecological crisis. Thus, human health in our time is largely associated with the use of biotechnology. However, new technologies have created new ethical issues that are dangerous to human well-being. What exactly does this mean?

1. The development of scientific knowledge today requires significant costs, which leads to an increase in the cost of qualified medical care. This leads to the fact that obtaining high-quality medical services becomes the privilege of rich people.

2. Advances in transplantation can save many people’s lives. This has created a shortage of donor organs, which makes possible the monetary exploitation of both donors and recipients who donate their organs for money.

3. Biotechnologies make it possible to expand and reduce the cost of production of medicines for the treatment of rare diseases. However,

pharmaceutical companies, due to commercial calculation, either do not produce them or artificially maintain high prices. The incidents about violation of the rights of subjects in clinical trials of new drug have been reported.

4. The use of modern diagnostic methods helps to identify people suffering from rare and congenital genetic diseases. But information about such diseases can be used for discriminatory purposes: dismissal from work, denial of insurance, causing moral damage. Some members of society are seen as undesirable or unattractive and therefore rejected as romantic partners or parents. Nevertheless, these people can be helped to have a family with artificial reproduction (ECO, surrogate motherhood, cloning). But these methods violate the self-determination of the child's personality.

5. Demographic problem.

1) With the help of hormonal contraceptives, it is possible to maintain birthcontrol, which reduces the number of abortions and social orphans. Against the background of artificially prolonging the life of the elderly with the help of the latest drugs and new methods of treatment, it has led to the aging of human populations in economically prosperous countries.

2) The development of preventive medicine saves many lives. Vaccination against malaria on the African continent in the 1960s led to an impressive reduction in child mortality.

6. A person from birth to death, due to his biosocial nature, is under control of physicians. This allows early detection of diseases and their treatment. But this led to a restriction of the right of a person to dispose of his body and make decisions regarding his life and death.

7. The introduction of new technologies in medicine and pharmacy has changed the traditional understanding of life and death - their beginning and end. This gave rise to the problem of the rights of unborn children to life, euthanasia, life support with the help of artificial life support devices.

For a long time, doctors often did not even suspect these consequences, and when they encountered them, they did not know how to avoid them. All moral and legal problems that arose during their professional activities were discussed behind closed doors. Medical errors were hidden from the public. Medicine more and more lost its humanistic content: technically it became more perfect, but at the same time more “soulless”. Technocratic thinking in medicine (orientation to technique and technology) has traditionally created a crisis and medical ethics. Its principles and rules have lost their function - the regulation of medical and pharmaceutical practice from a position of goodness and justice. Thus, the new possibilities of medicine and pharmacy related to treatment, management of human life, psyche, consciousness and activity came into conflict with the existing traditional moral values and principles. This has led to the fact that people's trust in medicine in general has been undermined. Important questions arose before society:

1. Does modern science comply with the principles of respect for the human person?

2. How to relate to the already accumulated biomedical knowledge, if they can be used both for good and for evil to a person? Should scientific research be further developed and are there ethical limits to scientific research?

3. What is the role of the scientist, who often has no control over his discoveries, and the physician, who uses new methods of intervention in the human body?

In response to the threats to the moral and physical well-being of a person, generated by rapid scientific and technological progress, a new cultural phenomenon has arisen - bioethics, in order to protect fundamental moral values.

Conclusion: the formation and development of bioethics is due to the following reasons:

1. Massive introduction of new biomedical technologies into everyday practice, and the moral, ethical and legal issues that arise in connection with this.
2. Technological re-equipment of modern medicine.
3. Non-traditional methods of intervention in the human body.
4. Transformation of traditional ethics in the context of scientific and technological progress.
5. A new understanding of the relationship between doctor and patient.

The solution of moral dilemmas in the modern conditions of the development of biomedical technologies required new approaches that consider the autonomy of the patient's personality, informed consent and other principles of bioethics. Bioethics proceeds from the notion of the insufficiency of a one-sided medical interpretation of physical and mental well-being as the goal of healing. An urgent need is an interdisciplinary dialogue of physicians with representatives of a wide range of humanities, a dialogue with patients and members of the public. Only in this way can the multifaceted nature of human suffering be adequately expressed and understood, and on this basis the modern regulative idea of the good can be developed both as the goal of healing for an individual and as a goal of public health in general.

A great contribution to the development of theoretical problems of bioethics was made by American scientists: Tom L. Beauchamp[1], Ruth R. Faden[2], Robert Veatch[3], Daniel Callahan[4], Edmund D. Pellegrino[5], Ph.D. Le Roy Walters and others. Robert Veatch, in The Theory of Medical Ethics (Theory of Medical Ethics, DALWKK W 50 V395t 1981) proposes a new contract between medicine and society. This "contract" includes the basic ethical principles for society, a contract between professionals and lawyers based on the rights and prerogatives of each. Another American scientist Daniel Callahan[6] suggests that "the first task of bioethics...is to help clarify what needs to be proven... points to such concepts as "informed consent", "brain death" and other concepts that are currently recognized and widely used in international bioethical practice. The development of bioethics is the call of the times, meeting the actual problems of the humanization of education, its focus on a new holistic worldview, new worldview guidelines and upbringing of a humanistic style of thinking. Bioethics contributes to these global

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[1] Tom L. Beauchamp Principles of Biomedical Ethics.Tom L. Beauchamp - 1979 - Oxford University Press.

[2] Ruth R. Faden, Tom L. Beauchamp, Nancy M. P. KingA History and Theory of Informed Consent 1986. Ruth R. Faden is an American scientist, academic, and founder of the Johns Hopkins Berman Institute for Bioethics. Faden is Philip Franklin Wagley's first professor of biomedical ethics.

[3] Vitch R. Models of moral medicine in the era of revolutionary changes // Questions of Philosophy. 1994. No. 3. S. 67-72.

[4] Daniel John Callahan was an American philosopher who played a leading role in the development of the field of biomedical ethics as co-founder of the Hastings Center, the world's first bioethical research institute.

[5] Edmund D. Pellegrino Pellegrino ED. Percival's medical ethics: the moral philosophy of an 18th-century English gentleman. Arch Intern Med. 1986;146:2265–9. Pellegrino ED. Humanism and the Physician. Knoxville, TN: University of Tennessee Press; 1979. Educating the humanist physician; p. 164

[6] Encyclopedia Bioethics, 1995, p. 254

processes. The rapid development of bioethics is due to both objective and subjective reasons.

Objective:

1. Progress in the field of biological and medical research.

2. Scientific and technological development, technical unification, computer and information boom.

All this made it possible to carry out the technological re-equipment of the material base of the biological and medical sciences.

3. Cardinal changes in medical and clinical practice and the value-loading of knowledge, which caused the complication of the decision-making situation and the resolution of moral and legal problems that arise both for medical personnel and for representatives of other professions.

Subjective:

1. Increasing the role of man as a “measure” and as a creator, improving the quality and normative-valued certainty of human life, aiming at empowerment of human rights and increasing the moral responsibility of the individual as a citizen and professional.

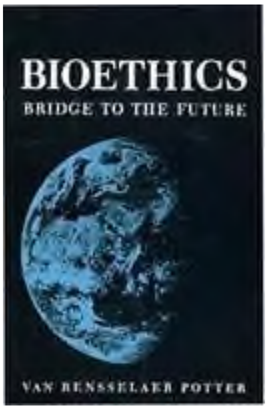
2. Globalization of world processes, consistently leading to enhanced dialogue between cultures, professions and people.

2. Bioethics as an academic discipline, its content, purpose and objectives

Bioethics appeared in the early 1970s and was a kind of "cry for help" from people who found themselves in the face of the risks and negative consequences of biomedical technologies. It arose as a response to technological challenges in medicine, as an intuitive feeling that the long-term survival of mankind as a species in a normal and sustainable civilization is possible only with the development of new ethics.

What is bioethics? The term "bioethics" consists of two words: “bio” – “life”. “ethics” is the philosophical science of morality - the system of values that guide people. Traditionally, ethics is interpreted as a humane philosophy and is regarded as one of the manifestations of philanthropy. Therefore, bioethics is the ethics of life.

Bioethics in the broad sense of the word is a field of interdisciplinary research, public discussions and political decisions related to understanding, discussing and resolving various moral problems that are generated by the latest achievements in biomedical science and healthcare practice. According to the American philosopher A Jonsen, the birth of bioethics can be dated to 1961 - the beginning of public discussions around the activities of the ethics committee at the Artificial Kidney Center in Seattle. However, the term "bioethics" itself entered scientific circulation in the United States in the 1970s. It was originally proposed by the American oncologist Van Rensselaer Potter in his book "Bioethics is a Bridge to the Future" (1971) to designate a special version of environmental ethics[1]. Potter's main idea boiled down to the need to combine the efforts of the humanities and biological sciences to solve the problems of preserving life on earth, considering the long-term consequences of scientific and technological progress (especially in the field of biomedical technologies). A new impetus to the development of bioethics was given by the work of American obstetrician and embryologist Andre Hellegers, an american doctor. (1926-1979). It was he who began to use the term "bioethics" to refer to interdisciplinary studies of moral problems of biomedicine, primarily related to the need to protect the dignity and rights of patients. A. Hellegers presented bioethics as a new way of understanding and resolving those moral conflicts that high-tech medicine generates. It was Hellegers who gave bioethics an academic status and promoted its recognition in the biomedical sciences, politics and the media. Hellegers founded Kennedy Institute of Ethics in 1971 and created the first courses in bioethics for physicians, philosophers, and other professionals. Since that time, bioethics has been rapidly developing in the United States as an interdisciplinary field of knowledge, then spreading in Western Europe and around the world. Today, it has all the features of an established and rapidly developing scientific discipline. Many books and textbooks are published, and there are departments of bioethics in universities and medical colleges, symposiums and conferences are organized (World Congresses on Bioethics have become regular), new national and international bioethical organizations are being created. Bioethics is changing the nature of scientific activity, forming new social institutions - ethical committees.



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[1] Pustovit S.V. Global Bioethics: Formation of Theory and Practice (Philosophical Analysis). - Kyiv: Arcturus - A, 2009. - 324 p.

Bioethics is seen by Potter as a "new discipline" that will bridge the gap between biology and ethics in order to solve the long-term problem of human survival as a species while ensuring a decent quality of life. Bioethics will become the science of survival. “The science of survival should not be just a science, but a new wisdom that would combine the two most important and urgently needed elements - biological knowledge and universal human values” (VR Potter).

Today, bioethics is not just a new field of knowledge, it is a field of public dialogue, which is designed to ensure the alignment of interests of science with interests of man.

Bioethics is a multidisciplinary field of knowledge that arises at the intersection of philosophy, law, medicine, sociology, political science, demography, cultural studies, and religious studies. It explores moral aspects of a person's attitude to life and death and includes the widest range of socio-economic, moral, ethical and legal problems of modern medicine. In this sense, bioethics is a concept of the moral foundations of protecting a person and the health of the population, protecting the quality of life, the physical and mental integrity of a person and human dignity. It studies the contradiction between the interests of people, as well as their communities in the field of health, and the achievements of biology, medicine and pharmacy, which can directly or indirectly damage health and quality of life.

Today, it is necessary to speak about bioethics as a reality of three types: research direction, the practice of ethical committees, and an academic discipline (only in medical universities). The origins of bioethics go to medicine and biology (the achievements of these areas of scientific knowledge have consequences that go beyond these sciences). Man “creates” not only the world of nature, but also himself, i.e., more and more goes beyond natural processes. Lagging moral principles here is unacceptable and dangerous. A moral assessment and a philosophical reflexive analysis of the consequences of human activity are required. Representatives of various specialties should be capable of it; therefore, bioethics unites physicians, biologists, philosophers, ecologists, jurists, theologians, etc. Hence it is clear how great the role of the worldview, psychological and practical readiness of future specialists in the field of medicine is to be included in the process of solving urgent social and medical problems. BIOETHICS is the requirement of time in which there is no alternative to the moral attitude to life in general, to human life as the highest value.

Bioethics cannot be called a separate science, because it cannot be approached with the standards of traditional science, when science has its own subject and its own theory. Bioethics is a multidisciplinary science.

The object of bioethics is life in general, human life, as the highest value. The above cannot be covered separately by any science, even philosophy will not go beyond general conclusions and abstractions if it is “torn off” from biological, medical, and environmental knowledge. It is impossible to clearly attribute bioethics to the humanities or to the natural sciences. Bioethics as an academic discipline is an integrated knowledge, a synthesis of the philosophical foundations of bioethics, biological, medical, environmental and deontological knowledge. For example, bioethics in its philosophical part covers problems ranging from responsibility for the living to the biological, environmental and medical literacy of an individual regarding himself. As for the philosophical foundations of bioethics, due to the integration of environmental, biomedical, deontological knowledge, the philosophical part of the discipline, through the doctrine of the duty of a person in a particular profession, will bring problems to the worldview level.

The main idea of bioethics is that universal human values should not be considered separately from biological facts. Man is a part of nature, they need healthy food, fresh air, clean water, wilds of nature, they cannot exist without animals, plants, rivers and soil, which are not only environmental resources, but also the main condition for the survival of mankind. The goal of bioethics is a development of moral standards, requirements and principles, other mechanisms that ensure the use of scientific and technological achievements only for the benefit of man and nature. So, bioethics includes several closely related forms of activity.

Firstly, it is a multidisciplinary field of study of the conditions and consequences of scientific and technological progress in biomedicine. The problems facing mankind are studied by doctors, biologists, philosophers, theologians, lawyers, psychologists, political scientists and representatives of other spheres.

Secondly, it is a sphere of academic and educational activity.

Thirdly, it is a rapidly developing social institution. It includes a complex system of international (at the level of the UN, UNESCO, WHO, Council of Europe, etc.), national (in the system of govenment and professional organizations), regional and local (in the structures of research and practical organizations) ethical committees. Bioethics in a certain aspect is a part of the human rights movement in the field of health.

The UNESCO Charter defines the structure of bioethics:

1) theoretical and philosophical bioethics (philosophical aspects of biological, medical, pharmaceutical and veterinary sciences; bioethics in various sociocultural contexts; history of bioethics).

2) Biomedical ethics (clinical bioethics).

3) Pharmaceutical bioethics.

4) Bioethics of creation and clinical trials of drugs.

Bioethics deals with the analysis of human actions in biology and medicine in the light of moral values, therefore the content of bioethics includes:

1. Search for dialogue and solidarity of citizens in protecting good and opposing it to evil in situations generated by STP in the field of medicine.
2. Axiological problems of modern medicine.
3. Ethical attitude towards life and death.
4. Ethical and legal relations "doctor-patient".
5. The moral attitude of man to all living things.

The purpose of bioethics: the search for moral and legal solutions to non-traditional medical and biological situations related to the beginning and end of life and interference in human life. The task of bioethics: the development of the theory of legal protection of the individual and its real implementation in practice.

Based on the content, goals and objectives of bioethics, we see that this is not just a new section of professional medical ethics. This phenomenon is deeper due to the coverage of broad moral, ethical, legal, medical, philosophical and religious problems of modern medicine. All these problems become a whole by a new understanding of human rights within the framework of biomedicine, a moral attitude to life and death, to all living standards.

The main problems of bioethics:

- protecting patients' rights (including those infected with HIV, psychiatric patients, children and other patients with limited competence);
- equity in healthcare;
- relationship with wildlife (environmental aspects of the development of biomedical technologies);
- abortion, contraception and new reproductive technologies (artificial insemination, in vitro fertilization with subsequent implantation of the embryo into the uterus, surrogate motherhood);
- conducting experiments on humans and animals;
- development of criteria for diagnosing death (new understanding of life and death);
- transplantology;
- modern genetics (gene diagnostics, gene therapy and engineering);
- manipulations with stem cells;
- cloning (therapeutic and reproductive);
- care for dying patients (hospices and palliative care organizations);
- suicide and euthanasia (passive or active, voluntary or forced).

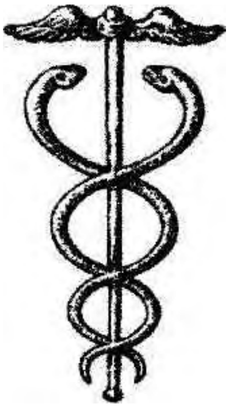
All these problems in one way or another affect the interests of each person and require new philosophical, legal and medical understanding and solution. A minimum of knowledge in the field of bioethics is necessary for every person, because the whole life of people from birth to death is under the close attention of medicine.

Bioethics, biomedical ethics, medical ethics.

Bioethics is a multidisciplinary science, the core of which is the attitude to life and death. Its starting point is the latest achievements in biology and biomedicine.

Biomedical ethics is applied medical ethics, an integral part of bioethics, which solves private ethical problems of biomedicine. BME is distinguished by the dynamics of its problematics, moving from an empirical description of medical morality problems to a philosophical understanding of morality in the light of biomedical research and manipulation.

In the historical aspect, medical ethics exists in four main models:



1) ***Hippocratic model*** (“The Oath”, “On the Law”, etc.). The main ethical requirement formulated by Hippocrates is the “do no harm” principle, the moral essence of which is a fundamental medical guarantee for the protection of human life. The following provisions follow from this:

a) any action of the doctor must be for the benefit of the patient;

b) maintaining medical secrecy;

c) respect for human life.

Hippocrates laid the foundation for paternalism in medicine.

2) ***Paracelsian model*** defines moral attitude of a doctor to a patient from the standpoint of the principle "do good". Such ethical principles as humanism, mercy, and beneficence come to the fore. Paracelsus considered the goal of healing as a creation of love for one's neighbor. Love is the basis of medicine, the power of the doctor is in his heart, healing must be guided by God and supported by the experience of a physician. Paracelsus gave rise to suggestive therapy as an effective component of treatment. He attached particular importance to a patient’s faith in the doctor.

3) ***Deontological model of ME*** takes shape in the late 18th - early 19th centuries. This model assumes moral impeccability in the behavior of the physician. The deontological model is a set of mandatory rules in the system of relationships between a physician and a patient, his relatives, colleagues and administration. The basis of this model is the principle of "observance of duty”; therefore, the morality and professionalism of a doctor are the readiness and ability to fulfill moral requirements that society imposes on them. To date, there are moral rules of conduct for each specialty. Medical deontology plays a special role in the nursing process. This is because, on the one hand, the nurse is a doctor's assistant (subordinate position), and, on the other hand, independently determines the needs of the patient and the course of nursing care. This puts her in an ambivalent position, which requires from her not only ethical behavior, but a great culture in general. The Soviet surgeon N. Petrov said that a good nurse should be valued and

respected, but not all doctors understand this. The highest moral duty of a nurse is selfless service to people, which is inseparable from high spirituality and a sensitive heart.

4) ***Biomedical model*** is based on the principle of respect for human rights and dignity. This implies a change in the essence of the relationship between the doctor and the patient. And above all, overcoming paternalism in medicine and introducing new models of relationships based on the autonomy of the patient and respect for his rights (informational, collegial, deliberative models). The main principles of BM model are patient autonomy, informed consent, “do no harm”, confidentiality and truthfulness.

Historical analysis of the ethics of healing shows that with the change in society, there is a transformation of moral principles in medicine. Scientific knowledge, humanistic morality and all the moral achievements of ME from Hippocrates to the present-day merge in BME.

As a socio-cultural phenomenon, BME is aimed at mutual enrichment, mutual complementation of legal and moral consciousness, setting ethical and legal guidelines for biology and medicine in general and medical teams in particular. This is due to the increased public interest in human rights in the field of modern medicine. The right of a person to protect his health, well-being and life determines today the ethical and legal problems in the field of practical medicine and pharmacy. Therefore, a fundamental problem of BME is the protection of human (patient) rights during medical and biological exposure and manipulation. This gave impetus to the development of medical law - a set of laws governing medical and pharmaceutical science and practice, as well as research in the field of biology.

In the twentieth century, medical activity is regulated by two forms of social regulation - morality and law. The fundamental difference between the legal regulation of human relations and the moral one is that the legal regulation is implemented through laws, government decrees, and court decisions. The coercive nature of the law remains, even though in Soviet times all these problems somehow affect the interests of each person and require a new philosophical, legal and medical understanding and solution. A minimum of knowledge in the field of bioethics is necessary for every person, because the whole life of people from birth to death is under the close attention of medicine[1].

Historical analysis of the ethics of healing shows that with the change in society, there is a transformation of moral principles in medicine. Scientific knowledge, humanistic morality and all the moral achievements of the ME from Hippocrates to the present-day merge in the BME.

UNESCO has two committees on bioethics - international and intergovernmental. In the Council of Europe, Bioethics Committee deals with this topic. There is also a working group on bioethics within WHO. Ethical and legal regulation in the field of Bioethics is carried out based on international normative documents. The most important of them:

- Universal Declaration on the Human Genome and Human Rights (UNESCO, 1997);
- Universal Declaration on Bioethics and Human Rights (UNESCO, 2005);
- Declaration on Human Cloning (UN, 2005);
- Convention on Human Rights and Biomedicine (Council of Europe, 1997) and additional protocols to it concerning the prohibition of human cloning, transplantation, biomedical research.
- Helsinki Declaration of the World Medical Organization (1964, last revised 2013) "Ethical Principles for Medical Research Involving Human Beings".

Bioethics has acquired a global character - bioethics conferences are held in all parts of the world; bioethics problems affect all people. On September 15-16, 2005, the 1st National Congress on Bioethics with international participation was held in Tashkent (in Charvak), and similar conferences were held in 2006 and 2007 in Tashkent.

In many countries of the world, quite influential national ethics committees or commissions operate under legislative or executive authorities. The first national ethics committee in Uzbekistan was organized under the Ministry of Health of the Republic of Uzbekistan in 2000, it was headed by Academician M.S. Abdullakhodzhaeva.

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[1] Mukhamedova Z.M. The role of bioethical committees in ensuring guarantees of social protection and health security in Uzbekistan. Bulletin of the Association of Doctors of Uzbekistan No. 2 2014 T. S. 96-100

Ethical committees prepare decisions on the most acute and topical problems of bioethics, over which the interests of different social, religious, ethnic, gender, age and other groups of the population collide.

Questions for self-examination

1. What is bioethics?
2. When did bioethics appear and why?
3. What are the goals and objectives of bioethics?
5. In the scientific community, there is a strong opinion that “medical students and doctors are often interested in the interpretation of bioethical problems from the perspective of a clinician, and a clearly defined professional orientation. Express and justify your opinion on this issue.

Bibliography

1. Tom L. Beauchamp Principles of Biomedical Ethics.Tom L. Beauchamp - 1979 - Oxford University Press.
2. Ruth R. Faden , Tom L. Beauchamp , Nancy M. P. KingA History and Theory of Informed Consent_ 1986
3. Robert M Veatch- - Theory of the Medical Ethics, DALWKK W 50 V395t 1981; 1994. № 3. p. 67-72.
4. Daniel Callahan. Bioethics. In: Encyclopedia of bioethics. Vol. 1. Ed. W.Th. Reich. N.Y. 1995; 247–248
5. Edmund D. Pellegrino Pellegrino ED. Percival's medical ethics: the moral philosophy of an 18th-century English gentleman. Arch Intern Med. 1986;146:2265–9. Pellegrino ED. Humanism and the Physician. Knoxville, TN: University of Tennessee Press; 1979. Educating the humanist physician; p. 164
6. Ph.D.Le Roy Walters - The Ethics of Human Gene Therapy Hardcover – October 1, 1996
7. Encyclopedia Bioethics, 1995.
8. Van Rensselaer Potter Bioethics: Bridge to the Future Paperback –Prentice-Hall; © 1971, 205 pages; Potter, Van Rensselaer, Global bioelhics. Michigan State University Press Cupyright © 1988
9. Pustovit S.V. Global Bioethics: Formation of Theory and Practice (Philosophical Analysis). - Kiev: Arcturus - A, 2009. - p.324

10. Hellegers A. Bioethics center formed. Chemical and engineering news. 1971; (11)
11. Bioethics. Textbook (russion)/ Z.M. Muxamedova, J.A. Rizayev, A.N. Maxmudova. Tashkent: Mohirbek Ziyo, 2021. – 344 p
12. Universal Declaration on Human Genome and Human Rights (UNESCO, 1997);
13. Universal Declaration on Bioethics and Human Rights (UNESCO, 2005);
14. Declaration on Human Cloning (UN, 2005);
15. Convention on Human Rights and Biomedicine (Council of Europe, 1997) and additional protocols to it concerning the prohibition of human cloning, transplantation, biomedical research.
16. Declaration of Helsinki by the World Medical Organization (1964, last revised 2013) "Ethical Principles for Medical Research Involving Human Beings".

CHAPTER II. MORAL ESSENCE OF INTERPERSONAL COMMUNICATION IN MEDICINE. CULTURE OF DOCTOR COMMUNICATION

“Who advances in the sciences, but lags behind in morality,
he goes more backward than forward.
Aristotle

Key words: *morality, medical ethics, moral conflicts, culture of doctor communication, professional solidarity.*

The expressions "bioethics", "biomedical ethics" include the term "ethics" as their constituent part. In the strict sense of the word, "ethics" is a philosophical discipline that studies the phenomena of morality and ethics.

In the original meaning, "ethics", "morality” are different words, but one term. Over time, the situation has changed. In the process of cultural development as the identity of ethics as a field of knowledge is revealed, different meanings begin to be assigned to different words: ethics mainly means the corresponding branch of knowledge, science, and morality («нравственность») - the subject studied by it[1]. There are also various attempts to breed the concepts of morality and ethics. According to the most common of them, dating back to G. Hegel, morality is understood as the subjective aspect of the corresponding actions, and morality is the actions themselves in their objectively expanded completeness: morality is how actions are seen by an individual in his subjective assessments, intentions, feelings of guilt, and morality is what a person's actions actually are in the real experience of the life of a family, people, government[2]. One can also single out a cultural and linguistic tradition,

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[1] Ethics” is a science, a field of knowledge, and “morality” or “нравственность”(in Russian) are studied by ethics, this is its subject. Morality is realized in the sphere of due, i.e. in the sphere of norms, principles, assessments, values, designed to ensure the harmonious development of society in certain historical periods. «Нравственность», on the other hand, characterizes existence. It is associated with social relations, communication, activities and manifests itself in the course of moral choice through actions."

[2] Hegel G.V. F. Huquq falsafasi. M.: Mysl, 1990

which understands morality as high fundamental principles, and morality as mundane, historically changeable norms of behavior; in this case, for example, the commandments of God are called moral, and the instructions of a schoolteacher are called moral.

1. Within the framework of the academic discipline, "ethics" we will call science, a field of knowledge, an intellectual tradition, and "morality”, - what is studied by ethics, its subject. Discussion of the problems of ethics, modern morals is now relevant and popular as never before. The division of ethics - the doctrine of morality and morality, into two levels - philosophical - theoretical (explains and clarifies) and normative (teaches and educates) - is didactically justified. It is also justified to isolate the ideological component (“practice of morality”) and descriptive moments. These are the functions of ethics: cognitive, educational, worldview. It is customary to distinguish between ethics and applied ethics. Any system of knowledge has a similar structure, for example, mathematics, mechanics, etc. Ethics does not have an empirical base, however, it solves the actual problems of the real life process, seeks a solution to complex ethical situations. Medical ethics, ethics of the pedagogical process, business ethics, ethics of science, etc. represent not so much a system of theoretical abstract judgments as a set of norms and ideals of a particular field of activity - what is called ethos (in medical practice, education, entrepreneurship, scientific research, etc.). Ethos also includes a set of specified rules of behavior. It so happened that instead of the term "ethos" the more familiar term "ethics" is used. Morality is above norms and requirements - this is a person's self-development through the search for truth, knowledge of oneself and the world. Knowledge of the world, its values is not an end, and it is not necessary in itself. The words “the highest art is an impeccable life”, which are attributed to Socrates, most fully reflect the purpose of ethics - to help a person live his life with dignity. The time has come to analyze the results of the past 20th century. Mankind has begun to think more philosophically, for the world has become tensely contradictory. The outgoing century has ceased to laugh at the philosophical questions about the essence of man, the meaning of life, so important to the thinkers of the past. They are important again. The dynamism of life, the global problems of our time, profound changes in international relations - all this increases attention to spiritual values, because they are eternal. The decisive principle was found by A. Schweitzer, the great humanist

of the twentieth century. He wrote: “During my work, I understood for myself the connection between culture and worldview. I realized that the catastrophe of culture is a consequence of the catastrophe of the worldview. Culture is a spiritual and material progress in all areas, which is accompanied by the moral development of man and mankind... the position in which he found himself as a result of this was proof of his error[1]. We emphasize that bioethics is a worldview, it is a moral philosophy that cannot be limited to purely medical problems. Who, if not doctors, should know what role psychological balance, harmony, lack of fear of life, understanding that death is inevitable play for the recovery of a sick person and for the well-being of a healthy person. Philosophy cannot say anything comforting today to a person regarding the security of life. After all, humanity is already living in a global environmental crisis. Will humanity be able to stop it? Spirituality, reliance on all manifestations of wisdom and morality - only this will give us at least some kind of stability. Unfortunately, in medicine there are such specialists who have a good command of medical equipment, but, pointing a finger at the display, relieve themselves of the responsibility to treat with a word, with their sincerity. Spirituality does not come from nowhere on its own. You must aspire to it and aspire yourself. So, when students comprehend the category of “duty”, it is necessary to emphasize the personal moment, that is, to say that the doctor does not always treat (and therefore has great power over people), but he himself can be a patient, and that then his own recovery will depend on other doctors. He will wait for the duty of another physician to himself. Essentially, we are united in this life, and the harsh words: “Today you are a doctor, and tomorrow you are a patient” will have to be voiced by the students. As you know, medicine is a process based on several sciences, but even in this case, medicine cannot stand exclusively on the firm path of science. It is impossible to discount what is called the "fire of the heart", the "state of the soul", what is not defined by science, but affects people. After all, it is a doctor who pastulates: to treat not the disease, but the patient. Experience and

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[1] Albert Schweitzer, "Kultur und ethik". Munchen 1960
("Reverence for life.") For scientific libraries
Translation from German by N. A. Zakharchenko and G. V. Kolshansky
General edition and foreword by prof. V. A. Karpushina
Publishing house "PROGRESS" Moscow 1973.

knowledge in this case are only part of the treatment. In the person of a doctor and a patient, two worldviews, two "models of the world" meet. The basis of successful interaction, in addition to high professionalism on the part of the doctor, will be what is called mercy, compassion, sympathy, trust, hope for good, i.e., all that is denoted by the word morality. The doctor always influences the soul of the patient. The doctor even heals the soul. And this even though so far there is no clear scientific explanation of what the soul is. So how does the doctor treat him/her? In addition to professional methods, with his soul, sincerity, empathy. Then this treatment is successful. Here there is a way out of the limits of only the material, since here there is a place for what touches, excites a person. Conclusion: no matter what bioethical problem we approach, morality is present everywhere, i.e., conscience, honor, duty. And this is something that cannot be “weighed”, “measured”. Therefore, bioethics strives to link medicine with other areas of culture, to rely on spirituality in all its manifestations.

2. Each historically specific society requires a strictly defined measure of social regulation of social relations. The regulation of social relations is carried out through the implementation of certain social norms: legal and moral norms, norms established by public organizations, norms of customs, traditions, rituals, etc. A special place in the formation of the spiritual world of the individual, their consciousness and culture, an active life position, belongs to law and morality, which are the most important social regulators included in the system of social relations, purposefully interacting to transform the consciousness of the individual. In regulating social relations, law interacts with other social norms, and, above all, with moral norms (ethical norms).

Morality is one of the ways to regulate human behavior in society with the help of rules. Morality is a well-known set of historically emerging and developing life principles, views, beliefs and norms of behavior based on them, which determine and regulate the relationship of people to each other, society, state, family, team, class, surrounding reality. This concept also includes psychological aspects: emotions, interests, motives, attitudes and other terms. The central place is occupied by the concept of good and evil. The conditions of normal life of people, requiring responsibility of a person for their behavior, are expressed, first, in morality and only then are perceived by the government in a “morally developed” form, as a result of which a “forensic part” of legal matter is formed - criminal law and legal divisions adjacent to it (including correctional, penitentiary law).

Man is a social being. Therefore, an indispensable condition for "admission" to the life of society is the process of socialization of the individual, i.e., the development of a specifically human way of life, the basic values of material and spiritual culture. And secondly, because modern industrial society relies on the broadest division of labor (material and spiritual), which gives rise to the closest interdependence of people. After all, the most ordinary, normal existence of each of us turns out to be dependent on how hundreds and thousands of people completely unfamiliar to us (manufacturers of goods, their sellers, transport workers, teachers, doctors, military men, etc.) perform their usual, routine work.

Morality is usually understood as a certain system of norms, rules, assessments that regulate communication and behavior of people in order to achieve unity of public and personal interests. A certain stereotype, template, algorithm of human behavior is expressed in the moral consciousness, which is recognized by society as optimal at this historical moment. The existence of morality can be interpreted as the recognition by society of the simple fact that the life and interests of an individual are guaranteed only if the strong unity of society as a whole is ensured.

Of course, when committing a moral or immoral act, an individual rarely thinks about "society as a whole." But in moral regulations, as ready-made patterns of behavior, public interests are already provided for. Of course, one should not think that these interests are deliberately calculated by someone and then formalized into moral codes. Norms and rules of morality are formed in a natural-historical way, for the most part spontaneously. They arise from many years of mass everyday practice of human behavior.

Moral requirements for an individual in moral consciousness take a wide variety of forms: these can be direct norms of behavior (“do not lie”, “honor elders”, etc.), various moral values (justice, humanism, honesty, modesty, etc.), value orientations, as well as moral and psychological mechanisms of self-control of the individual (duty, conscience). All these are elements of the structure of moral consciousness, which has a number of features. Among them it is worth noting: the comprehensive nature of morality, its non-institutional nature, imperativeness.

The comprehensive nature of morality means that moral requirements and assessments penetrate all spheres of human life and activity. Any political declaration will not miss an opportunity to appeal to moral values, any work of belles-lettres necessarily contains a moral assessment, no religious system will find followers if it does not include sufficiently strict morality, etc. Any everyday situation has its own “moral slice”, which allows you to check the actions of the participants for “humanity”.

The non-institutional nature of morality means that, unlike other manifestations of the spiritual life of society (science, art, religion), it is not a sphere of organized human activity. Simply put, there are no such institutions and organizations in society that would ensure the functioning and development of morality. The third feature of morality - imperativeness - consists in the fact that most moral requirements do not appeal to external expediency (act this is how you will achieve success or happiness), but to moral duty (do this because your duty requires it), that is, it takes the form of an imperative, a direct and unconditional command. Moreover, good should be done not for the sake of reciprocal gratitude, but for the sake of good itself as such. In this call, I think, there is a completely rational meaning - after all, the overall balance of the good done and the rewards for it is reduced only at the level of society.

Among the many functions performed by morality, the main ones are considered to be regulatory, evaluative-imperative, cognitive. The main function of morality is, of course, regulative. Morality acts primarily as a way of regulating the behavior of people in society and self-regulating the behavior of an individual who has the opportunity to prefer one act to another. The moral method of regulation, unlike others (legal, administrative, etc.), is unique. Firstly, because it does not need any institutions, punitive bodies, etc. Secondly, moral regulation involves the assimilation by individuals of the relevant norms and principles of behavior in society. In other words, the effectiveness of moral requirements is determined by the inner conviction of the individual. Such a regulator of behavior is certainly the most reliable of all possible. The only problem is how to form it. So far, few have succeeded.

The essence of morality is no less clearly manifested in its other function - evaluative-imperative. It provides for the division of all social phenomena into "good" and "evil".

Highest moral values in medicine.

The moral foundations of healing have become universal moral values, principles and norms. The highest moral values that set the most general guidelines for the medical profession include kindness, compassion, mercy, freedom, duty, conscience, justice, etc. In the context of bioethical knowledge, life as a value and goal of healing is of particular importance.

Goodness and evil are the central categories of ethical knowledge. They act as criteria for distinguishing between moral and immoral in any human activity, including medicine. The concept of good reflects the most generalized and stable ideas about the good and actions of a person, which involve spiritual exaltation and moral perfection. In medicine, in its most general form, kindness directs the doctor to save the life and health of a person. Being the highest value and moral guideline, goodness is absolute and unified. In real life, good is realized in a variety of actions and manifests itself through the struggle against evil and vice.

In modern medical practice, there are often situations of moral choice between good and evil, "lesser" and "greater" evil. The implementation of a moral choice is impossible outside of moral freedom - the ability of a person to self-determination, autonomy and will. In medicine, the doctor's moral freedom gives him the opportunity to take decisive action aimed at helping the patient, to discover and apply new knowledge and methods in medicine, to give a moral assessment to his actions, etc. The realization of freedom is closely connected with moral responsibility, i.e., the ability of a person to be responsible for actions and deeds.

The doctor, as a rule, deals with a patient who, due to his condition, is experiencing physical or mental suffering. Therefore, the values of compassion and mercy, which involve sympathy, empathy for another person, combined with a desire to help him, benevolence, care, and love for one's neighbor, are of particular importance in the medical profession. They are opposed to indifference, hardness of heart, malice, hostility, violence.

Moral conflicts in modern healthcare.

Professional conflicts in the healthcare sector have the same structure, phases and functions as other conflicts. But, nevertheless, conflicts in health care have their own characteristics associated with the specifics of the activity and personal characteristics of people working in medicine.

There are five levels of conflict in the organization: within the individual, between individuals, within the group, between groups, within the organization. These levels are closely related. For example, intrapersonal conflict can cause an individual to act aggressively towards others and thus cause interpersonal conflict.

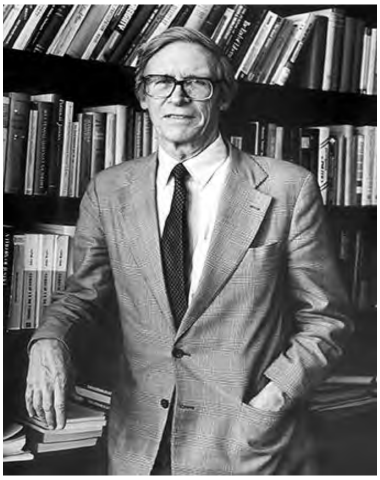
Intrapersonal conflict occurs within an individual and is often a conflict of goals or a conflict of views. It becomes a conflict of goals when an individual chooses and tries to achieve mutually exclusive goals. Intrapersonal conflict becomes a conflict of views when an individual recognizes the failure of his thoughts, dispositions, values, or his behavior in general.

Interpersonal conflict involves two or more individuals if they perceive themselves as being in opposition to each other in terms of goals, dispositions, values, or behavior. Another form of interpersonal conflict is the collision of individuals with different character traits, temperament, value orientations, which, due to opposite goals, are not able to get along with each other. The emergence is determined by the personal originality of the members of the team, the attitude of the individual to the situation, the psychological characteristics of the members of the team, the labor process and the production situation.

Intra-group conflict is not just the sum of interpersonal conflicts, but a clash between parts or all members of the group that affects group dynamics and the results of the group as a whole. Production, social and emotional processes within the group influence the emergence of causes and ways to resolve intra-group conflicts. Often, an intra-group conflict arises as a result of a change in the balance of power in a group: a change in leadership, the emergence of an informal leader, the development of grouping.

Intergroup conflict is a confrontation or clash between two or more groups in an organization. Such a confrontation can be professional, industrial, social or emotional. Usually, such conflicts are of an intense nature and, if they are not properly managed, do not give any of the groups a gain. The transition of an intergroup conflict to an emotional stage has a destructive effect not only on the groups involved in it, but also on the organization as a whole and on each individual participant separately. The development of intra-group conflict leads to intra-organizational conflict.

Let us consider the causes of conflicts in health care. Many authors pay special attention to the causes of conflict relations. The situation of rivalry is most typical for nurses. Their salary does not depend on their experience, but on advanced training courses, writing and defending attestation “for a category”. Almost in any medical institution there are conflicts related to the order of training and defending attestation. Each nurse strives to obtain a higher category, which inevitably leads to a clash of professional interests.



J. Rawls connects the main cause of conflicts in human society with the violation of the norms of social justice and, as a result, with an infringed sense of one's own dignity[1]. At the same time, justice itself is a correspondence between a person’s contribution to the solution of some issues and the benefits (moral or material) received for this. This "correspondence" is determined by the level of development of a particular society, group or individual. Based on this, conflict is often generated: either by a violation of existing and generally accepted norms of justice, or by a clash of different ideas about the norms of justice.

A characteristic for medicine is the fact that work in hospitals is around the clock. There is a special schedule according to which work shifts are distributed in the department. If a nurse for some reason does not go to work on her shift, another nurse replaces her, which often leads to a change in schedule, and an increase in work shifts for other nurses. Often, an unscheduled return to work interferes with rest on weekends or holidays. The stress caused by such interrupted rest is one of the common causes of conflicts in medical establishment, as it contradicts the subjective idea of justice.

Common causes of conflicts: opposite needs of interacting people (difference in needs); ideological reasons; causes of economic and social

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[1] Rawls D. Theory of Justice. – M., 1995

order; contradictions between elements of the social structure (for example, when the goals and objectives of different levels of organization or management of society do not correspond to each other).

These are the main causes of industrial and organizational conflicts:

1) Problems of distribution of resources in the organization (the problem of unfair distribution).

In medicine, a common cause of conflict is the distribution of work shifts. As a rule, no one wants to work on New Year's Eve. And with any work schedule, there are dissatisfied.

2) Differences in goals (the more specialization within the organization, the more mutual misunderstanding, since each structural unit has its own interests).

The department simultaneously employs several doctors and nurses with different specializations. It happens that patients need to do several medical procedures at the same time. For example, a nurse gets the IV into a patient, and at the same time a nurse from the dressing room comes to put the bandage, and the doctor calls this patient for an examination. In this case, there is a clash of interests, since in the presence of a common goal - the treatment of patients, each physician has his own professional duties, and, accordingly, his own goals.

3) Differences in the idea of values (for example, the freedom to express one's opinion in the presence of a superior ...).

Sometimes nurses and doctors allow themselves to be critical of their colleagues, which is contrary to medical ethics, and may cause professional conflict.

4) Differences in behavior and life experience (especially if people work in the same unit).

It often happens that one nurse allows patients what others forbid. For example, use a work phone or watch TV at an unscheduled time. Strict observance of official duties conflicts with the care of patients, which is the cause of a conflict of professional interests.

5) Unsatisfactory communications often leading to mutual misunderstanding of the cooperating parties.

6) Modern legislation lags the practical needs of modern healthcare in the field of regulating the legal framework for the relationship between a doctor and a patient. Therefore, there are situations when the rights of a doctor and a patient established in the law may contradict each other.

Often a medical team consists of only women. As a rule, women are more emotional, tend to share their experiences and events of their personal lives. Sometimes an excess of such information in the workplace can create an unattractive image. Which, in turn, will be a reason for professional conflict.

Ethics, etiquette, law, customs and morality in medicine.

The path of any science is difficult, and medicine - especially. After all, it, unlike other field of knowledge, affects the very life of people. Often, medical discoveries not only successfully cure specific patients, but also influence the worldview of society as a whole.

There are two opposite points of view on the relationship between medicine and society. Supporters of the first believe that inert public opinion hinders the progress of medicine. Proponents of the second are convinced that the development of medicine violates the harmonious unity of nature and man, is the main cause of the weakening of humanity as a whole and can even lead to its degeneration. Indeed, on the one hand, people have become healthier - life expectancy has increased, modern man is larger and stronger than his ancient ancestors. And on the other hand, medicines and vaccines “weaned” the body to fight diseases on its own.

However, medicine and society do not oppose each other, being in a complex interaction. Medicine voluntarily or involuntarily influences society, changing it. Everyone's life and health depend on compliance with medical standards in various areas of human activity, and society is interested in taking them into account.

It is necessary to talk about the humanizing influence of medicine. Suffice it to recall how much effort it took for doctors to explain to society the seemingly obvious things: HIV-infected people should not be outcasts, mental disorders are diseases, not vices, and they require treatment, not punishment.

However, society dictates its requirements to medicine. They hinder its development, but within reasonable limits - after all, the result of any process, if it proceeds uncontrollably, is unpredictable, and sometimes tragic. The development of gynecology has set the task of limiting abortions. The successes of intencive care have raised the question before society and doctors of how long it is necessary to continue the revival of an already incapable of life organism. Advances in genetic medicine have sparked debate about the line that scientists should not cross in experiments with cloning. Under public pressure doctors already in the 20th century began to approach the introduction of new drugs into medical practice with particular rigor. As a result, the laws of "evidence medicine" appeared, which are now followed by physicians around the world. The increase in the value of human life has influenced modern medical ethics, led to the legislative consolidation of the patient’s rights.

The fundamental requirement of medical etiquette is this: the appearance of a doctor must convince the patient that the doctor is a professional reliable to entrust health and life. No one wants to become a patient of a frivolous, sloppy person who treats patients with indifference, and even hostility. Appearance sometimes betrays a commitment to bad habits. The doctor must be collected, restrained, friendly and, of course, a healthy and fit person (or at least make such an impression).

According to medical etiquette, the appearance of a doctor is very important. It is preferable to wear a suit and tie to work rather than a T-shirt and jeans. It is not fitting for a doctor to shine with trendy outfits and expensive jewelry, to amaze colleagues and patients with unusual hairstyles. Good manners, courtesy, goodwill are obligatory for physicians. It is unacceptable to raise voice, be rude to patients and their relatives, even when faced with their inadequate reaction, the doctor should behave firmly, but correctly. If a patient and his relatives cause obvious antipathy in a medical worker (which happens not so rarely), negative feelings should not be manifested either in words or in gestures and, naturally, should not be reflected in treatment - this is not a requirement of etiquette, but of deontology.

Medical etiquette also requires correctness in relations between all members of the team regardless of rank. The respectful address to colleagues, as well as the white color of the medical gown, emphasizes the purity and high meaning of the profession. Especially strictly this principle should be adhered to if communication takes place in the presence of the patient. Familiarity, neglect on the part of superiors and flattering of subordinates harm the authority of physicians. A situation is considered extremely unethical when a doctor questions the professionalism of a colleague in the eyes of the patient.

Culture of doctor communication

Plato in the Laws writes that “under the same difficult circumstances” the behavior, movements, gestures and mannerisms of bold, courageous people differ from the behavior of cowards, people of weak character, “the brave have beautiful body movements, but they are ugly for cowards.[1]” An indisputable truth is impossible to disagree. The one who is well brought up has a refined artistic taste, his behavior and manners are beautiful, he has a beautiful walk, a rich vocabulary, etc. And vice versa, lack of education, lack of artistic taste is clearly expressed in movements and rough manners.

It is obvious that the doctor's speech should be deliberate, clear, and accessible. All this is as important as medicines. The doctor's first and most important weapon is his word. In every movement of a doctor, his manners and vocabulary, his education, sensitivity, spontaneity and an adequate assessment of the situation should be manifested. The strict style of behavior and manners of health professionals should indicate their inner restraint and responsibility. Each of us can remember a doctor we know, whose manner and speech instilled confidence in them. In his manners, behavior, you could feel the intelligence, spiritual wealth and inner confidence. On the other hand, the bad manners of the doctor, ugly speech and obscene behavior cause the patient not only physical, but also spiritual suffering. It is unlikely that the patient will trust a doctor who, in the presence of the patient, continues to talk on the phone, play with a phonendoscope or a pencil, comb his hair or apply makeup, especially, trying to emphasize his superiority, use foreign words that the patient does not understand. All this will have a negative impact on the psychological state of the patient. Hippocrates also said: "A doctor ... must be charming in his essence, without unnecessary jewelry and makeup.[2]" At the same time, the doctor's ugly manners, inappropriate clothing, excessive jewelry in themselves speak of bad taste and lack of a sense of proportion.

The facial expressions of the doctor, his manners are especially acutely perceived by patients who are doubtful by nature, full of anxiety. Such patients persistently try to find answers to the questions that concern them in the facial expressions and manners of the doctor. Thus,

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[1] Plato. Sob. Op. in 3 vols. T.3 (1). M., 1971

[2] Davtyan S.A. - Er.: Yerevan State Medical University named after. M. Heratsi .- Bioethics: Textbook/, 2013, 257 pp.

the doctor's manners, his whole appearance should be expressive, logically understandable, spiritually rich and attractive, and the movements of the head, hands and whole body should be understandable and natural. The same can be said about clothing. Usually, clothes are used to judge the aesthetic taste and internal culture of a person.

Clothing, being a means of external design of a person, acquires not only pragmatic, but also aesthetic significance, shows the taste of a person, his preferences, helps psychological adaptation and finding one's place in society. The doctor's clothing should be as clean, neat and comfortable as possible. Is it possible to enter the patient's room in shoes with French stilettos, in a decollete or party clothes?

As for speech, speech is a strong way of influencing the inner world of a person, awakens deep feelings in him. Words are meaningful, used both literally and figuratively. To be able to find the right words in a certain situation, to emphasize the meaning of these words is a great art. This is an art that requires a lot of inner upbringings. In oral speech, not only the meaning is of great importance, but also the sound, pronunciation, shades of sound and intonation of speech. No wonder pronunciation is called the soul of speech, which conveys the mood, the inner content. The fact is that language as a form of communication consists not only of words, but also of intonation and pronunciation. Differently pronounced words take on different meanings. After all, the expressiveness of the pronunciation of a word, its richness both in life and in practice is expressed by the correct pronunciation of the correctly chosen word. In the system of director K.Stanislavsky there is a method of "text and subtext". Here, “text” is the totality of spoken words, and “subtext” is the meaning that needs to be expressed in all possible ways. Practice proves that the subtext is richer, fuller and more complex than the text itself. The same text can be used to convey different subtexts. Even the unambiguous word “Yes”, pronounced in different intonations, can convey different meanings: both in the meaning of a question, and in the meaning of uncertainty, and in the meaning of a statement, etc. Although grammar has punctuation marks to convey intonation: question mark, exclamation point, etc., they are not sufficient to convey the entire subtext. It is very important that medical professionals master all methods of transmitting sound shades. If the doctor's speech is rich and full of not only verbal text, but also subtext, then the patient, as a rule, perceives not only the text, but also the subtext. If the pronunciation expresses the sensory meaning and content of the word, then a person's speech will be richer in content. A person can think and express his thoughts clear and definitely.

There are many cases where the patient learns the correct vocabulary from the doctor. There are doctors who are fluent in their native language, feel its inner beauty and richness of shades. Fears are caused by some negative trends in the modern vocabulary of doctors. When, for example, a patient is called not by his last name, but by the name of his illness, which he suffers from: ulcer, asthmatic, gastritis, etc. In fact, the spiritual richness of the patient's personality is artificially limited to the narrow limits of typical diseases. This undoubtedly leaves an unpleasant impression and causes negative feelings in the patient. It is also undesirable for doctors to use foreign words when there are equivalents in their native language. In such cases, not only the native language is distorted, but unacceptable, unbearable conditions for communication are created.

The hidden power of the word

The human ability to communicate is one of the most important human functions. Any doctor must know it. In the United States, under the leadership of D. Carnegie, sociological studies were carried out that revealed interesting facts. It turns out that in all spheres of human activity (especially in the field of healthcare), success depends only 15% on special knowledge, and 85% on his ability to get along with people, win them over, influence people. The doctor should be the driving force, the guiding force, the heart and soul of the doctor-patient relationship. Thanks to him, the patient comes to the hospital and begins treatment not by force, but with love, enthusiasm, hope and trust.

Professional solidarity and mentorship in medicine.

Another of the most important elements of ethics is mentoring, the transfer of experience and knowledge to novice doctors. Every good doctor, scientist, at the beginning of his journey had his own Teacher, great respect and gratitude to whom remains for life. In medicine, as in no other profession, it is customary to show signs of respect to honored doctors, professors, and academicians. Behind these people, the main asset of a physician is experience, which cannot be replaced by any abilities and education.

If the facts prove a medical error (for example, the results of the examination were incorrectly interpreted, an incorrect diagnosis was made, the treatment was carried out incorrectly), the doctor should think first how to help the patient, and not blame his predecessor for everything. However, corporate solidarity does not mean that mistakes should be ignored. First of all, it is necessary to discuss the situation with a colleague - in person and in private.

Criticism must be justified, correct and to the point, not passing on the personal qualities of a colleague. In difficult cases, when it is impossible to immediately unequivocally establish whether a mistake has been made and how to proceed further, you can jointly turn to a more experienced colleague or to a council of several doctors. Doctors are emphatically respectful towards the middle and junior medical personnel. A modern nurse is a highly qualified worker who knows and can do a lot. She is the first assistant to the doctor, without whom the treatment process is impossible. The most important requirement of nurse ethics - respect for the doctor - must be strictly observed. Respectful friendly relations with nurses allow a young specialist to learn a lot and avoid a lot of mistakes.

At all times, doctors were treated with respect. After all, people of this profession come to the rescue at the most critical moments of a person's life, from birth to the hour of death. But not only respect surrounds a man in a white coat - misunderstanding, skepticism, ridicule and even curses accompany doctors from ancient times to the present day.

A wary attitude towards doctors appeared already from the first steps of medicine. In ancient times, they laughed at the modest and even dubious possibilities of the then medicine against the backdrop of the exorbitant conceit of doctors. In the Middle Ages, a proverb appeared: "A doctor has three faces - the face of a decent person in everyday life, the face of an angel at the bedside of the sick person and the face of the devil when he demands a fee."

Even today, despite the amazing achievements in the fight against the most complex diseases, medicine is reproached for its inability to cope with AIDS, for the return of almost forgotten ailments - tuberculosis, diphtheria and much more. The source of most reproaches is the sharply increased expectations of people who are not able to justify modern practical medicine. Why does this profession cause so many passions, often opposite? First, it relates to human life itself. And secondly, every doctor - conscientious or not - deals with different patients, different characters. Some are grateful for any attention and help. Others, even the most selfless actions of doctors, are perceived indifferently or hostilely. But it is the good one - the person who really relieves suffering, and not rarely saves life - that causes a sincere feeling of deep gratitude in patients.

Doctors often must make decisions related to the life, health, dignity and rights of people. Therefore, ethics are principles of morality and the rules of behavior based on them - occupies a special place in medicine.

Over the long history of medicine, many ethical principles have taken shape in clearly formulated rules, norms of behavior for a doctor. The set of these norms is called medical deontology. The term "deontology" (derived from the Greek word *"deon" - due)* was introduced in the 18th century by the English philosopher I. Bentham. With this term, he designated the rules of professional behavior of a person. Medical deontology includes the doctrine of medical ethics and aesthetics, medical duty and medical secrecy, etc. It studies the principles of behavior of medical personnel, the system of their relationships with patients, their relatives and among themselves. The circle of its tasks also includes the elimination of "harmful consequences of inferior medical work."

Over the millennia of medical practice, many norms of deontology have become a kind of ritual, like the rules of etiquette, the deep meaning of which a person does not always understand but tries to observe them. These rules form medical etiquette - a set of "good manners" that every self-respecting doctor follows almost without hesitation.

Ethics, deontology and etiquette are closely related. Although the requirements of etiquette sometimes seem formal, one can detect their deep ethical basis. For example, it is not decent to walk in bright clothes and with defiant make-up in a hospital, among people who feel bad. The rules of deontology, even the most ancient and sanctified by tradition, can change when new ethical principles are formed. Thus, the deontology of Soviet medicine demanded that the true diagnosis be concealed from the terminally ill. According to the rules of modern deontology, the doctor must tactfully but honestly inform the patient about the severity of his condition. Treating a person, even a seriously ill person, as a free and rational being is a requirement of ethics.

Information about the disease, as well as about the personal life of the patient, which has become known to medical workers and is a medical secret and in no case can be transferred to unauthorized persons without the consent of the patient. Hippocrates insisted on this rule. Indeed, violation of medical confidentiality can have very serious consequences, literally destroying a person's life. The problem has become the most acute in connection with the spread of AIDS. Dozens of cases are known when the leak of information that a person is a carrier of the immunodeficiency virus led to his expulsion from society. There are medical specialties (gynecologist, andrologist, venereologist, psychiatrist) that deal with the most intimate side of a person’s life, and any careless word can cause gossip, destroy a family, provoke a severe self-esteem crisis in a person.

The requirement to keep a secret is not only ethical, but also practically expedient. The doctor will not be able to effectively treat if he does not have enough information about the symptoms of the disease, about the circumstances of the patient's life. And the patient will not be completely frank with him without the certainty that the information will remain between them. However, there are situations when secrecy can harm the sick person or other people. For example, information about the state of health of their child should not usually be a secret for parents.

However, life is complicated, and often it poses problems for the doctor and society, for which there are no ready-made answers, and deontology cannot help. Then the only way out is to directly address your own ethical sense, think for yourself and decide how to do the right thing.

The basis of professional solidarity and mentoring in medicine is professional ethics - a term used to refer to: systems of professional moral standards; directions of ethical research regarding the grounds of professional activity.

Currently, the meaning of the term, as a rule, is determined from the context, or is specified.

Professional ethics is a system of moral principles, norms and rules of behavior of a specialist, considering the characteristics of his professional activity and a specific situation. Professional ethics should be an integral part of the training of each specialist.

The content of any professional ethics consists of general and particular. The general principles of professional ethics, based on universal norms of morality, suggest:

a) professional solidarity (sometimes developing into corporatism);

b) a special understanding of duty and honor;

c) a special form of responsibility due to the subject and type of activity.

Private principles stem from the specific conditions, content and specifics of a particular profession and are expressed mainly in moral codes - requirements in relation to specialists.

Professional ethics, as a rule, concern only those types of professional activity in which there is a different kind of dependence of people on the actions of a professional, that is, the consequences or processes of these actions have a special impact on the life and fate of other people or humanity. In this regard, traditional types of professional ethics, such as pedagogical, medical, legal, ethics of a scientist, and relatively new ones, the emergence or actualization of which are associated with an increase in the role of the “human factor” in this type of activity (engineering ethics) or an increase in its influence in society (journalistic ethics, bioethics).

Professionalism and attitude to work are important qualitative characteristics of the moral character of a person. They are of paramount importance in the personal assessment of the individual, but at various stages of historical development their content and assessment varied significantly. In a class-differentiated society, they are determined by the social inequality of the types of labor, the opposite of mental and physical labor, the presence of privileged and unprivileged professions, they depend on the degree of class self-awareness of professional groups, the sources of their replenishment, the level of the general culture of the individual, and so on.

Professional ethics is not a consequence of inequality in the degree of morality of various professional groups. But society imposes increased moral requirements on certain types of professional activity. There are such professional spheres in which the labor process itself is based on the high coordination of the actions of its participants, exacerbating the need for solidarity behavior. Particular attention is paid to the moral qualities of workers in those professions that are associated with the right to dispose of people's lives, significant material values, some professions from the service sector, transport, management, healthcare, education, and so on. Here we are not talking about the actual level of morality, but about the duty, which, left unfulfilled, can in any way hinder the performance of professional functions.

A profession is a certain type of labor activity that requires the necessary knowledge and skills acquired as a result of training and long-term work experience.

Professional moral norms are guiding principles, rules, samples, standards, the order of internal self-regulation of a person based on ethical and humanistic ideals. The emergence of professional ethics in time preceded the creation of scientific ethical theories about it. Everyday experience, the need to regulate the relationship of people of a particular profession led to the realization and formalization of certain requirements of professional ethics. Public opinion plays an active role in the formation and assimilation of the norms of professional ethics.

Professional ethics, having arisen initially as a manifestation of everyday moral consciousness, later developed on the basis of a generalized practice of the behavior of representatives of each professional group. These generalizations were summed up both in written and unwritten codes of conduct of various professional groups, and in the form of theoretical conclusions, which testified to the transition from ordinary to theoretical consciousness in the sphere of professional morality.

The main types of professional ethics are: medical ethics, pedagogical ethics, ethics of a scientist, ethics of law, entrepreneur (businessman), engineer, etc. Each type of professional ethics is determined by the uniqueness of professional activity, has its own specific aspects in the implementation of the norms and principles of morality and together constitutes a professional code of morality.

Mentoring is a young but well-established form of work that effectively raises the deontological level of young medical workers. The authority of the older comrade, multiplied by many years of experience in working with patients, successfully enhances and corrects educational work. Everyday practical activity is characterized by the deontological tactics of the health worker.

The study of general "strategic" issues of medical ethics and deontology contributes to the formation of a holistic view of the subject among nurses, reveals the main modern problems and ways to solve them. In the process of teaching, private, “tactical” aspects of proper behavior should also be worked out.

Successful practical application of deontological principles and provisions is possible only, and above all, under the condition of a high professional level of the medical staff of the institution.

A selective approach to various categories of patients is extremely important for identifying "risk groups" in relation to the development of psychogenic disorders and the optimal solution of such problems of deontology as "medical secrecy", "patient participation in the choice of treatment", "compulsory treatment".

Questions for self-examination

1. What principles and rules for regulating the behavior of people in society do you know?
2. What unites medicine and ethics?
3. What principles and rules are designed to regulate the behavior of people in medicine?
4. What is conflict? Why do conflicts arise in such a regulated field of human activity as medicine?
5. Why is the conflict between the rights of a doctor and a patient becoming the main one in bioethics today?
6. What is iatrogenic?
7. What is the essence of the moral problems of medical teaching at patient’s bedside?
8. What medical and ethical problems may arise in the process of communication between a doctor and a patient at various stages of providing them with medical care?
9. What is the importance of the culture of communication between the doctor and the patient?

Bibliography

1. Hegel G.V. F. Philosophy of law. M.: Thought, 1990.

2. Albert Schweitzer, "Kultur und ethik". Munchen 1960 ("Reverence for life.") For research libraries Translation from German by N. A. Zakharchenko and G. V. Kolshansky General edition and

foreword by prof. V. A. KARPUSHINA PUBLISHING HOUSE "PROGRESS" MOSCOW 1973

3. Rolls D. Theory of justice. - M., 1995.

4. Plato. Inc. op. in 3 vols. V.3 (1). M., 1971

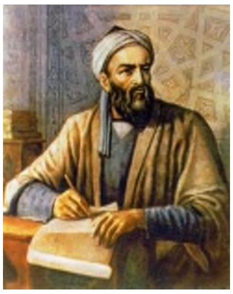
5. Davtyan S.A. - Yer.: YSMU under the name M. Heratsi .- Bioethics: Textbook /, 2013, p.257.

6. Biomedical ethics: Workshop / Under the general. ed. S.D. Denisova, Ya.S. Yaskevich - Minsk: BSMU, 2011.

7. Mukhamedova Z.M. Actual problems of development of bioethical culture of the population. Collection of mat. in inter. reg scientific.pract.sem.training "Bioethical expertise in biology, medicine and education." Dushanbe: Asia Print, 2010. p.317. pp.196-202

CHAPTER III. THE CONCEPT OF T. BEACHAMP AND D. CHILDRES. RULES OF BIOMEDICAL ETHICS. RIGHTS OF THE PATIENT. PRIVACY POLICY. MEDICAL SECRECY

The aim of scientific knowledge should be the
direction of the mind in such a way that it passes strong
and true judgments about all encountered objects.
R. Descartes



A fool and a braggart cannot keep secrets,
Caution is truly beyond praise,
Mystery is a prisoner if you keep it
You are a prisoner of a secret, if you just blurted it out.
(Avicenna (Abu Ali ibn Sina))

Key words*: concept by T. Beechamp, concept by D. Childres,* the principles of "do no harm" and "do good", *Medical confidentiality, Oath of Hippocrates.*

Concept by T. Beechamp and D. Childres

The literature on bioethics offers various options for systematizing the universal principles and norms of biomedical ethics. The concept proposed by well-known American experts Tom Beechamp and James Childres in his work "Principles of Biomedical Ethics" has received the widest recognition [1]. The authors put forward four principles as fundamental: respect for the autonomy of the individual, do no harm, do good and justice. The principles of "do no harm" and "do good" have been the fundamental foundations of traditional medical ethics since the time of Hippocrates, and the principles of respect for the autonomy of the individual and justice are becoming relevant at the present stage of development of biomedical ethics. According to Beechamp-Childres approach, principles do not have a hierarchical order. They are

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[1] Beauchamp T.L., Childress J.F. Principles of biomedical ethics / 4 th ed. New York; Oxford University Press, 1994

considered equivalent and act together, creating a kind of moral framework for medical activity.

1. The principle of respect for the autonomy of the individual is based on the recognition of a person as an unconditional value and implies a free choice of an individual in relation to his life and health (choice of a medical institution, an attending physician, consent or refusal of treatment, etc.). At the same time, the choice that the patient makes, no matter how it disagrees with the position of the doctor, should determine the further actions of the latter. Thus, the right to choose and responsibility for it are not entirely concentrated in the hands of the doctor but are distributed between him and the patient. The patient can perform an autonomous action if he is competent (aware of the consequences of his decision), informed and performs it without any external coercion, voluntarily. Obviously, compliance with these conditions is possible only in the case of an active dialogue between the doctor and the patient.

In medical practice, there are often situations when patients cannot make a fully conscious decision, either due to age (children) or health reasons (persons suffering from mental disorders, etc.). In this case, autonomy is transferred to their legal representatives (close relatives, adoptive parents, guardians, trustees). If there are no legal representatives or it is not possible to locate them, the decision may be made by a doctor or a council of doctors. At the same time, their action should be justified by the principles of “do no harm” and “do good”.

2. The principle of ***“do no harm***” in Latin wording “Primum non nocere!”, Which means “First of all, do no harm!”. This principle goes back to the ethics of Hippocrates and is considered a moral foundation of medicine. The principle implies a need to avoid harm that the doctor can cause to the patient. Causes of harm may be inaction and failure to help those who need it; negligence and malicious intent; accidental errors and thoughtless or unskilled actions of the doctor. A doctor can also inflict moral harm on a patient related to withholding information and deceiving the patient, disclosing medical secrets, rude and inattentive attitude, etc. Of course, a moral duty of a doctor is to exclude from his practice the harm caused by these reasons. However, it should be noted that any medical intervention is associated with a risk for the patient, and it is often impossible to completely avoid harm. Therefore, when deciding whether to perform a therapeutic, diagnostic or

prophylactic procedure, the physician must constantly weigh the benefits and risks associated with a particular intervention. It is important here, firstly, that the harm caused does not exceed the benefit that is acquired as a result of medical intervention, and, secondly, that with the chosen course of action, this harm should be minimal in comparison with all other possible options.

3. The principle of ***"do good"*** requires active action aimed at saving lives and restoring health, alleviating the pain and suffering of the patient. Unlike the “do no harm” principle, these actions involve not so much rational considerations as feelings and emotions such as compassion and mercy. At the same time, the doctor is obliged to take care not only of the welfare of the patient, but also of the welfare of society (for example, to fight the spread of epidemics), as well as the welfare of science, without which the progress of medicine is impossible. Difficulties arise when contradictions between these kinds of goods are revealed. From the standpoint of modern biomedical ethics, the interest of science should not prevail over the interests of a particular individual. However, in exceptional cases, it is considered morally justified to restrict the freedoms of an individual for the benefit of society.

4.The principle of justice at the level of doctor-patient relations involves providing assistance to the patient, regardless of his gender, age, race and nationality, social and financial status, political beliefs and religion, personal preferences of the doctor; at the level of the health care system as a whole - equal access for all groups of the population to obtaining biomedical services and benefits, the availability of pharmacological agents, and the protection of the most vulnerable segments of the population. When distributing scarce health care resources, one must turn to certain criteria of justice - equality, consideration of individual needs or merit, etc. Of course, none of them can be considered absolute and often several criteria are used to distribute limited medical resources.

In addition to these principles, the following can also be noted:

- the principle of respect for human dignity, which implies the recognition of the intrinsic value of each person, including people who, due to their physical or mental condition, do not have the opportunity to express their will;

- the principle of integrity, emphasizing the physical and mental identity of the individual to himself and prohibiting the manipulation or destruction of this identity;
- the principle of vulnerability, which characterizes the fragility and finiteness of every life, and requires special protection and attention in relation to certain groups of the population (the poor, the illiterate, children, the disabled).

In October 2005, the General Conference of UNESCO adopted the Universal Declaration on Bioethics and Human Rights[1]. The Declaration addresses ethical issues relating to medicine, the life sciences and related technologies, and establishes 15 principles to ensure that these areas of activity respect human dignity, human rights and fundamental freedoms.

***Rules of biomedical ethics*.**

The principles of biomedical ethics, which define the most general conditions for treating the patient as a person, are specified in the following rules: privacy, confidentiality, informed consent, truthfulness.

The rule of informed consent means that any medical intervention or biomedical research must be carried out with the consent of the patient or the subject, obtained voluntarily and on the basis of sufficient information. The patient should be informed about the state of health, including information about the results of the examination, the presence of the disease, diagnosis and prognosis; the purpose of the proposed intervention, its duration, expected consequences for the patient, possible discomfort (nausea, vomiting, pain, itching, etc.), risk to life, physical or socio-psychological well-being; financial costs associated with both treatment and rehabilitation. It is also necessary to inform the patient about the availability of alternative treatments and their comparative effectiveness. If the patient is not an autonomous person, informed consent to medical intervention is given by his legal representatives.

The rule of obtaining the informed consent of patients and those involved in clinical trials or biomedical research is enshrined in the Law. The head of the UNESCO Bioethics Department, Prof. A. Carmi, notes that basic human rights are based on the recognition of his personal status, the inviolability of his life, the fact that he was born and will

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[1] Universal Declaration on Bioethics and Human Rights. https://www.un.org/ru/documents/decl_conv/declarations/bioethics_and_hr.shtml

always be free. Respect for these rights of a citizen becomes stronger, the more vulnerable he is. Since the independence and responsibility of every person, including those in need of medical care, is accepted as an important principle, participation in decision-making regarding one's body or health must be considered as one's inalienable right.

The informed consent rule is, in fact, the whole new concept that modern bioethicists believe Hippocrates would find very strange. After all, he was convinced that the circumstances of the disease should be hidden from patients. The rule of informed consent is consonant with the principle of autonomy, because it is designed to ensure that patients or subjects in biomedical experiments are treated with respect as individuals. Thanks to this rule, the threat of harm to health is due to dishonest or irresponsible actions of specialists. This ensures the active participation of the patient in the choice of treatment method, its assessment in terms of the patient's life values.

According to this rule, any medical intervention must, as a prerequisite, include a special procedure for obtaining the voluntary consent of the patient or subject based on adequate information:

1) about the purpose of the intended intervention;
2) its duration;
3) expected positive consequences for the patient or subject;
4) possible discomfort (nausea, pain, vomiting, itching, etc.);
5) risk to life, physical and/or socio-psychological well-being;
6) the availability of alternative treatments and their comparative effectiveness;
7) about the rights of patients and ways to protect them when they are infringed.

The term "informed consent" appeared ten years after the Nuremberg trials, which demonstrated evidence of monstrous medical experiments in concentration camps. In the Nuremberg Code, the norm of voluntary consent was formulated when informing about the nature of the experiment. The term "informed consent" did not appear then and became a more rigid norm after a detailed study of this concept in the early 70s. This is no longer what was previously known as obtaining consent from the patient for surgery.

The rule aims at informing the patient with certain goals that were formulated by T. Beechamp and D. Childres:

1) to ensure respect for the patient or the subject as an autonomous person; 2) minimize the possibility of moral and material damage that may be caused to the patient;

3) create conditions conducive to increasing the sense of responsibility of medical workers and researchers for the moral and physical well-being of patients and subjects[1].

Currently, the issue of informed consent has become one of the main issues in bioethics. Moreover, the rule of obtaining informed consent from patients has become a generally accepted norm. The law "On the protection of the health of citizens of the Republic of Uzbekistan" refers to this in Article 26. Consent to medical intervention. A prerequisite for medical intervention is the informed voluntary consent of the citizen.

In cases where the condition of a citizen does not allow him to express his will, and medical intervention is urgent, the issue of its implementation in the interests of the citizen is decided by the council, and if it is impossible to convene the council directly, the attending (duty) doctor, followed by notification of officials of the medical institution. Consent to medical intervention in respect of persons under the age of fourteen years, and citizens recognized in the manner prescribed by law as legally incompetent, is given by their legal representatives. In the absence of parents or other legal representatives, the decision on medical intervention is made by a council, and if it is impossible to convene a council - directly by the attending (duty) doctor, followed by notification of officials of the medical institution and legal representatives. (Part as amended by the Law of the Republic of Uzbekistan dated April 15, 1999 N 772-I). Article 27 refers to the refusal of medical intervention. Article 27. Refusal of medical intervention. A citizen or his legal representative has the right to refuse medical intervention or demand its termination, except for the cases provided for in Article 28 of this Law. In this case, the doctor has the right to take a written confirmation, and if it is impossible to obtain, to witness the refusal by the relevant act in the presence of witnesses. If the refusal is given by the patient's legal representative, and it may have serious consequences for the patient, the doctor must notify the guardianship authorities of this. Article 28 on the provision of medical

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[1] Beauchamp T.L., Childress J.F. Principles of biomedical ethics / 4 th ed. New York; Oxford University Press, 1994

care without the consent of citizens. Article 28. Provision of medical care without the consent of citizens. The provision of medical care (medical examination, hospitalization, observation and isolation) to persons suffering from diseases that pose a danger to others, without the consent of citizens or their legal representatives, is allowed on the grounds and in the manner established by law. It is obtained from the patient or his legal representatives, and in an emergency, the issue is resolved either by a council or by the doctor on duty, followed by notification of the administration of the healthcare facility, and, if necessary, legal representatives.

A citizen cannot be forced to participate in biomedical research. When obtaining consent for biomedical research, a citizen must be provided with information about the goals, methods, side effects, possible risks, duration and expected results of the research. A citizen has the right to refuse to participate in the study at any stage.

On the methodological side, it is useful to distinguish between the procedural and moral content of the rule of informed consent. Oral consent is less formal, but practically excludes the possibility of subsequent control over what is actually reported by the doctor, reduces the responsibility of the doctor, and creates a prerequisite for violating the patient's rights. A written form of obtaining consent is a document that can be used both for monitoring and for litigation of the results of treatment, which is becoming more and more frequent in medical practice, in Russian public life.

In the form of certain ethical norms, the content of the informed consent rule finds its expression in ethical codes and declarations adopted by international and national medical associations and associations. The “Convention for the Protection of the Rights and Dignity of the Person with regard to the Use of Biology and Medicine: Convention on Human Rights in Biomedicine”, adopted by the Council of Europe since 1996, has acquired particular significance. The discussion of the informed consent rule can be conducted on the basis of a structure that includes its constituent elements. The following are distinguished: "Threshold" elements: a) the patient's competence, b) voluntary decision-making; information elements: a) the procedure for transferring essential information, b) the proposal of recommendations, c) the act of understanding; elements of consent: a) making a decision (in favor of some plan); b) authorization (approval) of a certain plan.

1a. Competence of the patient or examinee is a prerequisite for participation in the informed consent procedure. Two possible states are recognized: competence or incompetence of the patient or the subject. Persons under the age of 15, as well as citizens recognized as incompetent in the manner prescribed by law, are recognized as incompetent. The right to give informed consent from them is transferred to their legal representatives. The law does not take into account the child's right to receive information or participate in the decision-making process. It is morally detrimental if a teenager is forced to undergo surgical intervention by violence or deceit or contrary to the interests of the patient, a decision is made for him. The duty of doctors is to act in defense of the interests of the child, to take legal steps that would limit the rights of legal representatives. In such situations, the interests of disabled patients should outweigh the rights of their legal representatives. Examples of refusals of necessary blood transfusions are well known from practice.

1b. A decision is considered voluntary if, when it was made, there was no coercive influence on the patient from the outside: the threat of refusing treatment or free treatment, authoritarian imposition of a decision and manipulation of data that are selected so that the patient is forced to agree to treatment or research.

2a. An oral form of information transfer facilitates the ability to manipulate the patient's decision. Silence, concealment of information about negative previous experience, exaggeration of the chances of success - all this violates the rule of voluntariness. Moreover, this can happen unconsciously, for example, because of the scientist's passion for a new method of treatment. Written completion of a special form of informed consent creates opportunities for control over the objectivity of information, and its guarantees can be obtained if the tests being conducted are reviewed by an independent ethical committee.

2b. The question arises about the content of the information communicated to the patient: how much, how and what to communicate to the patient? In bioethics, there are norms - "informing standards". Firstly, the professional standard, which is determined by the practice that has developed in this medical community. This is a spontaneously emerging standard in medical practice, which is unconsciously assimilated by physicians in a stable society.

In Uzbekistan, it is necessary to develop new traditions and new moral standards that correspond to modern conditions. It is believed that the standard of a rational person is more suitable here, which, as it were, suggests imagining an “average citizen” who needs certain information in order to make an informed decision. The subjective standard also suggests considering the specific interests of this particular individual. "Subjective standard" outlines the tactics of individualization of the transmitted information.

2c. Effective understanding (consciousness) of the reported information by the patient is questionable due to his educational level, which may be low. Beechamp and Childres in these cases suggest, for example, to explain the risk, apply comparisons with the probability of risk known to the patient from previous experience of driving a car or working with electrical appliances. (Not using a lot of technical terms). It is important to take into account the psychological impact of the words used: the probability of survival in percentage is perceived as more encouraging than the same information about death. Understanding information does not always mean accepting it (cancer patients). Tests without informing the person and understanding the content of the study are unacceptable.

3a. Decision making is an independent process that takes time. The patient must be given time to think, to consult with relatives or specialists. Consent given by the subject or patient may subsequently be reviewed or withdrawn by him. Domestic legislation provides for the right of the subject to terminate his participation in the study at any stage, as well as the patient's right to refuse treatment.

3b. Authorization essentially means that the patient approves the planned examination and treatment plan, is ready the patient's ability to enter certain contractual relationships that will connect him with the doctors who provide him with assistance.

Historically, the rule of informed consent was originally developed in the United States in connection with cases of serious violations by doctors of the rights and interests of patients for scientific or commercial purposes. Procedures for obtaining informed consent were introduced into the practice of American and Western European health care precisely to minimize the risk of these disorders. The rule of informed consent is extremely important for the normal development of modern moral and legal standards of healing. However, the practical transformation of the doctor-patient relationship based on a new moral standard can also have negative consequences. The rule of informed consent, as a prerequisite for any medical intervention, can become a factor that undermines the sense of trust in the medical profession. After all, the patient seems to be told: “You must control the actions of doctors in every detail, otherwise you are in danger.” This fuels suspicion and can play a negative role. Therefore, the rule of informed consent should be understood as a norm of dialogical communication between a doctor and a patient in order to agree on a mutually acceptable method of medical intervention. The discussion should include all the elements of obtaining consent mentioned and discussed above. If this requirement is met, then the risk of harm to the health and interests of patients is reduced. Under these conditions, the rule of informed consent becomes not an end, but a means to ensure a partnership dialogue of interested parties. The doctor and the patient thus become equal partners in the treatment and diagnostic process.

B. The rule of truthfulness prescribes truthfully, in an accessible form (considering the psychological and age characteristics of the individual), tactfully (without causing harm) to inform the patient about the state of his health. The patient must also be truthful in dealing with healthcare professionals. The implementation of the truthfulness rule in some cases is associated with serious difficulties (informing when using a placebo, non-autonomous patients, cancer patients and patients in a terminal state, etc.) and involves situational solutions.

C. The rule of inviolability of private life (privacy) prohibits medical professionals from collecting, accumulating and distributing (transferring or selling) information relating to his private life without the consent of the patient.

D. The confidentiality rule implies strict observance of medical confidentiality. The subject of confidentiality is information about the fact of applying for medical care, data on the state of health, diagnosis, prognosis and all the information that the doctor receives as a result of the examination and treatment of the patient, as well as non-medical information about the patient or his relatives, which became known to the doctor in the process performance of their professional duties. This information can be transferred to third parties only with the consent of the patient.

Medical confidentiality and confidential information.

Every citizen has the right, in a form accessible to him, to receive information about his state of health, including information about the results of the examination, the presence of the disease, its diagnosis and prognosis, treatment methods, the risks associated with them, possible options for medical intervention, their consequences and the results of the treatment.[1] ("Law on the protection of the health of citizens of the Republic of Uzbekistan", art. 24). The patient has the right to adequate information about the state of his health. Articles 24, 25 of the "Law on the protection of the health of citizens of the Republic of Uzbekistan" refer to the duty of the doctor to provide the patient, at his request, with complete and truthful information about his state of health and prognosis, even if it is unfavorable. Partial provision of information distorts reality and can be misleading about the true situation, which sometimes adversely affects the adoption of any important decisions by the patient and his relatives. This applies not only to making decisions regarding medical interventions, but also decisions on property transactions, the timing of the completion by the patient of material or spiritual matters that are important for him and his close ones. Disinformation of patients grossly violates their rights and sometimes leads to the rejection of the necessary and optimal methods of treatment, to material losses. Unfortunately, we still must deal with this practice. In case of refusal to provide the patient with medical information, the patient has the right to apply to the court to resolve the situation in a civil procedure with a quite appropriate demand for compensation for moral damage caused to him, and in some cases - material damage and lost profits. For the onset of administrative responsibility, the subjective side is important - the guilty person's awareness of direct intent in providing incomplete or false information. For example, a patient with a malignant neoplasm is deliberately falsely informed about a benign process. The result of deliberately false information may be an underestimation of one's condition and the refusal of a misled patient from a timely operation, the subsequent formation of metastases. The doctor was obliged to foresee the possibility and inevitability of such consequences, since he studied the natural development of this

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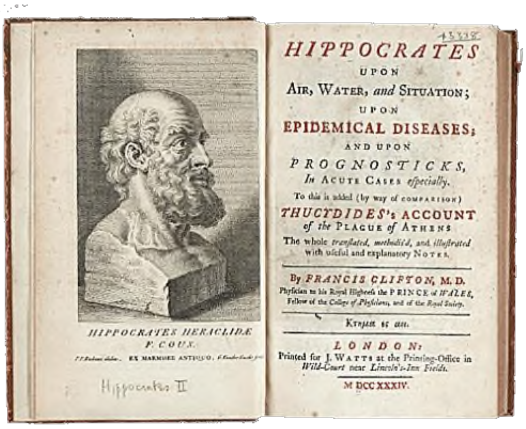
[1] Law on the protection of the health of citizens of the Republic of Uzbekistan https://www.lex.uz/acts/41329

pathological process. Information about the state of health is provided only to the patient himself. In practice, there are cases when, with an unfavorable prognosis for the development of the disease, the patient's relatives, and not himself, are the first to know about this from the doctor. A sick person, on the other hand, may have his own considerations, due to family and hereditary relations, which of his relatives could be entrusted with his secret and other information, and who not. The citizen has the right to get acquainted with the records in the medical records. This desire may appear in him and arises in cases of distrust of his attending physician. However, it must be considered here that the reading of medical documents by a person who does not have a medical education, due to incorrect interpretation of the records, can form iatrogenesis and further establish the patient on the path of false conclusions. For example, a patient, having read in medical history that he had "sigma and mesocolon", decided that these were the names of incurable diseases, and committed suicide. To prevent such negative phenomena and a possible conflict between the patient and the doctor, it seems quite reasonable to organize a meeting of the patient with the head of the department or a representative of the hospital administration for a joint study of the records in the medical records, and for the patient to receive advice on issues of interest to him. The doctor is obliged to take care of mitigating the possible negative effect of receiving truthful information by the patient by methods of psychotherapeutic and medicamentous influence. The process of informing in any case, with the proper approach, can and should carry with it a positive psychological charge. It should be remembered that objectively not justified, false optimism, sooner or later, will lead, if not to the "epiphany" of the patient, then to disappointment in official medicine, to statements of claim and complaints in all instances. Information about the state of health cannot be provided to a citizen against his will, i.e., the person himself has the right to decide on the refusal to provide him with such information; a person has the right not to know the state of his health. Until the patient has expressed his request to provide him with complete information about the state of health, the doctor has no right to impose it. On the other hand, it is the doctor's duty to ask his patient about his desire to be informed. From the point of view of Muslim faith (and other religions as well), a lie regarding the prognosis of life for dying patients deprives them of the possibility of repentance, spiritual preparation for death through prayers and reconciliation, spiritual comfort through appropriate participation in religious rites. It is not so terrible for a believer to die, as it is terrible not to prepare for death, which touches only the mortal body, freeing the eternal soul for a new life. Thus, the "good lie" damages the soul. The realization of this overshadows the religious feelings of the relatives of the deceased.

The history of the development of the institution of medical confidentiality

The development of medical confidentiality is associated with the development of medical ethics, which studies the problem of the relationship between medical workers and patients.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HIPPOCRATES
UPON
AIR, WATER, *and* SITUATION;
UPON
EPIDEMICAL DISEASES;
AND UPON
PROGNOSTICKS,
In ACUTE CASES *especially.*
To this is added (by way of COMPARISON)
THUCYDIDES's ACCOUNT
of the PLAGUE *of* ATHENS
The whole *translated, methodis'd, and illustrated* with useful and explanatory NOTES.

By FRANCIS CLIFTON, M.D.
Physician to his Royal Highness the PRINCE of WALES,
Fellow of the College of Physicians, and of the Royal Society.

Κτῆμα ἐς ἀεί.

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The beginning of medical confidentiality history dates back to the 5th-4th centuries. BC, when Hippocratic Oath first appeared[1]. One of the main provisions of the oath is: "Whatever during treatment - and also without treatment - I see or hear about human life from what should never be disclosed, I will keep silent about it, considering such things a secret. For a long time, this principle remained unchanged, even though it does not reveal the subject of the secret, that is, the information that will be hidden remains at the discretion of the doctor. 1512), Prussian Medical Edict (1725), Prussian Criminal Code (1794), French Code Penal (1810) and others.

Fundamental changes in this approach occurred in the era of the development of the concept of natural law in the 17th century. Natural human rights are absolutized, and together with them the right to confidentiality is absolutized. According to this concept, the doctor cannot disclose any information about the patient without his consent, regardless of the circumstances. The patient's secrets acquire attributes of private property. The principle of property does not depend on its value, damage to property must be punishable. Later, the concept of “public harm” appears in law, which forces doctors to reveal a secret, but only by a court decision or in conditions of public danger, and only

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[1] Text of the Hippocratic Oath https://www.rlsnet.ru/books_book_id_7_page_1.htm

to public authorities. The great physician Avicenna said: “A fool and a boaster cannot keep secrets, Caution is truly beyond praise, A secret is a prisoner if you protect it, You are a prisoner of a secret, only blabbed.".

“Like many other things, the Union has undergone colossal changes. On the one hand, the Soviet health care model, earlier than in other countries, solved the problem of access to qualified medical care for the majority of the population. This is the merit, first of all, of the "architect" of the Soviet healthcare system - the first People's Commissar of Health N.A. Semashko, who is convinced of the need for a "class approach", the ideologization of issues of professional morality in medicine[1]. Such an approach turned out to be especially destructive for the ancient ethical value of medicine - medical secrecy: in the 1920s, Semashko repeatedly argued that medical secrecy would die out in the USSR; Semashko gave doctors the right to choose. Each doctor could decide for himself what information to keep secret, and what can be left in the public domain. At one of the disputes held in Moscow in January 1928, N.A. Semashko, according to newspaper reports, said: “We are heading for the complete destruction of medical secrecy. There should be no medical confidentiality. This follows from our main slogan that "illness is not a disgrace, but a misfortune." Professor A.I. Abrikosov, on behalf of the Moscow professors, fully agreed with the words of the people's commissar and by this, as it were, recognized the issue as settled. Another revolution in medicine occurred after the Second World War, when the whole world learned about the terrible experiments of Nazi doctors. Adopted in 1947, the "Nuremberg Code", as an appendix to the verdict - 10 ethical rules for medical experiments on humans, is one of the first international documents in medical ethics.

With the adoption of the Geneva Declaration of the WMA, Soviet doctors again began to take the Hippocratic oath, in which they promised to keep medical confidentiality. For half a century, the text of the oath of Soviet doctors has changed more than once, but the basic principles given back in the 5th century BC remained unchanged.

Medical confidentiality is a multifaceted ethical-moral and legal-philosophical concept, the most important concept of deontology, as a doctrine of the principles of behavior of medical personnel in communication with a patient or his representative, as well as with the

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[1] From Hippocratic deontology to modern bioethics. http://www.bioethics.ru/rus/biohistory/

patient's relatives and other persons. Medical confidentiality and the conditions for its disclosure are enshrined in the Law of the Republic of Uzbekistan N265-I of August 29, 1996 "On the protection of the health of citizens" (Article 45)[1]. "Information about the fact of applying for medical care, the state of health of a citizen, the diagnosis of his disease, and other information obtained during his examination and license, constitute a medical confidentiality.

It is not allowed, without the consent of a citizen or his legal representative, to disclose information constituting a medical confidentiality by persons to whom they became known during training, the performance of professional, official and other duties, except for the cases established by part three of this article.

Providing information constituting a medical confidentiality without the consent of a citizen or his legal representative is allowed:

- for the purpose of examination and treatment of a citizen who, due to his condition, is unable to express his will;
- with the threat of the spread of infectious diseases, mass poisoning and lesions;
- at the request of the bodies of inquiry and investigation, the prosecutor's office and the court in connection with the investigation or trial;
- in the case of providing assistance to a minor under the age of fourteen to inform his parents or legal representatives (paragraph five of part three of Article 45 as amended by the Law of the Republic of Uzbekistan dated April 15, 1999, No. 772-I "On amendments and additions to certain legislative acts of the Republic of Uzbekistan";
- if there are grounds for believing that harm to the health of a citizen was caused as a result of illegal actions or an accident. All information in the medical documents of a citizen is also a medical secret. Without the consent of the citizen himself, it is transferred to outsiders only in the above five cases. Persons who, in accordance with the established procedure, are provided with information constituting a medical confidentiality, along with medical and pharmaceutical workers, are responsible for the disclosure of medical secrets in accordance with the law. "The legislation of the Republic of Uzbekistan provides that the disclosure of medical secrets can occur both with the consent of the

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[1] Law of the Republic of Uzbekistan Ensuring guarantees of the rights of citizens to health protection by the state; www.lex.uz/acts/41329

patient, and without. With the consent of a citizen or his legal representative, it is allowed to transfer information constituting a medical secret to other citizens, including officials, in the interests of examining and treating a patient, for conducting scientific research, publishing in scientific literature, using this information in educational process and for other purposes.The bearer and custodian of medical secrets is any doctor who, by definition, graduated from higher medical educational institutions of the Republic of Uzbekistan, when receiving a doctor's diploma, take an oath of a doctor of the Republic of Uzbekistan (Article 44 of the Law of the Republic of Uzbekistan "On the protection of the health of citizens "). At the same time, doctors swear to "keep medical secrecy."

However, the law does not limit the list of keepers of medical secrets only by doctors, imposing the obligation to keep information constituting a medical secret also on persons to whom they became known while training, performance of professional, official and other duties. Thus, a potential custodian of a patient's secret is any person who, to one degree or another, has received information about the patient. (Code of the Republic of Uzbekistan on administrative responsibility, article 46 "Disclosure of information that could cause moral or material damage to a citizen"). According to the law, not only doctors, but also paramedics, nurses, students doing practice in medical institutions, as well as other persons, along with medical and pharmaceutical workers, who, in the manner prescribed by law, are provided with information constituting medical confidentiality. Practice shows that the disclosure of medical confidentiality is quite common among medical personnel. Among the employees of medical institutions there are doctors and paramedical personnel discussing the features of the course of the disease of specific patients with their families, with colleagues, without thinking about violating the requirements of the law and the principles of deontology. In addition, most doctors, when communicating with relatives of patients, are never interested in documents confirming kinship, and are willing to talk about the diagnosis and prognosis of the disease with people who simply introduce themselves as relatives of the patient. Disclosure of a medical secret takes place when information constituting a medical secret is published in the press, broadcast on radio and television programs, shown in newsreel programs and other media, presented in judicial characteristics (without a special judicial request or a requirement unequivocally formulated by the court during the trial), proceedings, public speeches, statements addressed to officials, or communication in any form, including oral, to several or at least one person. Of course, the greatest public danger is the disclosure of medical secrets to an unrestricted circle of people through the media (magazines, newspapers, television and radio). However, almost always such facts gain publicity and public outcry and, as a rule, end with statements of claim for the protection of honor, dignity and business reputation. Practitioners, when discussing professional issues with colleagues, should not disclose the patient's personal data, not disclose information constituting a medical secret to persons regarding whom there is no certainty that they are related to the patient or that the patient does not object to the disclosure of information about him to this person. In addition, disclosure of medical confidentiality often takes place in correspondence with third parties. Moreover, if the private correspondence of a doctor cannot be accounted for, then official correspondence, unfortunately, is replete with information in which, with the proper approach, one can see the disclosure of medical secrets. Thus, the authors themselves have repeatedly observed the presentation and interpretation of information about the diagnosis and treatment of the disease, indicating the personal data of the patient in correspondence with third parties.

Practice shows that violation of medical secrecy is extremely common in the following situations: when a patient is in a hospital, relatives and acquaintances are interested in the state of his health. The anxiety of relatives for the health condition of a loved one is understandable. However, information about the state of health of a citizen, information about the diagnosis and other information obtained during the examination and treatment of a citizen constitutes a medical confidentiality and cannot be disclosed without the consent of the patient himself. Currently, the legislation of the Republic of Uzbekistan on issues of medical secrecy focuses on the priority protection of personal rights and freedoms of a person and a citizen. Information constituting a medical confidentiality simultaneously falls under the definition of both “official confidentiality” since access to such information is limited and only persons by virtue of the performance of their professional medical duties (or persons equated to them by law), and “personal data ”, since they relate to facts, events and circumstances of private life, may constitute a personal or family secret, and also allow the identity of a citizen to be identified. Regarding ensuring the secrecy of personal data, the state establishes additional guarantees obliging legal entities and individuals who own such information to ensure the protection regime, processing and procedure for its use and establishing liability for violation of these requirements (Articles 23–26, 30 of the Law of the Republic of Uzbekistan “On Information")[1]. Individuals whose rights or interests have been violated by the owner or users of information may demand through the judicial authorities the restoration of their rights and compensation for the damage caused.

Thus, in addition to the responsibility of persons, by type of activity and in responsibility with their powers involved in medical secrets, for its disclosure, the protection of personal data constituting a medical secret is ensured by the responsibility of organizations for providing organizational and technical conditions for creating a regime for their preservation from unauthorized access.

Here is an example of how it is recommended to resolve the issue of medical secrecy in Islam by the Council of Islamic Academy of Jurisprudence (fiqh) under the Organization of Islamic Cooperation: Decree №.79 (10/8) “On medical secrecy”[2]. The Council of Islamic Academy of Jurisprudence (Fiqh) under the Organization of Islamic Cooperation during its Eighth Session, appointed in Bandar Seri Begawan (Brunei Darussalam) 1-7 months of Muharram 1414 AH (21-27 June 1993), having read the results of studies received by the Academy on the topic “Medical secrecy”; having heard a discussion on this matter there were decided:

10. A secret is something that one person tells another, having stipulated ahead of time or later that the latter will not divulge the information received. This information may contain circumstances and facts that in themselves indicate the need to conceal them in accordance with generally accepted rules. They may relate to the individuality of a person, in particular his shortcomings, which he does not want to reveal to others.

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[1] Law of the Republic of Uzbekistan on principles and guarantees of freedom of information https://lex.uz/docs/52709

[2] Resolution No. 79 (10/8) On medical confidentiality https://islam.uz/fikh/akademiya-fikxa/2275-o-vrachebnoy-tayni.html

11. A secret entrusted to another person imposes an obligation on him to keep it in accordance with Shariah, concepts of honor and norms of behavior.

12. The fundamental principle regarding secrecy is the prohibition of its disclosure. According to Sharia, divulging a secret without good reason requires condemnation.

13. Secrecy is obligatory for representatives of certain professions, when its disclosure may harm professional activities. This applies, for example, to medicine, since people who need advice and help turn to doctors. Patients tell doctors everything related to their life and health, including secrets that a person hides even from their loved ones.

14. The obligation to keep a secret is removed in cases where its non-disclosure could lead to even greater harm to individuals or society as a whole. Such cases can be divided into two groups:

* • when revealing a secret is necessary in order to avoid even more harm by causing the least possible harm, and also in order to maintain the public interest at the expense of private ones. These cases are also divided into two groups:

a) protection of society from vicious actions;

b) protection of the individual from vicious actions;

• when disclosure of a secret is permitted in the name of:

a) observance of the interests of society;

b) protecting society from vicious acts.

In all cases, it is necessary to adhere to the principles of Sharia and its priorities for the sake of preserving faith, spirituality, reason in the interests of future generations and their well-being.

Exceptional cases, when disclosure of confidentiality is indispensable, should be spelled out in the code of conduct for medical personnel and other guidance documents. Such cases should be listed and described in detail. Relevant authorities are obliged to bring this information to all interested parties.

Some which can br recommended:

Call on the trade unions of medical workers, ministries of health, medical schools to include the subject "Medical confidentiality" in the curricula, pay attention to its importance, bring information related to this discipline to everyone working in this field, develop appropriate instructions based on scientific work on this topic.

It should be noted that in all other cases, information without the consent of the patient cannot be disclosed at all. Here, for non-disclosure of information, there should be not just the absence of the patient's consent, but also a direct prohibition of the patient to provide information about the unfavorable prognosis of the development of the disease to his family members. It appropriate to note that family members here mean the spouse, adult children, parents, brothers and sisters of the patient. Despite all the vows, only at the end of the 20th century, for example, in Russia with the adoption of the "Fundamentals of the legislation of the Russian Federation on the protection of the health of citizens" in 1993, doctors stopped entering the diagnosis into the temporary disability sheet, which is the most massive medical document.

Principle of confidentiality - is a principle of bioethics.

However, it can be considered as a legal custom, since it finds its logical conclusion in the article "Law on the protection of the health of citizens of the Republic of Uzbekistan”[1]. Almost all countries have similar laws. Naturally, the boundary between the ethical interpretation and the legal application of this principle is very flexible. It can be determined based on the concept of human rights in the interpretation of each specific case. This article, as you know, regulates the activities of medical workers. It does not apply to people outside the medical community. At the same time, the ethical principle can be applied to everyone.

As you know, many people sometimes show excessive interest in personal information that the patient discloses to the doctor. This information is traditionally, ethically and legally protected confidentiality.

Confidentiality is a strict but not absolute obligation. There are principles and circumstances that justify exceptions to the rules of medical ethics. This is perhaps one of the most difficult problems in medical ethics: the value of confidentiality requires that physicians who are in breach have a very good reason for doing so. The ethical justification for a breach of confidentiality is based on the principle of justice and depends on the context of the case. In general, there are two grounds for exceptions to the rules of medical ethics: a threat to the safety of others and a threat to public welfare.

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[1] Law of the Republic of Uzbekistan Ensuring guarantees of the rights of citizens to health protection by the state. www.lex.uz/acts/41329

The conditions of modern medical care give rise to the problem of careless handling of confidential information. The reports are not protected enough and are available to many people, including those who do not have a professional relationship with medicine. Providers and non-medical staff can talk about patients in public places. The real challenge to privacy in modern healthcare has been the use of information technology to create, store, correct and access information. The computerization of medical records increases statistical information and facilitates administrative tasks. But the relative availability of medical reporting information to interested third parties. entrepreneurs, management services, family members and others, threatens the patient and even the doctor responsible for the preservation of information. For example, recent technologies for predicting genetic diseases or susceptibility to them produce information of interest not only to the patient and his doctor, but also to the patient's relatives, employers and insurance companies.

Oath of Hippocrates translated into English

I swear by Apollo the Physician, Asclepius, Hygiea and Panacea and all the gods and goddesses, taking them as witnesses, to fulfill honestly, according to my strength and my understanding, the following oath and written obligation: to honor the one who taught me on an equal basis with my parents, to share my wealth with him and if necessary, help him in needs; consider his offspring as his brothers, and this is an art, if they want to study it, to teach them free of charge and without any contract; instructions, oral lessons and everything else in the teaching to communicate to their sons, the sons of their teacher and students bound by an obligation and an oath according to the law of medicine, but to no one else. I will direct the regimen of the sick to their advantage, according to my ability and my understanding, refraining from causing any harm and injustice. I will not give to anyone the lethal agent asked of me, nor show the way for such a design; nor would I give any woman an abortion pessary. Purely and undefined shall I conduct my life and my art. In no case will I make sections for those suffering from stone disease, leaving it to people involved in this matter. In which whatever house I enter, I will enter there for the benefit of the sick, being far from everything intentional, unrighteous and pernicious, especially from love affairs with women and men, free and slaves. Whatever, during treatment - and without treatment - I see or hear about human life from what should never be divulged, I will keep silent about it, considering such things a secret. To me, who inviolably fulfills the oath, may happiness be given in life and in art, and glory among all people for all eternity; but to the one who transgresses and gives a false oath, let it be the opposite of this. Lest I see or hear anything about human life that should never be divulged during treatment - and without treatment - I will keep silent about that, considering such things a secret. Whatever, during treatment - and without treatment - I see or hear about human life from what should never be divulged, I will keep silent about it, considering such things a secret.

Modern version of the Hippocratic Oath (according to the Declaration of Geneva, approved by the General Assembly of the World Medical Association in 1948): I solemnly swear to devote my life to the service of mankind. I will give my teachers due respect and gratitude; I will perform my professional duties with dignity and conscientiousness; the health of my patient will be my primary concern; I will respect the secrets entrusted to me; I will, by all means in my power, uphold the honor and noble traditions of the medical profession; I will treat my colleagues as brothers; I will not allow religious, national, racial, political or social motives to prevent me from fulfilling my duty towards a patient; I will hold the deepest respect for human life from the moment of conception; even under threat, I will not use my knowledge against the laws of humanity. I promise this solemnly, voluntarily and sincerely.

HIPPOCRATIC
OATH

I SWEAR by Apollo the physician and Asclepius and Hygieia and Panacea, invoking all the gods and goddesses to be my witnesses, that I will fulfil this Oath and this written covenant to the best of my powers and of my judgment. I will look upon him who shall have taught me this art even as on mine own parents; I will share with him my substance, and supply his necessities if he be in need; I will regard his offspring even as my own brethren, and will teach them this art, if they desire to learn it, without fee or covenant.

I WILL IMPART it by precept, by lecture and by all other manner of teaching, not only to my own sons but also to the sons of him who has taught me, and to disciples bound by covenant and oath according to the law of the physicians but to none other.

THE REGIMEN I adopt shall be for the benefit of the patients to the best of my power and judgment, not for their injury or for any wrongful purpose. I will not give a deadly drug to any one, though it be asked of me, nor will I lead the way in such counsel; and likewise I will not give a woman a pessary to procure abortion. But I will keep my life and my art in purity and holiness. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein.

WHATSOEVER HOUSE I enter, I will enter for the benefit of the sick, refraining from all voluntary wrongdoing and corruption, especially seduction of male or female, bond or free.

So, Biomedical ethics is a criterion of the correctness of modern medical law.

Questions for self-examination

1. What criterion of the correctness of modern medical law do you know?

2. What rights are granted to the patient by the current legislation of the Republic of Uzbekistan?

3. What are the arguments in favor of supporters of "holy lies" in medicine in case of an unfavorable outcome?

4. Can the patient's informed consent to any

medical intervention or biomedical research, obtained voluntarily and based on sufficient information, become a guarantee of the quality of a medical service?

5. Analyze the main provisions of the patient's informed consent rule

6. What illegal, immoral ways for disclosing medical secrets do you know?

7. Why can confidentiality raise ethical privacy issues?

8. Analyze the evolution of the concept of "medical confidentiality"

9. What normative documents regulate the right of citizens of the Republic of Uzbekistan to health care?

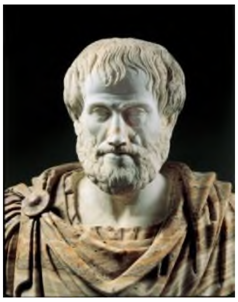
10. List the principles and rules of biomedical ethics, disclose their content.

11. How to explain that the state is forced to take care of preserving the health of citizens?

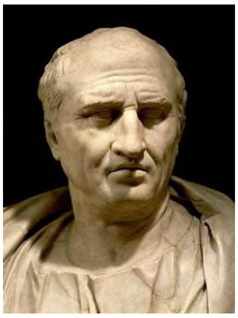
Bibliography

1. Beauchamp T.L., Childress J.F. Principles of biomedical ethics / 4 th ed. New York; Oxford University Press, 1994.
2. Law of the Republic of Uzbekistan "Ensuring guarantees of citizens' rights to health protection by the state; ... (paragraph ten of Article 4 as amended on June 13, 2017 No. ZRU-436 - SZ RU, 2017, No. 24, Art. 487..... www.lex.uz/ acts /41329
3. Text of the Hippocratic Oath https://www.rlsnet.ru / books_book_id_7_page_1.htm
4. From the deontology of Hippocrates to modern bioethics http://www.bioethics.ru/rus/biohistory/
5. Law of the Republic of Uzbekistan on the principles and guarantees of freedom of information. https://lex.uz/docs/52709
6. Decree №79 (10/8) On medical secrecy. Council of the Islamic Academy of Jurisprudence (fiqh) under the Organization of Islamic Cooperation. during its Eighth Session convened at Bandar Seri Begawan (Brunei Darussalam) 1-7 Muharram 1414 AH (21-27 June 1993) https://islam.uz/fikh/akademiya-fikxa/2275-o-vrachebnoy-tayni.html
7. Mukhamedova Z.M. Ethical problems of biomedical cultural research in the field of organ and/or tissue transplantation. Ethical aspects of new biotechnologies in biology and medicine. Collection of reports of scientific conference.T.2006 pp.44-54

CHAPTER IV. MORAL AND ETHICAL PROBLEMS OF CLINICAL TRIALS AND EXPERIMENTS ON HUMANS. LEGAL PROTECTION OF THE PATIENT IN UZBEKISTAN. BIOETHICS IN PHARMACY.



"We do not argue in order to know what is virtue, and in order to to be good people."
Aristotle



"It is not enough to master wisdom;
you also need to know how to use it."
Cicero

***Key words**. Nuremberg lessons, Legal protection of the patient in Uzbekistan, Bioethics in pharmacy, the first Cochrane Center, The Declaration of Helsinski by the World Medical Association, Convention on Human Rights and Biomedicine, Ethics Medical Research.*

Moral and ethical problems of conducting clinical trials and experiments on humans. Adoption of the principle of informed consent

The World Health Organization (WHO) and the World Medical Association (WMA), recognizing the coexistence of various ethical and medical positions and moral and ideological orientations, regulate this coexistence with the help of international medical and ethical codes and agreements. Fundamental to the issue of informed consent are the Lisbon Declaration on the Rights of the Patient (WMA, 1981[1]) and the Declaration on Policies for Ensuring Patient Rights in Europe (WHO, 1994[2]).

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[1] Lissabonskaya deklaratsiya prav patsienta, prin. v 1981 g., Lissabon, Portugaliya, dopoln. v 1995 g., Bali, Indoneziya [Lisbon Declaration of Patients' Rights, adop. in 1981, Lisbon, Portugal; updated in 1995, Bali, Indonesia]. Available at URL: http://www.e-stomatology.ru/star/info/2010/lissabon_declaration. (accessed Jan. 20, 2012). [in Russian]

[2] Deklaratsiya o politike v oblasti obespecheniya prav patsientov v Evrope, Amsterdam, 1994 [Declaration of Policy in Sphere of Patients' Rights Assurance in Europe, Amsterdam, 1994]. Available at URL: http://europadonna.by/index . php?option=com_content&view = article&id = 89:2010-01-18-11-42-13&catid=38:2010-01-10-09-32-1 1&Itemid=41 (accessed Feb. 14, 2012). [in Russian]

The assertion of the principle of informed consent in the system of relations between a doctor and a patient is largely consistent not only with democratic processes in modern culture, but also with objective trends in the development of medical knowledge. For example, within the boundaries of "predictive medicine" using intrauterine diagnosis, it is possible to determine a person's predisposition to certain diseases. How to obtain consent to treatment if the patient does not have traditional, for example, pain symptoms of the disease? How should confidentiality be ensured? What should be the notification procedure? It is obvious that these factors, which today determine medical knowledge, actualize the problem of "information" and "consent", turning informed consent into a form of relationship between a doctor and a patient that is most consistent with the changes taking place in medicine. Historically, the concept of "informed consent" It was formed in the course of the work of the 1st US Military Tribunal in Germany, which, along with the Judgment in the case of "medics" in 1947, prepared a document called the "Nuremberg Code", which became the first international "Code of rules for conducting experiments on humans". In the first paragraph of this Code, for the first time, the concept of “voluntary consent” of a person involved in a medical experiment is used.

Nuremberg lessons[1].

In 1947, on August 20, Nuremberg Tribunal completed its work, the defendants of which were 23 leading German medical scientists. The prosecutors and judges involved in the trial were shocked by the systematic and cold-blooded cruelty with which

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[1] Gustav Mark Gilbert Nuremberg Diary. [translation from English A.L. Utkin]. - M. : Veche, 2012. - 480 p. : ill. - (Military archive). http://www.pseudology.org / Pobeda/Gilbert _ Nurenberski_Dnevnik2.pdf: Nuremberg trials. http://nurnbergprozes.narod.ru/; Glazer G. Dramatic medicine. - M., 1965. Howard-Jones N. Experiments on humans in historical and ethical perspective // Health of the world, - 1982, - No. P. - P. 9-16; https://idd.mid.ru / informacionno-spravocnye-materialy/-/asset_publisher/WsjViuPpk1am/content/uroki-nurnberga-i-sovremennost-

medical scientists conducted medical experiments on people with tuberculosis or malignant neoplasms, the disabled, the elderly, people with physical disabilities and the mentally ill, conducted experiments on prisoners of war and deported from occupied countries, newborns with “improper development” were killed, contrary to Hippocratic oath. A special industry of killing was created in the form of gas chambers, crematoria, etc. The International Military Tribunal in Nuremberg qualified these actions as crimes against humanity. The Nuremberg trials of 1947 demonstrated for the first time how fragile and unreliable, moral and ethical barriers that separate good from evil. 23 doctors appeared at the trial (of which 20 were Doctors of Sciences), including Hitler’s surgeon von Brandt. In the death camps, prisoners of war were vaccinated with typhus, tetanus, people cooled to +3 degrees C, abused children and women, transplanting bones from one person to another. Hippocratic Oath was not an obstacle for German doctors to conduct cruel inhuman experiments on prisoners of war. The death sentence, the suicide of several convicts in prison - this is the finale of the tragedy. Scary facts of history. They must not be repeated. One of the most important regulations of the Nuremberg Code was the ban on the experiments on a person without his voluntary consent. The Nuremberg Code, the most important document in the history of the ethics of medical experiments on humans, was adopted during the Nuremberg trials of fascist doctors who conducted experiments on prisoners of war. Numerous testimonies of the subjects (it would be more accurate to say - victims), as well as the results of experiments collected and summarized with pedantry, which were at the disposal of the court, lined up in a terrible picture. Never in the history of human experiments have they been carried out with such sadism as they did during the Nazi era. Here are just a few of the facts given in the opening speech by the Chief Prosecutor at the trial, US Attorney Telford Taylor. Experiments carried out with the approval of Himmler, which studied the reactions of the body to high altitudes and rarefied air. In the Dachau concentration camp, imprisoned Jews, Poles and Russians endured the effect of lack of oxygen in atmospheric conditions at altitude of 12 km. Usually the subject was dead within half an hour; at the same time, the successive stages of his suffering were carefully recorded in the protocol of the experiment (for example, "spasmodic convulsions", "agonistic convulsive breathing", "groans", "shrill cries", "convulsions of arms and legs", "grimaces, biting of one's own tongue", " inability to respond to speech") and electrocardiogram data were recorded. These experiments, which were intended to help German pilots, were subsequently supplemented by the study of hypothermia, when the subjects were kept naked in frost up to 29 degrees for 9-14 hours or placed in ice water for several hours.

Experiments were carried out in the same concentration camp, during which over 1200 healthy people (including Catholic priests) were infected with malaria. Thirty subjects died directly from malaria, from 300 to 400 from complications caused by it, many others from excessive doses of neosalvarin and pyridone.

Experiments with mustard gas were carried out at Sachsenhausen, Natzweiler and other camps. The test subjects were deliberately injured, and then the wounds were infected with mustard gas. Others were forced to inhale the gas or ingest it in liquefied form. "Experimenters" reported that when gas was injected into wounds on the hands, the hands swelled greatly, and the person experienced extreme pain. The experiments, conducted mainly on women at the Ravensbrück camp, explored wound infections, as well as the possibilities of bone, muscle and nerve regeneration and bone transplantation. So, incisions were made on the subjects' legs, and then bacterial cultures, pieces of wood shavings or glass were introduced into the wounds. Only a few days later, the wounds began to be treated, testing certain methods. In other cases, the wounds became infected with gangrene, after which some subjects began to be treated, while others from the control groups were left without treatment. Regarding transplantation experiments, for example, in one case a scapular bone was removed from a prisoner in Ravensbrück for transplantation.

Dachau explored the possibility of using sea water for drinking. At the same time, one group of subjects was not given water at all, the other drank ordinary sea water, the third sea water containing salt, but devoid of salty taste, and the fourth demineralized sea water. The experiment was carried out for 4 weeks on 40 subjects. The question of who should be tested on Jews or Gypsies was specially discussed, since some doubted whether the data obtained in experiments on Gypsies would be applicable to Germans. In the end, Himmler nevertheless decided to conduct experiments on gypsies. In other experiments, infectious jaundice was studied on concentration camp prisoners; methods were developed for cheap, "insensitive" and rapid sterilization of people so that in the future the Germans could populate the territories occupied by Poles and Russians; mass infection of people with typhus was carried out; studied the speed and nature of the action of poisons, which in Buchenwald were mixed into the food of Russian prisoners of war; the effect on the body of phosphorus compounds contained in English incendiary bombs was tested.

To replenish the anthropological collection at the University of Strasbourg in the Auschwitz camp, 79 Jews, 30 Jewish women, 2 Poles and 4 Asians were selected. In total, the "researchers" selected 1,200 Jews. After photographing and anthropological measurements, they were all killed, and their corpses were transported to Strasbourg. The Nuremberg Tribunal was not limited to punishing criminals. The verdict included a section called "Permissible Medical Experiments", later it became known as the "Nuremberg Code" and acquired an independent meaning, becoming the first international document in history regulating the conduct of medical experiments on humans. Its preamble noted: "The weight of the evidence before us leads us to conclude that certain types of medical experiments on humans are ethical for the medical profession as a whole only if their conduct is limited to appropriate, well-defined limits."

Although the "Code" was adopted in the form of a court decision, it had and still has not so much legal as ethical force. It includes ten principles, the first of which is: "The absolutely necessary condition is the voluntary consent of the subject." This means that the person involved in the experiment must have the legal capacity to give consent; the situation in which he finds himself must allow him to exercise free choice without the influence of any elements of violence, deceit, fraud, cunning or other hidden forms of pressure or coercion; have sufficient knowledge to understand the details of the experimental procedure and make an informed decision. In the Nuremberg Code, for the first time in the history of mankind, the idea of the primacy of the good and interests of the individual over the interests of both science and society was put forward. For all its apparent simplicity, this idea can be considered a fundamental achievement in the moral experience of mankind. The norm of voluntary consent contained in the first article of the Nuremberg Code became a specific mechanism for protecting the subjects. In subsequent years, many other documents were adopted that regulated the practice of biomedical experiments in more detail and strictly (in particular, at present, in legal and ethical regulations, it is customary to speak of informed consent rather than voluntary consent, which is a more stringent norm), but the Nuremberg code" and to this day retains the function of the fundamental model.

Subsequently, the concept of "informed consent" begins to be used in the practice of US legal proceedings and is associated with a certain order of court cases for compensation for harm caused by negligent treatment. In the 1950s and 1960s, the term informed consent itself and the corresponding practice of recognizing the obligation of a doctor to inform the patient about the risk of medical intervention, about alternative forms of treatment, appeared before he gives consent to medical treatment. And if in the 50s the information was of a professional nature, then in the 70s the “patient-oriented” criterion was introduced for information, according to which the information should be given in a publicly accessible form and include three parameters: a description of the goal treatment, possible risk and existing alternatives to the proposed treatment. Currently, in US jurisprudence, informed consent is the legal criterion for whether and to what extent care was provided by a physician to a patient. The principle of informed consent can be considered as a long-sought and finally found form of legal protection of a patient that restores the original, natural and actual inequality in relation to the doctor-patient. The patient, who, as a rule, does not have special medical knowledge, is doomed in advance to depend on the doctor, relying on his professionalism. On the one hand, this inequality is the risk of a patient trusting his health, dignity, and life to a doctor. On the other hand, the risk of a doctor who is not insured against so-called “medical errors”, which, however, legally qualify as “non-punishable conscientious error in the absence of negligence” or as “a circumstance mitigating the responsibility of a doctor”.

A kind of compensation for this "natural inequality" is to provide the patient with full legal protection. Its main forms include: the right to consent to medical intervention and to refuse it, the patient's right to information about the state of health and the duty of the doctor and medical institution to ensure this right.

A few decades ago, the traditional ideal for Euro-American civilization of the relationship between doctor and patient was "paternalism". This "paternal" or "parental" model assumed a thorough study by the doctor of the patient's condition, the doctor's choice for each specific case of treatment aimed at eliminating pain and its causes. The patient's consent to the planned intervention was determined by the choice of treatment methods made by the doctor. One of the reasons for the retreat from paternalism in the second half of the 20th century is the practically revolutionary changes in medical science, which led to fundamentally new possibilities for influencing and managing human life. This retreat was especially easy in the US, where there was and still is no legal right to health care, i.e., the right to health care is not guaranteed by the state (except when a person is in acute, life-threatening conditions). If bioethics focuses on the life problems of any living being, then biomedical ethics (BME) concretizes the principles of bioethics in relation to a person.

Biomedical ethics is an ethical and applied discipline, the subject of which is the moral attitude of society as a whole and professionals - doctors and biologists in particular - to a person, his life, health, death, and which sets itself the task of making their protection a priority right of every person. In contrast to the "traditional" medical ethics, BME is integrative in nature, uniting, linking, concentrating common bioethical problems and requirements; at the same time, it relies on the so-called medical incidents - specific situations, turning them into precedents that become the basis for ethical generalizations, conclusions and subsequent recommendations. This is the situational nature of BME. The range of the main problems of the BME: establishing the status and role of moral values in the professional activities of physicians and biologists; resolution of moral conflicts in specific situations that arise in the process of biomedical research and treatment of patients; ethical regulation of interpersonal relations in the system of vertical and horizontal connections in the field of medicine. BME solves its problems not on a professional-corporate basis, but on a broader basis, with the involvement of representatives of other professions and the general public. The development of new medical technologies leads to the fact that today the relationship between the doctor and the patient is undergoing significant changes. If earlier the patient simply entrusted the doctor with the solution of questions about his treatment and even life, now he increasingly demands information about what is offered to him in this regard. In the United States, the practice has become widespread when the patient even "follows" the doctor, meaning the possibility of a lawsuit for "wrong treatment". Therefore, the role of the doctor is increasingly being replaced by the role of a consultant, adviser or competent professional expert, shaping the patient's decision making and informing the patient about the state of his health, the benefits and risks of possible interventions. The rights of patients in medical interventions are protected not only by the rule of truthfulness and the rule of confidentiality, but also by the rule of voluntary informed consent. According to this rule, any intervention, including when conducting experiments on humans, must include the voluntary consent of the patient. In turn, the doctor must inform the patient about the goals, methods, side effects, possible risks, duration and expected results of the study. For the first time, the rule of "free consent" is formulated in the Nuremberg Code (1947) - the first "Code of rules on conducting experiments on humans." Then the principle of “free consent” began to be considered in the United States in litigation for damages for negligent treatment. The term “informed consent” has taken root in Europe 10 years later. In practice, indeed, a situation of natural inequality develops between the doctor and the patient. The patient without special medical knowledge trusts the doctor with his life. But the doctor himself is not immune from medical errors. The legal protection of the patient eliminates this inequality, and the principle of voluntary informed consent establishes new norms for the relationship between the doctor and the patient. The concept of voluntary informed consent establishes the duty of the doctor to inform the patient, as well as respect the patient's privacy, be truthful and keep medical confidentiality on the one hand, but on the other hand, this principle obliges the doctor to accept the patient's subjective decision for execution. The incompetence of the patient can render this model of doctor-patient relationship sterile and even harmful to the patient himself, as well as cause alienation between patient and doctor. A positive feature of voluntary informed consent is that it is aimed at protecting the patient from the experimental and testing intentions of the doctor and researcher, at reducing the risk of causing moral or material damage. At the same time, in a situation where harm has occurred, although voluntary informed consent was issued between the doctor and the patient, it is a form of protection for the doctor, weakening the legal position of the patient.

2. Legal protection of the patient in Uzbekistan

The main regulatory and departmental acts that regulate relations in the field of healthcare and protect the rights of a consumer of medical services (patient) are the Constitution, the Civil Code, the Laws of the Republic of Uzbekistan “On protecting health of citizens”, “On protecting the rights of consumers”. In addition, there are a number of legal acts that establish the rights of citizens in providing them with emergency, specialized medical care for socially significant diseases, as well as those that pose a danger to others. The right of citizens to qualified medical care is guaranteed by the Constitution of the Republic of Uzbekistan. It imposes on the state the responsibility to finance the program for the protection and promotion of public health, to take measures to develop public and private health care systems, to encourage activities that contribute to the improvement of human health.

Article 3 of the Law "On Health Protection" provides that the main principles of protecting the health of citizens are respect for human rights in the field of health protection, access to medical care for all segments of the population, priority of preventive measures, social protection of citizens in case of loss of health, unity of medical science and practice. The patient, in accordance with the Law on the Protection of the Health of Citizens, has the right to:

- Respectful and humane attitude on the part of medical and service personnel;
- Choice of doctor and medical institution;
- Examination, treatment and maintenance in conditions that meet sanitary and hygienic requirements;
- Conducting, at his request, a consultation of other specialists in the manner prescribed by the Ministry of Health of the Republic of Uzbekistan;
- Keeping confidential information about the fact of applying for medical care, about the state of health, diagnosis and other information obtained during his examination and treatment;
- Voluntary consent or refusal of medical intervention;
- Obtaining information about their rights and obligations and the condition of their health, as well as the choice of persons to whom, in the interests of the patient, information about the condition of his health can be transferred;

- Receipt of medical and other services within the framework of voluntary medical insurance; Compensation for damage in case of harm to his health during the provision of medical care in the manner prescribed by law;
- Admission to him of a lawyer or other legal representative to protect his rights.

The rights of the patient, as consumers of medical services, are protected by the Law "On Protection of Consumer Rights"[1]. Article 4 of this Law provides that the consumer has the right to receive reliable information about the service, freely choose its proper quality, its safety, compensation in full for material losses, moral damage caused by the service with defects that are dangerous to life and health, as well as illegal action (or inaction) of the performer.

In case of violation of the rights of the patient, he or his legal representative may file a complaint directly with the head or other official of the medical institution or with the court of the Republic of Uzbekistan.

Bioethics in pharmacy.

An essential prerequisite for the formation of bioethics is the ideology of environmental movement, which arises as a response to a threat to the physical (natural) well-being of a person. The influence of ecological thinking on the field of biomedicine was especially intensified after Halidamide catastrophe of 1966 (the birth of children without limbs from mothers who took the drug Halidamide as a sleeping pill during pregnancy). This tragedy contributed to a radical change in the structure of the relationship between science and practical medicine. The goal of biomedical science has become not only the development of

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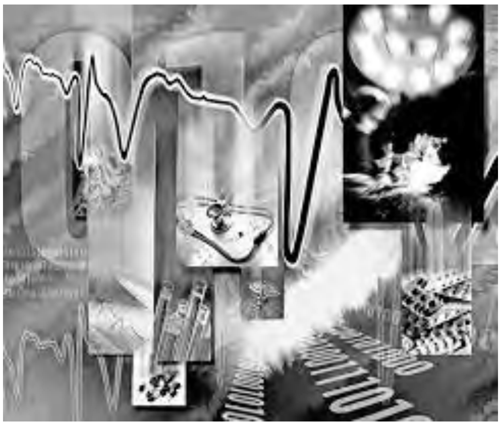
[1] Law of the Republic of Uzbekistan On the protection of consumer rights. No. 221-I 04/26/1996, 12/25/2019, No. 03/19/597/4193); Resolution of the Cabinet of Ministers of the Republic of Uzbekistan on measures to complete the experiment and deepen reforms in the healthcare system. https://www.lex.uz/acts/303433 ; Law of the Republic of Uzbekistan On compulsory health insurance. https://regulation.gov.uz/oz/document/4930 ; Resolution of the Cabinet of Ministers of the Republic of Uzbekistan On guaranteed volumes of free medical care covered by funds State Budget of the Republic of Uzbekistan https://regulation.gov.uz/oz/document/3710

new therapeutically effective drugs or medical technologies, but also the prevention of their negative side effects. Achieving the latter goal is given no less, and sometimes much more time and money. As a result, the time between the synthesis of a new therapeutically active substance and the start of its clinical use has increased dramatically. If in the early 60s it was a few weeks, then in the early 80s it jumped to 10 years. At the same time, the development price increased by 20 or more times.

Safety – a prevention of negative effects of drugs, has become one of the rapidly developing areas in the development of medical science, i.e., into pharmaceutical bioethics, which studies the moral, legal, social, environmental and legal issues that arise during the creation, clinical trials, registration, production, retail sale and bringing to the consumer of medicines and pharmacy products. Among the factors that shape pharmaceutical bioethics are the current state and development trends of economics, sociology and biology, as well as a whole range of situations that arise in the process of circulation of medicines and pharmacy products, sanitary and epidemiological, ideological and medical activities, research work and the use of the results. A model of the influence of these factors on bioethics has been built, which makes it possible to systematically solve problems that arise in the formation of ethical codes for pharmaceutical workers and all those involved in the system of drug circulation (drugs)



The drug industry developed most vigorously in the post-war period. By the 1960s, more than 20,000 different pharmacological preparations had appeared on the market. In 1958, the first pharmaceutical tragedy occurred, which was already mentioned above: in Germany, about 20 thousand children were born with anomalies from mothers who took Halidamide as a sleeping pill. In 1960, in Japan, there was a mass poisoning with a drug from an intestinal disorder, which led to the development of the disease - “smon”. The World Medical Association sounded the alarm. In 1964, a declaration was adopted in Helsinki, supplemented by a number of provisions 11 years later in Tokyo (work on the provisions of the declaration continued further after the 29th General Assembly of the World Association of Physicians, Tokyo, Japan, October 1975[1]; 35th General Assembly of the World Association of Physicians, Venice, Italy, October 1984; 41st General Assembly of the World Association of Physicians, Hong Kong, October 1989; 48th General Assembly of the World Association of Physicians, Somerset West, South Africa, October 1996; 52nd General Assembly of the World Association of Physicians, Edinburgh, Scotland, October 2000)

The Helsinki-Tokyo Declaration[2] emphasized the need for the maximum tightening of requirements for testing on humans in order to obtain new data on physiology. For the first time, the Guidelines for Conducting Human Clinical Trials also provide for the need to be controled by independent commissions or committees of research protocols. In addition, the rights to publish data without a corresponding examination of primary materials are limited. Later, the so-called GCP rules (Good Clinical Practice) were developed[3].

At the end of the 1980s, in the context of a rapid development of biomedical sciences and a danger of negative consequences of their practical application, the Council of Europe decided to create an appropriate pan-European document. In 1993, the General Assembly of the Council of Europe adopted the Convention for the Protection of the Rights and Dignity of Man regarding the Application of Biology and Medicine. At present, most European countries have joined this convention.

Nevertheless, pharmaceutical production and pharmaceutical markets are developing in accordance with the mechanisms of commodity-money relations, defined by such a concept as "pragmatism". However, the doctor's behavior should be motivated by the interests and welfare of patients, and not by the desire for personal enrichment. The problems associated with the existence of medicine as a social and economic institution are relevant and related to numerous issues that are part of the mainstream of bioethical problems. Among them, we can name the tacit collusion of the pharmaceutical business with medical practice and marketing that has become tougher all over

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[1] Declaration of Helsinki of the World Medical Association: recommendations for doctors on conducting biomedical research on humans. - Helsinki. - 1964, additions 1975, 1983, 1996, 2000

[2] WORLD MEDICAL ASSOCIATION DECLARATION OF HELSINKI Ethical Principles for Medical Research Involving Human Subjects https://web.archive.org/web/20071027224123/http://www.wma.net/e/policy/pdf/17c.pdf

[3] Good clinical practice (GCP) https://www.ema.europa.eu/en/ich-e6-r2-good-clinical-practice

the world (suggestion to the patient of the need to use new, more and more expensive drugs); the selfishness of the researcher and the commercial impatience of the pharmaceutical giants, which often give rise to the use of insufficiently tested drugs; methodological poverty of chemotherapy, shameless exploitation of human phobias (diet, etc.).

One of the ways to combat this trend is to replace paid medicine with compulsory health insurance (compulsory medical insurance) and national public health systems. Recently, this process has been going on in almost all developed countries. Under these conditions, bioethics is designed to protect the personality of the doctor and patient from the negative consequences of the impact of modern medicine and pharmacy (here it is appropriate to point out the role of evidence-based medicine, which will be discussed below.) It is known that advertising is one of the main tools for promoting medicines on the market. It is essential to ensure their safe and effective use, which should involve the ethics of marketing pharmaceutical products.

Concern about the many negative trends that have emerged in recent years on the global pharmaceutical market, the need to protect the rights of patients has led to a mandatory ethical review of drugs participating in clinical trials. In other words, pharmaceutical activity in the 20th century, along with positive results, had such negative consequences that it became necessary to speak and include pharmaceutical ethics as one of the sides of a new field of scientific knowledge - bioethics. In this regard, we note the importance of ethical review of clinical trials involving humans, the history of which dates back to the Declaration of Helsinki. This document was a public reaction to the facts of Nazi experiments on people and to the facts of discrimination against patients based on racial characteristics in the studies. Then, to protect the rights of patients participating in trials in the USA and Western Europe, a system of examination began to take shape with the help of ethics committees. They were created as a counterweight to the interests of the state and companies that could infringe on the interests of patients participating in research. In no Western country, a test without an ethical review can not be carried out.

Established in 2000, the Committee on Bioethics under the Ministry of Health of the Republic of Uzbekistan is guided by the Constitution of the Republic of Uzbekistan, the Laws of the Republic of Uzbekistan “On the Protection of Health of Citizens” (1996, with amendments and additions 1999, 2001) and “On Medicines and Pharmaceutical Activities (1997)[1], the principles of Helsinki Declaration (1996), Balmont's report "Ethical principles and guidelines for the protection of people who have been subjected to research", Guidelines for GCP (Good Clinical Practice), WHO recommendations, Ethics Committee conducting the examination of biomedical research (2000-2002), as well as the regulation on the Committee, approved by order of the Republic of Uzbekistan № 370 dated on July 10, 2000. Despite the democratic nature of the Law of the Republic of Uzbekistan “On protecting health of citizens”, its legal development in terms of including bioethical issues needs a more fundamental approach, the legal foundations of bioethics and guarantees for its provision in the Republic of Uzbekistan.

Problems of safety and efficacy of drugs in the context of Evidence Based Medicine

The work of ethical committees that control pharmaceutical bioethics issues are based on ethical and legal principles formulated in the Declaration of Helsinki of the World Association of Physicians (adopted by the 18th General Assembly of the World Association of Physicians, Helsinki, Finland, June 1964). The spirit and letter of the WHO Recommendations to Ethics Committees is expressed in the following words: “In their composition, procedures and decision-making mechanisms, ethics committees should be independent of political, administrative, managerial, departmental, professional and financial and economic influences.” Problems of safety and efficacy of drugs, diagnosis, treatment, new methods of prevention, etc. associated with the development of a new field of knowledge in medicine and the rapid development of information technology - evidence-based medicine (EBM).

The development of evidence-based medicine abroad was largely facilitated by the success of modern information technologies, and especially biostatistics, which made it possible to more quickly and objectively assess the quality of medical decisions and scientific

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[1] Resolution of the Cabinet of Ministers of the Republic of Uzbekistan on introducing amendments and additions to some decisions of the Government of the Republic of Uzbekistan (Decree of the President of the Republic of Uzbekistan dated December 7, 2018 No. UP-5590 “On comprehensive measures to radically improve the healthcare system of the Republic of Uzbekistan”) https://regulation.gov.uz/ru/document/2043

research results. This was also facilitated by the presence of numerous faculties and departments of epidemiology and biostatistics in foreign medical universities and centers.

The systematization of the rudimentary ideas of EBM was made in 1972 by the British physician Archie Cochran, who can be called the first clinical epidemiologist. The main goal of evidence-based medicine, as the name implies, is to prove or refute the assumption about the effectiveness of any therapeutic or diagnostic method in each population of patients. Because it is not possible to conduct a study involving all members of the population for technical and many other reasons, tests are usually carried out with the participation of a sample - the group of people being studied.

In 1972, A. Cochran drew attention to the fact that "society is in the dark about the true effectiveness of medical interventions." He writes that "it is a great shame that physicians have not yet established a system for the analytical compilation of all relevant randomized clinical trials in all disciplines and specialties with periodic updates of reviews." He suggested creating scientific medical reviews based on a systematic collection and analysis of facts, and then regularly updating them with new data. Great importance is attached to the ethics of the study (drugs, method of treatment, etc.). Randomized clinical trials mean controlled by a case; not fully determined by other factors. Randomization – a division of patients into groups in a random way, for example, into groups of investigational and control interventions.

Conducting clinical trials of fundamentally new, previously unused drugs, as well as generic drugs (from English generic - tracing paper, as copies of reproduced original drugs were called) is associated with a number of ethical issues. They are due to the fact that the subject of study is a person. Are clinical experiments on humans allowed, and if so, what should be the restrictions and conditions for their implementation? What should be considered an experiment in the clinic? How to reduce the possible risk for the patient, ensure confidentiality? How to conduct generic drug trials in healthy volunteers? How to avoid possible abuses in scientific research?

Conducting trials of a new drug or treatment people is necessary to prevent the development of possible dangerous adverse reactions during the use of drugs. For this, multicenter clinical trials are carried out, and in some cases, cross-national studies. At the same time, ethical issues also arise, for example, how to properly organize randomized trials, considering the peculiarities of the legislation and social conditions of different countries, as well as respect and protect the rights of those who took part in them. These and many other ethical, legal and social issues require attention and are discussed all over the world by both professionals and members of the public in the context of bioethics, law, and religious traditions.

In October 1992, the first Cochrane Center was opened in Oxford. In October 1993, the first annual Cochrane Colloquium was held, where 73 representatives from 9 countries co-founded the Cochrane Collaboration. The main objective of the Cochrane Collaboration is to create, update and disseminate systematic reviews of the results of medical interventions, which should help stakeholders make decisions in various fields of medicine. Systematic reviews are regularly published electronically Cochrane Database of Systematic Reviews. Cochrane Library is an electronic database of evidence-based medicine. The main product of Cochrane Collaboration, an international organization of researchers whose goal is to find and summarize the results of all randomized clinical trials of treatment interventions ever conducted[1]. Cochrane Library consists of four separate databases:

1. Database of systematic reviews. Cochrane reviews summarize mainly the results of randomized controlled trials. The data included in the reviews are drawn from studies, each of which is peer-reviewed for validity using strict criteria. This reduces the chance of systematic errors. Quantitative research results are combined using statistical methods (meta-analysis), which allows a more accurate and reliable assessment of the degree of effectiveness of treatment interventions.

2. Base of abstracts due to the effectiveness of medical interventions. Staff at the Center for the Preparation and Dissemination of Systematic Reviews at University of York search for publications of systematic reviews and meta-analyses from a variety of sources, critically evaluate these publications for methodological quality, and present them in the form of extended structured abstracts.

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[1] Medical resources on the Internet Evidence-based medicine (5) http://nlr.ru/res/inv/ic_med/cat_show.php?rid=347 ; The Cocrane Library https://www.cochranelibrary.com/

3. Register of controlled clinical trials. Cochrane Register of Controlled Trials is a bibliographic database of controlled trial publications identified by members of Cochrane Collaboration and other organizations. The database building process reflects international efforts to systematically examine electronic bibliographic databases (such as Medline, Embase, HealthStar), manually search a large number of journals and other medical publications around the world to create a universal and unbiased data source for systematic reviews. .

4. Cochrane Database on Review Methodology.

The following resources are available on Cochrane Library website:

- Tutorial for writing systematic reviews
- Abstracts of analytical studies on the assessment of medical technologies
- Glossary of methodological terms
- Details of the structure of the Cochrane Collaboration
- Catalog of Internet resources on evidence-based medicine.

Access to the table of contents and summary is free. A subscription is required to access the full texts. The beginnings of the system, which is now called evidence-based medicine, arose in the 19th century and were associated with the struggle of advanced doctors with elements of scholasticism and traditionalism that have existed in medicine for a long time. Its main principles were formed in France 150 years ago. At that time, medical practice had little connection with science, and for doctors, information about pathophysiological mechanisms was due to the greatest interest. If it was possible to find out the cause of the disease, then the treatment consisted in eliminating this cause. Such methods made it possible to successfully deal with infections and other major causes of morbidity and mortality of the time. Thanks to the use of this method in the USSR, the USA and in European countries in the 20th century, it was possible to significantly increase the average life expectancy.

Many researchers equate the terms clinical epidemiology and evidence-based medicine[1]. The term "evidence-based medicine" (EBM)

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[1] Vlasov. V.V. Introduction to evidence-based medicine. M. 2001
Melnichenko G.A., Buziashvili I.I., Proskurina I.A. Evidence-based medicine and international multicenter clinical trials in endocrinology. Scientific Center for Expertise and State Control of Medicines of the Ministry of Health of the Russian Federation, M. Vedomosti NTSEGKLS-September 1999 No. 1

was introduced into practice by specialists from McMaster University (Canada) as an integration of the best scientific data with clinical experience and patient values. For a physician who wants to judge the reliability of clinical information, knowledge of clinical epidemiology is as necessary as knowledge of anatomy, pathology, biochemistry, and pharmacology. Clinical epidemiology is considered as one of the fundamental sciences on which the building of modern medicine is based.

The modern definition of the term evidence-based medicine (EBM) can be formulated as the use in the diagnosis, treatment and prevention of diseases only of those methods whose effectiveness has been proven by a rationally organized comparative objective study. EBM is a real system of action, it is the integration of one's own clinical experience with the experience reflected in reliable clinical reviews, which should not be enforced.

The main reasons that led to the spread of EBM are: the unpredictability of the clinical efficacy of not only “new” drugs, but also drugs that have been used for many years, but have not been subjected to rigorous evaluation due to the complexity of methodological approaches; coordination of scientists' efforts and the urgent need to improve the quality of clinical decisions, their reliability, the provision of cost-effective treatment, the bioethical context of these issues; the emergence of computer and information technologies and their use as tools for EBM itself; formation of a new paradigm of clinical thinking, critical analysis and transition from a traditional approach and worldview to a new one, as a natural result of the development of science, clinical practice and general trends in the development of society.

An important component of EBM is an economic factor. In a situation of shortage of funds associated with rising health care costs, among a large number of drugs, it is necessary to choose those drugs that have the highest efficiency and best tolerability. It is important to note that the novelty or high cost of a new drug is not a guarantee of its higher efficiency. A professional physician committed to the principles of reliability needs to be able to distinguish evidence-based information about the effectiveness of medical interventions from information that is descriptive or just hidden advertising. Drugs that have not yet received confirmation of their effectiveness, of course, should not be excluded from practice, but if there is reliable, evidence-based information on a particular method of treatment, then it should be preferred. Indeed, enormous funds are spent on the implementation of unfounded recommendations, and as a result of this, at best, there may be no positive effect, and at worst, a negative effect. Obviously, it makes no sense to try to reduce the cost of treatment by using inexpensive, but little effective drugs, but it is just as pointless to prescribe expensive drugs in cases where cheaper drugs can give an equal or even greater effect. Both ultimately lead to higher costs.

Medicine has become a field of application of high technologies and, consequently, expensive equipment and drugs. Even in the most economically developed countries, questions arose about the choice of optimal medical interventions - with a high ratio of their effectiveness (for patients) and cost (for the healthcare system). In this regard, criteria for the evidence of the results of studies of numerous methods of treatment, prevention and diagnosis have been developed. Modern medical practice requires the doctor to diagnose diseases, prescribe effective treatment, minimize the adverse effects of interventions and make an individual prognosis for the patient, based only on the most reliable information. For this simple principle to be put into practice, it was not enough just to formulate it. There had to be an information revolution that made it possible to quickly search for information, medicine itself had to accumulate a sufficient amount of reliable data on the effectiveness of interventions. It would be a big exaggeration to say that all treatment interventions widely used in modern medicine have been tested in large randomized clinical trials. According to various sources, only 30-50% of interventions passed such a check. At the same time, the volume of reliably verified information is growing rapidly every year.

The relevance of the value of the ethical side of EBM consists of several directions. The first is due to the fact that the change in the structure of morbidity in favor of chronic diseases has led to the fact that the duration of many diseases has become comparable with the time of a doctor's active work. The doctor loses clear guidelines, based on which he could say that the therapy prescribed by him leads to an improvement in the prognosis for the patient. With respect to therapy, he becomes more and more dependent on secondary sources of information, scientific publications, which overcome the problems of simultaneously monitoring a large number of patients and long study periods.

The second reason is that drug therapy and diagnostics have become a big, multi-billion-dollar business. The development of new drugs has become a highly costly and unsafe enterprise. Investing in the development of a drug that turns out to be ineffective can bankrupt even a large corporation. Therefore, pharmaceutical companies are trying to "squeeze" everything they can out of drugs.

The third reason: an aggressive advertising policy is carried out, marketing specialists strive to present the medicine in the most favorable light, using all the latest developments and psychological tricks for this. Doctors and nursing staff have been targeted by the most interesting advertising campaign in business history - a campaign in which the target audience is people who make the buying decision but do not finance it out of their own pocket, and patients have become significantly more educated.

The medical staff caring for the patient is no longer the only source of information for him and his family. Magazines, newspapers, television, the Internet - all pay great attention to health issues and treatment. It is indicative that the media have a significant influence on patients' perception of the prescribed treatment and their agreement with the therapy. It is difficult to overestimate the danger of a situation in which a patient asks a doctor to prescribe a medicine about which the patient has already found information, and the doctor did not have such an opportunity or time.

The fourth reason for the emergence of EBM is associated with the general humanization of society, the emphasis on the independence and self-sufficiency of the individual. The need to obtain informed consent for treatment implies that the doctor offers information to the patient and helps him critically evaluate it. At the same time, self-improvement is becoming increasingly important for the doctor himself, which should be based on an independent search for new information, its critical assessment and implementation in practice. It is no coincidence that EBM appeared at McMaster University, which, back in the late 60s, took the risk of completely restructuring education at the Faculty of General Medicine in such a way as to strengthen independent work of students through the introduction of problem-based learning.

Issues of ethics and law in biomedical research are interrelated and should be considered together. Ethics extends not only to the totality of all the rights of the patient, and the very concept of "ethics" is much broader than the concept of "law". If for the observance of the law it is enough to strictly follow certain rules, then ethics requires from the doctor decency, honesty, disinterestedness in the broadest sense of the word, and this cannot be regulated by any law. Ethics imposes certain obligations on doctors and provides patients with guarantees of safety even before they are legally formulated and enshrined in law. The path of development of international law in the field of human rights protection in general, and in the medical field in particular, is quite long. There are a number of aspects of the doctor-patient relationship, the legal regulation of which has not yet been developed. In this case, high ethical principles and spiritual culture underlying the actions of a doctor who participates in clinical trials should play a decisive role.

Today, the ethics of biomedical experimentation is by no means just a wish list. There are norms for conducting such experiments that have been developed and tested by practice, as well as structures and mechanisms that make it possible to strictly control the observance of these norms.

A kind of "mechanism" of such control in most countries of the world today has become the so-called ethical committees created in research institutions that conduct experiments on humans and animals. To date, there are many normative documents developed and adopted by various international organizations, which, in fact, are the guidelines on which the members of ethical committees should rely in their activities.

Documents of biomedical ethics include: Nuremberg Code (1947), Helsinki Declaration (adopted at the 18th session of the World Medical Assembly in 1964), the Convention for the Protection of Human Rights and Dignity in Connection with the Application of Biology and Medicine: Convention on Human Rights and Biomedicine” of the Council of Europe (adopted in 1996).

The provisions of Nuremberg Code boil down to the main thesis that the voluntary consent of the subject and full disclosure of all the details of the experiment are absolutely necessary. The Nuremberg Code served as the basis for many subsequent international documents, each of which repeats its principles, expanding and adding new aspects of human experimentation. The principal provision of the Declaration of

Helsinki was the thesis that "the interests of the subjects must always prevail over the interests of science and society."

The Declaration of Helsinki by the World Medical Association.

Ethical principles for conducting scientific medical research involving humans. Adopted by the 18th session of the WMA General Assembly in Helsinki, Finland, in June 1964. This fundamental document had a marked influence on the formulation of international and national medical laws and codes. The Declaration includes the requirements of the widest spectrum for physicians participating in experiments and clinical trials. In 1966, the UN General Assembly approved the International Convention on Civil and Political Rights, which entered into force in 1976. Article 7 states: "No one ... shall be involved in medical or scientific experiments without his free informed consent."

The importance of the document in the life of society is emphasized by the fact that it has been revised several times. Amended by: 29th WMA General Assembly in Tokyo, Japan, October 1973; 35th WMA General Assembly, Venice, Italy, October 1983; 41st WMA General Assembly, Hong Kong, September 1989. the 48th WMA General Assembly in Somerset West, South Africa in October 1996 and the 52nd WMA General Assembly in Edinburgh, Scotland in October 2000.

Currently, new approaches and requirements for biomedical research are clearly defined. The scientific goals of clinical trials in the treatment of a patient and non-clinical biomedical trials in the performance of purely scientific medical research on humans must be justified, clearly stated in a special protocol, and approved by an independent ethical committee.

The Council of Europe Convention "On Human Rights and Biomedicine" [1] was adopted in order to prevent the possibility of negative consequences of the use of new medical technologies, to protect the rights and dignity of a person who finds himself in the role of a patient or test subject. Here are some of the provisions of the Convention. In the field of the human genome: genetic testing is allowed only for therapeutic purposes; intervention in the human genome can

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[1] Council of Europe Convention on Human Rights and Biomedicine http://hrlibrary.umn.edu/russian/euro/Rz37.html

only be carried out for preventive, therapeutic or diagnostic purposes. In the field of embryonic research: the creation of human embryos for research purposes is prohibited. In the field of transplantology: organ retrieval from living donors can be carried out only with their consent and exclusively for the treatment of the recipient; the human body and its parts should not serve as a source of financial gain. The Additional Protocol to the 1997 Convention proclaims a ban on human cloning.

The documents of Uzbek national legislation should be added to the above documents regulating the ethical foundations of biomedical research. First of all, this is the Law of the Republic of Uzbekistan on medicines and pharmaceutical activity. This law was adopted in a new edition in accordance with the Law of the Republic of Uzbekistan dated January 4, 2016 № ZRU-399 "On Amendments and Additions to the Law of the Republic of Uzbekistan "On Medicines and Pharmaceutical Activities" [1] , where article 10 establishes that clinical trials pharmacological agents are carried out in research institutes and clinical institutions, the list of which is approved by the Ministry of Health of the Republic of Uzbekistan. The right to make a decision on conducting clinical trials of pharmacological agents on a person is granted to the Ministry of Health of the Republic of Uzbekistan. The basis for the decision is: the consent of the patient-volunteer participating in the trials; results of preclinical study of the safety and efficacy of pharmacological agents; there is evidence that the possible risk of side effects from the use of a pharmacological agent will be significantly lower than the expected positive effect. In the event of unusual reactions during testing or a threat to society or the health and life of a volunteer patient, the head of clinical trials is obliged to suspend the trials and notify the Ministry of Health of the Republic of Uzbekistan about this. Financing of trials of pharmacological agents is carried out at the expense of legal entities and individuals who submitted the tested pharmacological agent. Article 11 of the above law defines the rights of a volunteer patient participating in a clinical trial. A volunteer patient who has given written consent to participate in clinical trials of a pharmacological agent must first receive from the doctor conducting the trial a detailed explanation of the meaning of the method, nature and

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[1] Law of the Republic of Uzbekistan "On Medicines and Pharmaceutical Activities" https://www.lex.uz/acts/2229

possible risk of such a trial, and must also be notified of their right to refuse participation at any stage tests. In the case of testing involving a minor or incapacitated patient, consent must be obtained in writing from parents or other legal representatives. A trial in juvenile patients should be preceded by a trial, usually in adult patients. Before starting a clinical trial of a pharmacological agent, the medical institution conducting the trial is obliged to conclude a life and health insurance contract with the insurance company.

The State Standard of Uzbekistan for Good Clinical Practice (GCP)[1] put into effect by the order of the Ministry of Health of the Republic of Uzbekistan №. 42 dated on February 13, 2013, was aimed at developing and improving the ethical review of clinical trials (CT) on the paradigmatic basis of bioethics. It is an important condition for the humanization of research activities, the practice of evidence-based medicine[2], and the healthcare system. The ethical review of clinical medicine refers to practices, standards, mechanisms and procedures for implementing the values and principles of bioethics in clinical medicine. The more medicine claims to serve the interests of society, the more significant role is played by CTs, the risk of participation in which for the patient is higher than in the case of an ordinary visit to a doctor for medical help. According to the adopted State Standard of Uzbekistan (GCP), a clinical trial / study is “any study involving a person as a test subject, conducted to identify or confirm the clinical, pharmacological and / or other pharmacodynamic effects of an investigational product, and / or identify any adverse reactions on it, and/or to study its absorption, distribution, metabolism and excretion in order to establish its safety and efficacy. Today, CTs are understood more broadly - as any research involving the patient as a test subject, conducted with the aim of improving clinical practice. At the same time, not only drugs can be studied, but also diagnostic and therapeutic schemes, medical equipment, and medical devices. Compliance of the study with this

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[1] The GCP standard (Good Clinical Practice) is an international standard for ethical standards and quality of scientific research, describing the rules for the development, conduct, documentation and reporting of studies that involve the participation of humans as subjects (clinical studies).

[2] ***Evidence-based medicine*** is a new technology for collecting, analyzing and interpreting scientific information. Evidence-based medicine is the use of the best clinical research results to select treatment for a particular patient; it is the integration of the best scientific evidence with clinical experience and patient expectations.

standard indicates public observance of the rights of study participants; rules to ensure their safety; intention to do no harm; requirements for the reliability of research. These rules were initiated in the Declaration of Helsinski of the International Conference on Harmonization (ICH). Together with GMP (Good Manufacturing Practice) and GLP (Good Laboratory Practice), GCP aims to standardize certain aspects of the quality of health care for the population. GCP, GMP and GLP standards are considered "three pillars" of evidence-based medicine. In paragraph 3.23. The State Standard of Uzbekistan determines the status of the ethics committee, its activities as an independent body that controls the implementation of the ethical principle of voluntary informed consent of the research participant, actively when reviewing the protocol of clinical trials with human participation, ensuring ethical guarantees for the protection of the rights, health and confidentiality of the subjects in the course of biomedical experiments.

3.23 Independent ethics committee; IEC (Independent Ethics Committee; IEC): An independent body (Committee operating at the institutional and national levels), composed of medical professionals as well as non-medical professionals, that ensures the protection of the rights, safety and well-being of research subjects and advocates for society as a guarantor of such protection, in particular by reviewing, approving the study protocol, nominations of researchers, research centers, as well as materials and methods that are supposed to be used to obtain and document the informed consent of research subjects. NECs shall operate in accordance with this standard (IS).

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Convention on Human Rights and Biomedicine (Strassburg, 2005)[1]. Ethics of clinical trials is an area of BME that defines the relationship between the subject and the object in the process of conducting clinical trials (CT) with human participation. It assumes that the conditions for conducting CTs comply with generally accepted norms of morality, the requirements for observing the rights, interests and personal dignity of CT participants, the subordination of the interests of science and other interests to the priority of individual rights and freedoms. Regulated by the rules for conducting qualitative clinical trials - GCP, adherence to which is considered as a public guarantee that the rights and health of the subjects, as well as their privacy, are protected, and the collected clinical data are reliable. The ethics of CI on a person presupposes the observance of a number of rules.

1. CTs must be conducted in accordance with generally accepted scientific principles and be based on adequate laboratory studies, animal experiments and knowledge of the current scientific literature. In any case, the subject must be a volunteer.
2. The program and implementation of clinical trials in humans should be clearly formulated in the experimental protocol, which is submitted to an independent committee for consideration, comments and suggestions.
3. A patient participating in a clinical trial should be informed about the objectives and methods of the study, the expected benefits, possible harm, as well as all the inconveniences associated with the study. He should be given the right to refuse to participate in the study or withdraw from it at any time. The physician must obtain prior written consent from the subject to participate in the study. In this case, the subject should not be in a position dependent on the doctor or consent must be obtained by another doctor who is not associated with the study. If it is physically or mentally impossible to give written consent (or if the study is a minor), permission can be obtained from relatives in accordance with the law.
4. CTs in humans should only be performed by qualified professionals under the supervision of a competent physician.

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[1] Additional Protocol to the Convention on Human Rights and Biomedicine in the field of biomedical research (ETS N 195) (Russian, English) Strasbourg January 25, 2005 http://docs.cntd.ru/document/901921573

Responsibility for human health lies with the doctor, not the researcher, even if he gave his consent to this.

5. Each planned trial should be preceded by a precise definition of the degree of risk and potential benefit; Human trials should not be performed if the expected benefit does not outweigh the potential risk. The interests of the researcher should be above the interests of science and society.

6. Measures should be taken to ensure respect for the personality of the test subject and to reduce the impact of the test on his physical and mental abilities.

7. When publishing the results, the doctor must observe their accuracy. Reports of experiments carried out without observing the principles set forth in the declaration should not be accepted for publication.

8. The CT protocol must contain a section with an ethical justification and a note that it is drawn up in accordance with the principles of the declaration of research in humans.

Ethics Medical Research - provides for additional moral rules-obligations of a doctor when conducting research related to the provision of professional medical care to a patient.

1. Within the framework of the research program, the physician should have the freedom to apply new diagnostic or therapeutic measures if they offer hope of saving lives, restoring health or alleviating the suffering of the patient.

2. The likely benefits, harms, risks, or inconveniences of the new method must be weighed against the best available diagnostic and therapeutic methods.

3. In any medical study, every patient, including patients in the control group, must be guaranteed the use of the best proven methods of diagnosis and treatment (in this sense, the use of placebo for patients in the control group is unethical).

4. In any case, the subject must be a volunteer; the patient's refusal to participate in the study should not violate his relationship with the doctor and medical staff.

5. The doctor may combine medical research with professional assistance to obtain new medical knowledge to the extent that these researches are of diagnostic or therapeutic value for the patient.

6. When conducting purely scientific clinical research, the duty of the doctor is to protect the life and health of the person - the object of clinical research. The researcher must stop the experiment if the continuation of the research may cause harm to the health of the subject.

7. In human research, the interests of science and society should never be placed above the health of the subject.

Questions for self-examination

1. What organizations regulate various ethical and medical positions and moral and ideological orientations of the international community?

2. What documents have been adopted in the field of ensuring the rights of the patient?

3. When and where was the first international "Code of Rules for Conducting Experiments on Human Beings" adopted?

4. In what code for the first time in the history of mankind was the idea of the primacy of individual interests over the interests of both science and society put forward?

5. What is the principle that has become a form of legal protection for the patient?

6. What is a clinical trial/study experiment?

7. What ethical standards govern biomedical research?

8. List and describe the main provisions of the patient's informed consent to participate in a clinical trial

9. What are the functions of Ethics Committees (international, national)?

10. What are the main questions of pharmaceutical bioethics?

11. What events preceded the adoption of the World Helsinsk Declaration?

12. What is the meaning of the Helsinsk-Tokyo Declaration?

13. What is the role of evidence-based medicine (EBM) in solving the problems of pharmaceutical bioethics?

14. Ethics of conducting clinical trials of fundamentally new, previously unused drugs. The need to obtain informed consent.

15. The main objective of the Cochrane collaboration.

16. The main reasons that led to the spread of EBM. The relevance of the value due to the ethical side of EBM.

Bibliography

1. Lisbon Declaration of the Rights of the Patient, prin. in 1981, Lisbon, Portugal, add. v 1995, Bali, Indonesia [Lisbon Declaration of Patients' Rights, approx. in 1981, Lisbon, Portugal; updated 1995, Bali, Indonesia]. Available at URL: http://www.e-stomatology.ru/star/info/2010/lissabon_declaration. (accessed Jan. 20, 2012). [in Russian]

2. European Patient Rights Policy Declaration, Amsterdam, 1994 [Declaration of Policy in Sphere of Patients' Rights Assurance in Europe, Amsterdam, 1994]. Available at URL: http://europadonna.by/index.php?option=com_content&view=article&id=89:2010-01-18-11-42-13&catid=38:2010-01-10-09-32-1 1&Itemid=41 (accessed Feb. 14, 2012). [in Russian]

3. Gustav Mark Gilbert Nuremberg diary. [translated from English. A.L. Utkin]. — M . : Veche, 2012. - 480 p. : ill. - (Military archive). http://www.pseudology.org/Pobeda/Gilbert_Nurenberski_Dnevnik2.pdf : Nuremberg Trials. http://nurnbergprozes.narod.ru/;

4. Glyazer G. Drama medicine.- M., 1965

5. Howard-Jones N. Experiments on people in the historical and ethical perspective // Health of the world, - 1982, - No. P. - pp. 9-16.

6. https://idd.mid.ru/informacionno-spravocnye-materialy/-/asset_publisher/WsjViuPpk1am/content/uroki-nurnberga-i-sovremennost-

7. Law of the Republic of Uzbekistan On the protection of consumer rights. No. 221-I 04/26/1996, 12/25/2019, No. 03/19/597/4193); Resolution of the Cabinet of Ministers of the Republic of Uzbekistan on measures to complete the experiment and deepen reforms in the healthcare system. https://www.lex.uz/acts/303433; Law of the Republic of Uzbekistan On Compulsory Medical Insurance.

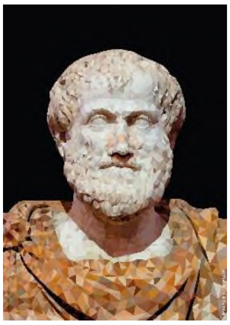
https://regulation.gov.uz/oz/document/4930; Resolution of the Cabinet of Ministers of the Republic of Uzbekistan On guaranteed volumes of free medical care covered by funds State budget of the Republic of Uzbekistan https://regulation.gov.uz/oz/document/3710

8. Declaration of Helsinki of the World Medical Association: recommendations for physicians on conducting biomedical research in humans. — Helsinki. - 1964, additions 1975, 1983, 1996, 2000
9. WORLD MEDICAL ASSOCIATION DECLARATION OF HELSINKI Ethical Principles for Medical Research Involving Human Subjects https://web.archive.org/web/20071027224123/http://www.wma.net/e/policy/pdf/17c.pdf
10. Good clinical practice (GCP)https://www.ema.europa.eu/en/ich-e6-r2-good-clinical-practice
11. Decree of the Cabinet of Ministers of the Republic of Uzbekistan on amendments and additions to some decisions of the Government of the Republic of Uzbekistan (Decree of the President of the Republic of Uzbekistan dated December 7, 2018 № UP-5590 “On comprehensive measures to radically improve the healthcare system of the Republic of Uzbekistan”) https://regulation.gov.uz/ru/document/2043
12. Medical resources of the InternetEvidence-based medicine (5) http://nlr.ru/res/inv/ic_med/cat_show.php?rid=347
13. The Cocrane Library https://www.cochranelibrary.com/
14. Vlasov. V.V. Introduction to Evidence-Based Medicine. M.2001; Melnichenko G.A., Buziashvili I.I., Proskurina I.A. Evidence-based medicine and international multicenter clinical trials in endocrinology. Scientific Center for Expertise and State Control of Medicines of the Ministry of Health of the Russian Federation, M. Vedomosti SCMMH-Sept. 1999 № 1
15. Mukhamedova Z.M. Ethical problems of biomedical cultural research in the field of organ and/or tissue transplantation. Ethical aspects of new biotechnologies in biology and medicine. Collection of reports of scientific conference.T.2006 pp.44-54
16. Convention for the Protection of Human Rights and Dignity with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. http://hrlibrary.umn.edu/russian/euro/Rz37.html

17. Law of the Republic of Uzbekistan dated January 4, 2016 № ZRU-399 “On amendments and additions to the Law of the Republic of Uzbekistan “On medicines and pharmaceutical activities. https://www.lex.uz/acts/2229

18. Additional Protocol to the Convention on Human Rights and Biomedicine in the Field of Biomedical Research (ETS N 195) (Russian, English) Strasbourg 25 January 2005 http://docs.cntd.ru/document/901921573

CHAPTER V. DEATH AND DYING. LEGAL AND MORAL AND ETHICAL ASPECTS OF EUTHANASIA. PROBLEMS OF EUTHANASIA - MYTHS AND REALITY OF EUROPEAN PRACTICES. MEDICAL, BIOMEDICAL AND PHILOSOPHICAL ASPECTS OF MODERN PALLIATIVE CARE.



Although we are mortal, we should not be subject to corruptible things, but as far as possible, rise to immortality and live according to what is best in us.
Aristotle

Without knowing what life is, is it possible to know death?
Confucius

Where there is me, there is no death;
where there is death, there is no me.
Therefore, death is nothing to me.
Lucretius

Key words. *Clinical death, Stages of dying (E. Kübler-Ross): ethical and medical aspects of the problem, Resuscitation is a direct personification of the scientific and technological achievements of man, Tantology (from the Greek thanatos - death, logos - teaching), The right to a dignified death is the natural right of every person, the same as the right to a dignified life because death is the other side of human life, euthanasia.*

The concept of "death" (clinical, biological). Brain death. The problem of death criteria

Death is the cessation of the vital activity of the organism and, as a result, the death of the individual as a separate living system. Determining the philosophical and ontological status of death involves solving the problem of the existence and essence of death. It appears as a process of dying: the transition of one quality into another, one form of being into another - the living into the dead.

Clinical death - a special kind of existence - a terminal state, the border of being and non-being of the living; the process of dying as a transition from one quality to another. The time interval characterizing the CD - 5–6 minutes (sometimes less) - is a quantitatively expressed measure of the still remaining life. There are ongoing disputes around the concept and essence of the CD. Some scientists point out that the CD "is no longer life, but is not yet death" (V.A. Negovsky)[1]. Others consider it a "qualitatively special form of life", since, from a biological point of view, a sufficient number of "elements of life" are still preserved during CD, many of whose functions have only been suspended (A.Ya. Ivanyushkin)[2]. Hence, the specific feature of "clinical death" is its fundamental reversibility, which gives rise to an ethical imperative that requires physicians to treat CD as a condition in need of urgent measures to help the dying.

Criteria for death are signs that determine the final degree of degradation of the life process and the objective onset of death. Modern concepts propose to consider necrosis of the brain as such a criterion for the death of a human individual. It is in this case that the autonomy and individuality of the individual is lost, since the brain is the bearer of life, ensuring its autonomous integrity, sovereignty and individuality (even in the biological sense). Therefore, the death of the brain is the splitting of the foundation of life, because it is in this case that its attributive qualities are lost.

Stages of dying (E. Kübler-Ross): ethical and medical aspects of the problem[3].

The problem of death is essentially a moral-religious and medical problem. And if religion and morality are a kind of "metaphysics" of human death, then its "physics" is medicine. For centuries in the space of European Christian civilization, they complemented each other in the process of forming mourning rituals, customs, burial norms, etc. Medical hygiene standards and the recognition of the possibility of errors in the diagnosis of death (cases of imaginary death and premature

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[1] Moroz V.V., Bobrinskaya I.G., Vasilyev V.Yu., Kuzovlev A.N., Perepelitsa S.A., Smelaya T.V., Spiridonova E.A., Tishkov E.A. / Cardiopulmonary resuscitation. M.: FNKTs RR, MGMSU, NIIOR, 2017, – 60 s.

[2] Биомедицинская этика : слов.-справ. / Т.В. Мишаткина, Я.С. Яскевич, С.Д. Денисов [и др.] ; под ред. Т.В. Мишаткиной . — Минск : БГЭУ, 2007. — 90 с.

[3] Kübler-Ross E. About death and dying. - Kyiv: Sofia, 2001, 110 p.

burial) were reasonably combined with the custom of Christian funeral service and burial on the third day after mouth. Medical diagnosis of death, associated with a statement of the cessation of breathing and cardiac arrest, was consistent with the Christian understanding of the heart and breathing as the foundations of life. Not surprisingly, the first scientifically based attempts to revive the dead were associated with the restoration of respiratory capacity and circulatory function. So, for example, in 1805, Dr. E. Mukhin proposed, in order to revive the supposedly dead, to blow air into the lungs with the help of furs. By the beginning of the 19th century, in many European countries, the question of a new definition of death was raised, which was already associated with the absence of the effect of the body's response to artificial respiration.

In the 19th century, the rapid development of medical technical means began, which were successfully used to more accurately ascertain death and at the same time tested new methods of reviving the body. In Russia, the first successful attempt to revive a heart extracted from a human corpse was made in 1902 by Dr. A. A. Kulyabko (Tomsk University). and S. I. Chechelin, he was called "autojector". During the Great Patriotic War, V. A. Negovsky and his colleagues developed a "complex method of reviving" the body. At the same time, a detailed study of the processes of the final stages of life is taking place. Negovsky distinguishes five stages of dying - preagonal condition, terminal pause, agony, clinical and biological death.

The difference between clinical death (reversible stage of dying) and biological death (irreversible stage of dying) was decisive for the development of resuscitation - a science that studies the mechanisms of dying and reviving a dying organism. The term "resuscitation" itself was first introduced into circulation in 1961 by V. A. Negovsky at the International Congress of Traumatologists in Budapest.

The formation of resuscitation in the 1960s and 1970s is considered by many to be a sign of revolutionary changes in medicine. This is due to overcoming the traditional criteria of human death - the cessation of breathing and heartbeat - and reaching the level of acceptance of a new criterion - "brain death". The fundamental changes introduced by the achievements of medical science into the temporal space of death turn into an increase in the ethical tension of medical practice. Is resuscitation the best outcome for the patient in each case? Of course, a set of technical means for maintaining life makes it possible to prevent death for a number of patients, but at the same time, for others, this “maintenance” turns out to be only a way to prolong dying.

Resuscitation is a direct personification of the scientific and technological achievements of man.

However, a rather rigid relationship arises between a person and the technical means created by him. M. Heidegger gives the following comparison: “Technical, in the broadest sense of the word, is nothing but a plan” created by a person, but which, in the end, forces a person to act, regardless of whether he wants it or not[1].

The intensive care units of modern hospitals are equipped with state-of-the-art facilities that make various resuscitation procedures possible.

A healthcare system equipped with this technology is no longer able to refuse its use, often turning its patients into disenfranchised victims. The line between the maintenance of life and the prolongation of dying becomes so thin that death turns out to be a long-mechanized process of dying, which can be technologically extended up to 10 years.

Speaking of comatose patients, Professor B. G. Yudin very aptly calls the period between the state of "definitely alive" and "definitely dead" - "a zone of uncertainty." this “zone” is typical of such judgments of doctors: “The person is still alive, but he is unconscious, it is necessary to wait for his physical death from hunger, infection”, or, which is the same thing, “the person is dead, but he is still breathing, it is necessary to stop breathing” . Within the limits of the new achievements of medicine, a beating heart and breathing are not signs of life. The statement of “brain death” defines personal death, within the boundaries of which “vegetative” (at the cellular level) life is acceptable. New medical postulates are adapted with great difficulty in the public mind, for which the judgment that death has been ascertained, but the person is still breathing is very strange.

Modern medicine corresponds to the modern image of a person as, first of all, a rational being, which also corresponds to a new criterion for his death - “death of the mind” or “death of the brain”, or “neocortical death”, i.e., failure of the brain to perform its functions of

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[1] Heidegger M. The Law of Identity. Conversation on a country road. – M.: Higher School, 1991. – P. 75.

thinking, reasoning, contact with people. Relatives of a patient who finds himself in the "zone of uncertainty" must reach the level of new guidelines that correspond to what is happening in medicine.

Indeed, the “zone of uncertainty” turns out to be literally outside the space of biblical ethical precepts. The sixth commandment “Thou shalt not kill” does not work in this zone, because in terms of traditional morality is the “zone” of inevitable killing or “withdrawal of life supportive care”. But who should make and implement the decision on the death of a person? Technological advances require the most objective and rational attitude of a person to his death. A rational attitude to one's death presupposes answers to the questions, how would he like to die, who should make the decision in the corresponding situation, how strictly and by whom his will should be carried out?

Trying to free from moral and legal responsibility the unwitting executors of the "will of the zone" - doctors, culture turns to the principle of euthanasia - the deliberate, painless killing of hopelessly ill people.

Tantology (from the Greek thanatos - death, logos - teaching) - a branch of medicine that studies the causes, signs and mechanisms of death, the course of the dying process, changes in body tissues associated with dying and death. T. is also interested in the ethical issues of medical intervention in the processes of dying - the revival of the body (resuscitation) and the relief of the patient's dying suffering (euthanasia, hospice movement). The duty of "perjury" in the name of ensuring the right of a terminally ill person to "ignorance" has always been a feature of professional medical ethics in comparison with universal morality. The basis of this duty are quite serious arguments. One of them is the role of the psycho-emotional factor of faith in the possibility of recovery, maintaining the struggle for life, and preventing severe spiritual despair. It is known that "perjury" in relation to incurable and dying patients was the deontological norm of Soviet medicine. “In matters of life and death, Soviet medicine admits a single principle: the struggle for the life of the patient does not stop until the last minute. It is the duty of every medical worker to sacredly fulfill this humane principle,” the textbooks on medical deontology instructed. Since it was believed that the fear of death brings death closer, weakening the body in its fight against the disease, the communication of the true diagnosis of the disease was considered tantamount to a death sentence. However, there are cases when the "holy lie" did more harm than good. Objective doubts about the well-being of the outcome of the disease cause anxiety in the patient, distrust of the doctor, which are negative psychological factors. The attitude and reaction to the disease in patients are different, they depend on the emotional and psychological warehouse and on the value-worldview culture of the patient. It is known that when Z. Freud learned from a doctor that he had cancer, he whispered: “Who gave you the right to tell me about this?” Questions: is it possible to open a diagnosis to a patient or relatives, or should it be kept secret, or is it advisable to tell the patient a less traumatic diagnosis, what should be the measure of truth - the inevitable and eternal questions of professional medical ethics.

Numerous studies of the psychology of terminal patients are currently available to specialists. Noteworthy are the works of Dr. Elisabeth Kübler-Ross (German: Elisabeth Kübler-Ross; July 8, 1926, Zurich - August 24, 2004, Scottsdale, Arizona, USA) - an American psychologist of Swiss origin, the creator of the concept of psychological assistance to dying patients and a researcher of near-death experiences. Her 1969 book On Death and Dying became a bestseller in the United States.

The first raised the question of the doctor's responsibility not only for the health of the dying, but also for the fact that the last days of the patient's life were lived with dignity, without fear and torment. She became interested in the topic of death in childhood, when she first saw a dying person. It was her neighbor who fell from a tree and died in his bed among family and friends. According to another version, when her roommate died, alone in a cold medical atmosphere, away from her family. Then Elizabeth thought that there was a right way to die.

Kübler-Ross graduated from the medical faculty of the University of Zurich, after which she left for the United States in 1958. She worked extensively in hospitals in New York, Chicago and Colorado. She deeply resented the treatment of dying patients by doctors. Unlike her colleagues, she communicated with the dying, listened to their confessions. This is how the course of lectures on the near-death experience appeared.

Later, in her books, lectures, and seminars, she increasingly focused on her own travels out of the body and the afterlife. Kubler-Ross did not believe in the existence of death and considered death to be a transition to another state. She believed in an afterlife and believed that after death people become full-fledged: the blind can see, the deaf can hear, and the crippled cease to be crippled since all their injuries cease to exist. and her colleagues came up with the concept of "death as a stage of growth". Schematically, this concept is represented by five stages through which a dying person (usually an unbeliever) passes. The first stage is the "stage of denial" ("no, not me", "this is not cancer"); the second is the “protest” stage (“why me”); the third stage is the "request for a delay" stage ("not yet", "a little more"), the fourth stage is the "depression" stage ("yes, I'm dying"), and the last stage is "acceptance" ("let it be"). The stage of "acceptance" attracts attention. According to experts, the emotional and psychological state of the patient at this stage changes fundamentally. The characteristics of this stage include such statements by once prosperous people as: “Over the past three months I have lived more and better than in my entire life.” Surgeon Robert Mack, a patient with inoperable lung cancer, describing his experiences - fright, confusion, despair, in the end, states: “I am happier than I have ever been before. These days are now actually the best days of my life." One Protestant priest, describing his terminal illness, calls it "the happiest time of my life." As a result, Dr. Elisabeth Kübler-Ross writes that “I would like cancer to be the cause of her death; she does not want to lose the period of personal growth that terminal illness brings with it. This position is the result of awareness of the existential drama of human existence, which lies in the fact that only “in the face of death” does a person discover new knowledge - the true meaning of life and death.

The right to a dignified death is the natural right of every person, the same as the right to a dignified life because death is the other side of human life. Includes two aspects:

1. The right to die (RD), based on the moral right of a person to freely, at his own discretion, dispose of himself, his life, and death, up to the refusal of treatment in situations where it is too painful, unpromising and leads to the loss of human dignity. Adherents of traditional medical deontology speak out against RD, believing that it does not belong to such fundamental human values as the right to life, and if recognized, it will lead to adverse consequences for society (mass abuses, discrediting the medical profession, patients' panic fear of doctors). Their opponents claim that the desire and free choice of a person should be considered

the highest law, that the recognition of the patient's right to end his own life does not contain any threat to public interests, since it concerns the sphere of personal freedom that is not subject to social regulation.

2. The right to a dignified death (RDD), in which the generic essence of a person is manifested - the natural desire to receive pleasure and avoid suffering - physical and spiritual. PDS fixes the moral aspects of dignity, harmonizing the life of an individual and society as a whole. Not only death for personal reasons, when a person himself prefers a dignified death to an unworthy life, but also non-standard situations generated by scientific and technological progress in the practice of medicine (organ transplantation, maintaining a person in an unconscious - "vegetative" state, new approaches to determining the criterion death, etc.) force the society to revise and deepen its attitude towards the RDD. This right implies a moral concern for the autonomy and dignity of the dying person, first of all, on the part of medical professionals who must give the patient truthful information about the diagnosis of his disease, about medical procedures, and the arguments for and against them, so that the patient himself can make a choice. RDD includes the concept of "dying with dignity".

Ethical problems arising in the curation of terminally ill patients

The modern hospice movement is based on a special ethics and philosophy of healing, according to which death, like birth, is a natural process, it cannot be rushed or slowed down. The dying person needs a special kind of help: he can and should be helped to cross the border between life and death. This is the challenge that hospices set for themselves. Hospice is not a house for death, it is a house for a quality life to the end. Chronic pain and suffering change the worldview of a person: experiencing unbearable pain, he is unable to think, and remember; pain is able to displace moral needs and moral motivation of behavior. Hospice creates such conditions, the patient's lifestyle, such a "living space" that allows you to take control of the pain and suffering of even the most severe patients. It provides such a quality of life when the present, not the future, is self-sufficient and relevant. The relationship between patients and medical personnel is formed here on the basis of the principles of the hospice movement, the implementation of which depends on the training and personal qualities of medical personnel. Currently, a new medical specialty is being formed for the hospice service, which studies the end-of-life process - the palliative care physician.

Cultural-religious and moral-philosophical aspects of human death

From black dust to heavenly bodies
I unraveled the secrets of the wisest words and deeds.
I avoided deceit, unraveled all the knots,
Only the knot of death I could not unravel ...

Abu Ali Husayn ibn Sina

Death is the final stage of life.

Humanity has been trying to unravel the phenomenon of death since ancient times. Death is a dream from which there is no return to the real world, death is a transition to another, extraterrestrial world, and death as the cessation of the life of the human body ... These and other options for explaining the phenomenon of death have replaced each other in the history of mankind and still exist within different cultures. Understanding what constitutes the life and death of a person is at the same time the answer to the question of what a person himself is - one of the forms of matter that take place in earthly conditions or something else. In bioethics, the problem of death and dying of a person has been considered from the standpoint of modern scientific ideas that death is a state of complete cessation of human life. The functioning of all organs and systems of the human body stops and a state sets in in which no kind of human activity is possible - neither spiritual, psychological, social, nor physiological. The entire spiritual and social life of a person is understood as the result of mental activity, and the psyche is a property of a highly organized matter - the brain. Brain death becomes death for a person at the same time in all other respects. The irreversibility of the physiological changes that occur at the moment of biological death means the cessation of the existence of a person in a certain qualitative state as a material object - in the fullness of his physiological, psychological, sociocultural, spiritual characteristics as a person, a representative of the earthly genus Homo sapiens. Man perishes as an integral biosocial entity. Death is a natural state that ends a person's life.

The task of bioethics is to study the phenomenon of human death as a biosocial system included in the system of sociocultural relations of society. The bioethical analysis involves consideration of other points of view that exist within the theological, philosophical, psycho-esoteric, and other approaches:

1) Currently, in medicine, clinical and biological death is distinguished. The main sign of biological death is brain death. Biological death is characterized by the complete and irreversible disappearance of the functions of the brain and all organs. Clinical death is characterized by respiratory arrest, circulatory arrest, artificial maintenance of blood flow, and ventilation of the lungs, preserving the functions of the central nervous system.

2) In the theological understanding of human life and death, the soul and body become the initial concepts. The physical body is mortal, subject to destruction, the soul is immortal. In all world religions, biological death is understood as a transition from one form of life (terrestrial) to its other form - the life of the soul in another, extraterrestrial region of the universe. The results of medical and psychological research are in consistent agreement with the Abrahamic religious consciousness (Judaism, Christianity, Islam) about a dying person. Death in Islam is the end of worldly life and the beginning of the afterlife. Death is seen as the separation of the soul from the body and its transfer from this world to the afterlife. Thus, it is the continuation of life in another form for which the Muslim must prepare. There is an ethic towards those who leave this world. It is necessary to remind a person on his deathbed of the words of the shahada “la ilaha illa Allah”, since a person during this period experiences a difficult condition that can distract him from these words. Suicide, euthanasia, and murder as a means of death are prohibited in Islam and are considered the most serious sin. Death is an important event in Islamic life and theology. It is seen not as the cessation of life, but as the continuation of life in another form. Orthodoxy does not accept the principle of "perjury" towards dying believers, and religious people. This lie "deprives the personality of the decisive final moment of the lived life and thereby changes the condition of humans not only of life in time, but also in eternity." Within the framework of the Christian worldview, death is the door to the space of eternity. Deadly illness is an extremely significant event in life, it is preparation for death and humility with death, it is repentance and a

chance to beg for sins, it is deepening into oneself, it is intensely spiritual and prayer work, it is the exit of the soul into a certain qualitative state, which is fixed in eternity. “Hiding information about a serious condition from a patient under the pretext of preserving his spiritual comfort often deprives the dying person of the opportunity to consciously prepare for death and spiritual comfort gained through participation in the Sacraments of the Church, and also darkens his relationship with relatives and doctors with mistrust.” The patient's right to a personal image of the world, and freedom, and self-determination, despite the obvious inconsistency of one or another choice with the "principle of benefit", no matter how obvious it may seem to someone, is the basis of the doctrine of "informed consent". The duty and responsibility of a doctor within the framework of this doctrine are understood as a duty to the freedom and dignity of a person and a responsibility for preserving the value of human life, "following from the high divine dignity of a person."

3) The third position in understanding the phenomenon of death is a combination of scientific and religious ideas, based on the data of modern psychophysiological studies of brain activity, studies of the psyche by representatives of transpersonal psychology, etc.

R. Moody conducted a study of the experience of people who survived clinical death. After analyzing the medical histories and stories of people who survived clinical death, he came to the conclusion that everyone had a feeling of separation from their own physical body, the ability to see and understand what was happening with their physical body, but the inability to make contact with people whom a person sees and hears, then a quick movement through a dark tunnel, at the end of which he sees the light. Once in the stream of this light, people heard someone's voice and decided that they needed (or could) return to their former life. The results of this study by R. Moody are evaluated by scientists as very ambiguous, primarily because it is extremely difficult to verify this experimentally. From the standpoint of modern science, these phenomena are explained mainly by cerebral hypoxia, which occurs at the time of clinical death. Since the activity of the brain does not stop at once, but its various departments are gradually turned off, several images and experiences associated with them arise.

In the theological approach, the states described by R. Moody that occur in a person at the time of his clinical death are experiences of the soul leaving the physical body and communication with God, who decides whether the person returns to his earthly life or stays in the other world[1].

What happens to a person at the time of his dying, and then death - an outside observer can't find out due to the lack of complete objective data, the fact that the person himself can no longer share the content of his experience of death.

Human death is inherently ambivalent. On the one hand, it is a painful [2] transition to another physical state, breaking ties with everything dear, and loved, and on the other hand, liberation as a result of this transition from everything unpleasant, and painful that took place in life, including suffering caused by illness. “The annihilation of all our conscious experience implies the disappearance of not only all painful memories commemorations but also all pleasant ones” writes R. Moody. The process of dying can be extended in time (months, years), or it can be reduced to several minutes (sudden death). When the process of dying lasts long enough and is accompanied by excruciating human suffering, the question of euthanasia arises.

Is a person free in his actions regarding his death, especially in the case of an incurable disease? Society has recognized a person's right to life, the right to health, and the right to dispose of one's health at will (the right to information about one's health, the right to lead any lifestyle, etc.), but the right to free will regarding one's death is not completely recognized.

Death is a natural phenomenon that crowns the end of life. There is no choice: Man is finite, and his life is limited by conception and death. Therefore, the most important ethical task is to develop mechanisms of protection against the fear of death - emotional and rational. The English philosopher F. Bacon sees the possibility of emotional protection from the fear of death in the fact that “... there is not even the weakest passion in the human soul that would not overcome the fear of death, which means that death cannot be such a terrible enemy, since a person has a whole army capable of defeating it. Revenge triumphs over death; love despises her; honor calls her; sorrow seeks refuge in it; fear anticipates

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[1] Moody Raymond. Life after life. Sofia 2009.

[2] Bacon F. Experiments, or moral and political instructions. Works in two volumes. 2nd, rev. and additional ed. T. 2. Comp., total. ed. and will enter, article by A. L. Subbotin. M., “Mysl”, 1978. 575 p. (USSR Academy of Sciences. Institute of Philosophy. Philosophical Heritage).

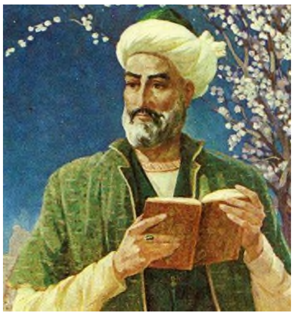
it…” Rational protection against the fear of death was provided even in ancient religious cults.

The teachings of Socrates, Plato, and Aristotle about the immortality of the soul soften the tragedy of death. A simple argument that removes the fear of death is given by Epicurus: “... the most terrible of evils, death, has nothing to do with us; when we are, there is no death yet; and when death comes, we are no more.” Subsequently, these and other similar ideas are perceived by Christianity and become a tradition of European spiritual life.

An important modern ethical and philosophical problem is the definition of the status of death: in what sense should its existence be recognized? If death exists, then it exists as dying, as the transition of one quality into another: the living into the dead. The boundary between the existence and non-existence of the living is a special kind of existence – “clinical death”. Its specific feature is its fundamental reversibility, which gives rise to an ethical imperative that prompts immediate assistance to the dying. The main form of such assistance is resuscitation – “reviving” a person, bringing him back to life. At the same time, the process of resuscitation often returns a person not only to life, but also to suffering, or maintains life at such a low level of its quality that it can be unbearable for the patient. Therefore, one of the most important moral problems of resuscitation is the problem of choice, decision-making on the need for resuscitation, its duration or termination; the solution to the question of how long the efforts of resuscitators to prolong the life of a hopelessly ill person are reasonable, and what ethical and legal standards should be guided by.

What should be considered the criterion of death? The phenomenon of “clinical death” is closely related to the ethical problem of determining the criterion of death: what degree of degradation of the life process should be considered as objectively occurring death? Modern concepts see such a criterion in brain death. However, some signs of life still visible (for example, contractions of the heart muscle) may remain, so centuries-old medical traditions do not allow a person to be recognized as dead. And then the question arises: isn't the shutdown of the equipment that artificially maintains its existence a murder? This question is not abstract and speculative; it contains ethical grounds for solving the practical problems of modern biomedicine. One of the most significant precedents in this regard was the “Quinlen incident”, which forced not only physicians, but also ethicists, philosophers, and lawyers to solve the difficult issue of saving or terminating the life of a young girl who had been in a state of clinical death associated with brain death for many years... How to relate to this phenomenon of “vegetative existence”: is it life or not, what should be done in this situation - to maintain this existence or stop it, how to qualify the actions of doctors in the latter case? Today, with appropriate medical and economic support, patients in a "vegetative" state can live, or rather, exist for a long time even after brain death. The question is, is it necessary, what does it give? Even in the most favorable case, it is not known whether normal consciousness will return to the saved person (after all, until recently brain damage was considered irreversible).

Why then preserve this plant-animal existence if a man has ceased to be a person? At the same time, today there are more and more reports of return to the life of people who have existed for a long time in a vegetative state. This further complicates the doctor's decision in case of ascertaining brain death. Is it possible to talk about the progress of medical humanism in connection with the recognition of brain death as a criterion for human death? Isn't medicine inferior to considerations of utilitarian expediency, substantiating and justifying the right to cut down the thread of human life in this case? Similar questions, primarily moral ones, arise when discussing other problems of BME: euthanasia, transplantation, etc.



***Legal and moral-ethical aspects of euthanasia*.**

“Words can prevent death;
words can revive the dead."
Navoi

The English philosopher F. Bacon (1561 - 1626) introduced the term "euthanasia" (from the Greek Euthanasia, eu - good, Thanatos - death) to denote an easy painless death, that is, a good, calm, and easy death, without torment and suffering. Literally, the term "euthanasia" is translated as "good dying", but the term itself began to mean not so much a "good" death in itself, but rather its infliction.

Euthanasia can be defined as “deliberate actions or omissions by a medical professional, which are carried out following the explicit and unambiguous request of an informed patient or his legal representative to stop the physical and mental suffering of a patient who, according to medical indicators, is in a life-threatening condition, as a result of which come to his death."

The term ***"euthanasia"*** is characterized by extreme inconsistency, which makes it difficult to unambiguously interpret, causing terminological confusion. Depending on the definition of the term, the approach to the problem of euthanasia also changes. There is passive and active euthanasia (the criterion is the position of the doctor), voluntary and involuntary (the criterion is the position of the patient).

Passive euthanasia (or as it is also called the “delayed syringe method”) is expressed in the fact that the provision of medical care aimed at extending life is stopped, which accelerates the onset of natural death - which in practice is quite common in our country.

Most often, when people talk about euthanasia, they mean active euthanasia. Active euthanasia (“the method of a filled syringe”) is understood as the introduction to a dying person of any drugs or other means, or other actions that entail a quick and painless onset of death.

Active euthanasia can take the following forms:

1) "Mercy killing" occurs in those cases when a doctor, seeing the painful suffering of a hopelessly ill person and being unable to eliminate them, for example, injects him with an overdose of an anesthetic drug;

2) "Physician-assisted suicide" occurs when a doctor only helps a terminally ill person to end his life;

3) Active euthanasia can occur without the help of a doctor. The patient himself turns on the appropriate device as if laying his hands on himself.

We are talking about euthanasia only when we are dealing with the deliberate infliction of death. In one case, the life is taken from a hopelessly, terminally ill person - to save him from unnecessary suffering - either through direct intervention (for example, injections), or "leaving him to die", stopping the artificial nutrition of the patient. In another case, a severely handicapped newborn child is deprived of his life when he is directly killed or doomed to certain death by cutting off the supply of food and basic medical treatment just so as not to inflict further pain on his parents. So, euthanasia itself is placed on the level of intentions:

- euthanasia is mentioned only when there is an intention to end the life of the person or hasten his death;
- we are not talking about euthanasia when they try to alleviate the suffering of a person who is in the last stage of a serious illness by prescribing him medicines that can only indirectly accelerate the physiological process of dying. In this case, they do not set themselves the goal of "helping die" the patient but try to reduce his pain with the help of drugs that, only as a side effect, can hasten the approach of the end. Death here is not provoked intentionally, or directly, but is a possible consequence of analgesic therapy.

Many scientists fear that the formal permission of euthanasia may become a certain psychological brake on the search for new, more effective means of diagnosing and treating seriously ill patients, as well as contribute to dishonesty in the provision of medical care to such patients.

Euthanasia can be put into several different medical practices:

- euthanasia is present when a drug that causes death is used, and also if the patient is deprived of everything that he needs for life (food), or of what is beneficial for him (resuscitation, which would allow him to recover and self-sustaining life, or such treatment that can give a chance to continue life under normal conditions);
- there is no euthanasia in the case when such treatment is stopped, which would hurt the patient (for example, a treatment that would only prolong life itself in inhuman conditions, without alleviating the patient's condition);
- there is no euthanasia in case of termination of resuscitation when the state of cerebral death is irreversible (no treatment alleviates suffering, does not give any chance for further recovery, but only prolongs the agony and, in addition, brings suffering to the family and disproportionate costs to the state);
- there is no euthanasia in case of non-resuscitation of a newborn child affected by congenital deformities, or in a severe pathological case if it naturally leads to death (when it is only artificially possible to

continue life, without hope for improvement and the emergence of the ability to independent existence);

- there is no euthanasia if the patient is "allowed to die in peace" with an incurable disease, which naturally leads to death in a short time - in the case when any therapy would allow only for a short time to prolong life in unbearable conditions.

Moral, ethical, and legal aspects

Speaking of euthanasia, two questions arise - moral and ethical (“What can be said about the character of a person who commits such actions?”) And legal (“Should such actions be prohibited by law?”). Some argue that while euthanasia is immoral, it should not be banned by law. They argue that, firstly, the costs of implementing these sanctions are too high, and secondly, the prospect of disobedience is so wide that it already undermines general respect for the law – not applicable in this case.

Others argue that while euthanasia is not wrong in all cases, it should not be allowed by law. One variant of this argument argues that euthanasia is morally permissible only in rare cases, but even there it should be banned because the practice is so easily abused that legalizing euthanasia will do more harm than good. Another option is that legalization puts many people in the difficult position of either continuing to live or dying and getting out of the way—a position in which no one should be put.

In foreign literature, many options for the moral assessment of euthanasia are offered. Most authors support passive euthanasia and reject any possibility of active euthanasia. However, there are also opposing opinions. For example, the prominent American philosopher J. Reigels sharply criticized the Decree of the American Medical Association of December 4, 1973, which says: “…intentional termination of life of one human being by another - merciful killing - contradicts both the very purpose of the medical professions and policies of the American Medical Association.

J. Reigels believes that if the patient is conscious, understands that his days are numbered, can no longer endure physical suffering, and asks the doctor to hasten his death, the doctor will fulfill his request by simply stopping treatment (passive euthanasia), the patient's suffering can do this time to intensify. Although they could be less intense and prolonged than with continued treatment. In this situation, lethal injection (active euthanasia), according to J. Reigels, is more humane, since it immediately stops the patient's suffering.

Most scientists do not agree with him, primarily because it is contrary to the principles of humanism and the purpose of medicine. The value of human life encourages us to fight for it even contrary to objective medical laws and in the most hopeless situations since medical science and practice are rich in cases of healing the most hopeless patients.

It is severe pain that is usually the reason for the patient's request to hasten the onset of death, and therefore it is forced and insincere. Here, the doctor must counter them with the rich selection of painkillers that medicine has today, and not follow the patient's lead. Another thing is when, for example, a person is in a coma for a long time and his consciousness has already been irretrievably lost, and advanced medical technologies allow life-sustaining treatment to be carried out for an arbitrarily long time.

Many scientists fear that the formal permission of euthanasia may become a certain mental brake on the search for new, more effective means of diagnosing and treating seriously ill patients, as well as contribute to dishonesty in the provision of medical care to such patients. Resuscitation assistance to them requires not only large material costs but also a huge strain on the physical and mental strength of the attending medical staff. It is the lack of proper treatment and care that can provoke the patient's demands to hasten the death, which will allow the doctor to completely stop all treatment and care for a seriously ill patient. And this is another reason for the need for legal regulation of this issue.

A more general view was that euthanasia, from a moral point of view, is permissible only in exceptional cases, but in such cases, it should be legalized.

From a legal point of view, the problem is the need to develop a legal procedure for the implementation of euthanasia if this act is allowed by law. The most important issue within this problem should be considered the need for a possible law on euthanasia. And here it is necessary to consider biological and medical aspects.

His problem lies, first of all, in establishing the categories of patients in relation to which the possibility of using euthanasia can be considered. Among these are patients whose biological death is inevitable and who, when dying, experience severe physical suffering. The question of terminating the life of a patient whose physical suffering can be eliminated using appropriate medical means should not be considered at all.

Another category are patients who are in a stable vegetative state. In this case, a medical side of the issue is the problem of determining severity of the disease, its incurability; reaching a stage in the treatment process when all possible medical means are exhausted; establishing the irreversibility of a stable vegetative state.

For and against euthanasia

The intentional killing of an innocent is always a moral evil. Euthanasia is an intentional killing of an innocent person. So, euthanasia is a moral evil. Supporters of euthanasia may appeal to the fact that the above inference implies a distinction between justified and unjustified killings.

Let's try to argue that euthanasia goes beyond unjust killing based on two key statements.

First, the condition of some people is such that it is better for them to die than to continue to live. A vivid example of such a situation is those patients who suffer from severe pain or are doomed to a life of humiliating dependence on others for even the most basic needs. Here, as beneficiaries of euthanasia, the terminally ill and those who are in a permanent vegetative state are often included.

The second assertion is that helping someone improve their situation is always morally permissible. If killing will improve someone's situation, and the person himself wants to be deprived of his life, how can such killing be considered to cause undeserved harm to this person?

This argument has serious flaws, especially when used to justify conventional permission. It remains to be asked whether the situation of all those patients has actually improved, and even if so, whether killing them is the only alternative to inaction.

First, it is not clear how the terminally ill (as such, regardless of any other particulars of their situation) and those who are in a vegetative state benefit from their early death.

Secondly, one might ask whether the disgust expressed by many at being dependent on others in the later years of their lives is really based on self-respect and not on false pride.

Thirdly, there are always other ways to get rid of the pain.

Advocates of euthanasia often ask the question, isn't euthanasia a case where you must choose between two evils? If one is worse than the other, what's wrong with choosing the lesser evil?

If both the death of innocent and constant suffering is bad, then choosing (and striving for) one of them means striving for bad, choosing an action that is evil in relation to its goal. By choosing death (i.e., mortification), as opposed to simply resigning ourselves to the futility of continuing life and allowing death to come, we are making a mistake. Any act of euthanasia, as a choice of death, falls under this prohibition.

Speaking of euthanasia, one inevitably comes across the concept of incurability. When can we say with certainty that the patient is incurable?

It is widely known how large the possibility of error is when doctors make their predictions. In addition, the concept of incurability depends to a large extent on the means and opportunities available at the moment at their disposal. There is also a case with a doctor who, having barely finished with his son, who was sick with diphtheria, heard about the discovery of Roux serum. In fact, most doctors remain true to their oath and prefer to act as professionals rather than "sympathizers". This is also observed in Holland, where some doctors even specialize in euthanasia, while others refuse to resort to it.

The ambiguity of the concept of "pity".

Suffering in itself evokes sympathy in many: they kill a dog that is writhing in pain, and they finish off a man doomed to death. Is it possible to refuse such an act of mercy? Even some convinced Catholics considered it their duty to shorten the suffering of their neighbor. But this pity is already ambiguous in itself: of course, often the pain itself is unbearable, but often it is even more unbearable for those who are close to the patient. "Rescuing" the patient from pain often relieve them of suffering. Is the freedom of choice of the patient respected in this case? A cry for help is answered with a fatal blow. To inflict death means to save, first, oneself from the need to hear this call, because behind the words "kill me" lies a plea: "Share my pain and help me!" From a purely human point of view, it is always more difficult to "accompany" a patient in his suffering than to destroy him.

The church completely condemns euthanasia. Condemnation applies to any encroachment on human life - both abortion and euthanasia. However, on the issue of refusing artificial life support, the church is not so categorical and puts forward the following criteria:

- If there is the slightest chance of getting out of a coma, it is necessary to use all possible methods to support the life of the patient, since the cause of saving a human life is worth any effort. This is especially important when the patient is not able to independently express his consent.
- If the comatose state is irreversible and hopeless, then it is not necessary to use painful and expensive methods, both material and personal since all this would only prolong the agony without any hope that the patient will regain consciousness. But the usual treatment is mandatory. It should be repeated that the definition of irreversibility and hopelessness to return to consciousness is always one of the most difficult and dubious.
- Artificial maintenance of life in the complete absence of brain activity, direct EEG, absence of reflexes, respiration, and heartbeat would be an outrage to the deceased and his death and a heavy blow for the relatives of the deceased.

Philosophical evaluation of euthanasia

The sacredness of life. Usually, people who oppose the practice of euthanasia appeal to the principle of the sacredness of every life as unique. I. Kant comes out with a philosophical defense of this uniqueness employing his categorical imperative. Stated in simple terms, its principle is that we must always regard sentient beings as an end in itself, and not as a means to something else, some "intermediate stage." I have no right to interrupt your life just because it is difficult for you. Kant might have added that you, too, cannot end your life because it has become unbearable for you. This act will use the will to put an end to the will, which it considers contrary to our rational nature. Those who apply the principle of the sacredness of life to the question of euthanasia believe that ending life is morally wrong in all circumstances.

Killing or letting die? The second issue philosophers have concerning euthanasia is the difference between killing and allowing one to die. Some authors argue that passive euthanasia is not euthanasia at all, but this approach is only putting the problem aside. Even if allowing one to die is not euthanasia, it is necessary to show why this permission is moral and permissible.

The American Medical Association Code states that doctors should never end a life. But, despite this, doctors are not obliged to prolong life, making exceptional efforts when restoration of health is impossible. Thus, the AMA appears to make two distinctions. The first, between killing and allowing to die, is that killing is forbidden by law, but allowing to die is permitted. The second is the difference between exceptional efforts and ordinary ones. So, for example, the use of an expensive life support system for a severely comatose patient is considered something exceptional. It is not clear, however, whether the price of treatment has moral significance.

It is not necessary to argue that killing is sometimes even more humane than allowing one to die to override the AMA's distinction. If the intention in both cases is for the patient to die, then one action cannot be considered more morally acceptable than the other.

The doctrine of the double effect. It is known, for example, that large doses of morphine can not only alleviate pain but also hasten the death of a patient. The doctrine of double effect applied here might argue that if the intended effect is to relieve pain, then the action is morally permissible, even if the act causes a "collateral" detrimental effect. But in applying this principle, everyone must be careful and be fully aware of both of his components. If a doctor knows that certain doses of morphine hasten death, then by prescribing them he cannot claim that this is not his intention. This is a distinct part of his intention, which he added to the intention to relieve pain.

The problems associated with euthanasia are of concern to legislators and the public in many modern states and become the subject of discussion and research by specialists in various fields. It should be understood that no law, including criminal law, can provide for all particular cases. Medical decisions cannot be replaced by legal ones. This is especially true for human life. But there is such a problem as euthanasia, and it requires a solution, including a legal one. In my opinion, active euthanasia has no right to life, as it hides a lot of opportunities for the misuse of the act of euthanasia. For example, in the conditions of our state, with the poverty of medicine, euthanasia can turn into a means of killing lonely old people, disabled children, and people suffering from cancer and AIDS, for the maintenance and treatment of which there is not enough money.

The only way euthanasia can be manifested in our society is through voluntary and passive euthanasia. It is necessary to clearly and unambiguously formulate a legislative norm, according to which the patient has every right to know the diagnosis of his illness, its possible consequences, the degree of risk of an unfavorable outcome if treatment is refused, and the degree of hope for recovery. If the patient is in a vegetative state, the irreversibility of such a state should be determined. The issue of euthanasia should be resolved in the presence of the patient himself or his representative who has a document - a pre-prepared declaration of will, if this is not possible, for several reasons, all the same, the issue of killing should not be decided by one person, but, for example, by a council of doctors.

The problem of euthanasia, like many other health problems, is not only a medical problem, and not only physicians but also philosophers, bioethicists, lawyers, psychologists, and other specialists should be involved in discussion. Euthanasia is a general cultural and social problem. Many believe that euthanasia (as the killing of an innocent) is an unconditional moral evil and should not be allowed by law, even in cases specified in the generally accepted permission. The danger of abuse is considerable. Recognition of euthanasia as a law may also deprive the government of the incentive to fund research into effective treatments. On the other hand, one cannot fail to see that euthanasia already actually exists in medical practice. It is obvious that this problem requires an urgent legal solution, and we cannot turn a blind eye to it.

Problems of euthanasia - myths and reality of European practices

Advances in medical technology and clinical pharmacology have widened the borderline between life and death. Ethical contradictions, the history of origin and development, forms, legal, and religious aspects of euthanasia are studied. The Abrahamic religions—Christianity, Islam, and Judaism—traditionally oppose euthanasia, viewing it as a form of suicide.

The attitude towards the practice of euthanasia in the world today is ambiguous - from its complete rejection to justification. In most countries in the world, euthanasia is prohibited by law. A pioneer in the field of euthanasia, the adoption of a law on euthanasia - in Holland, to the law on the legalization of prostitution and same-sex marriage, in 2000 added another one that allows the death of seriously ill patients with the help of physicians. Belgium, along with the Netherlands and Luxembourg, remains one of three EU countries that have legalized euthanasia.

More than 10 years have passed since active euthanasia was legalized in Holland and Belgium. What are the results of the work? In 2003, 200 terminally ill patients, mostly elderly patients, voluntarily passed away. In 2004, euthanasia was performed on 360 patients. The popularity of euthanasia is on the rise. Among the factors that may "explain" the spread of euthanasia is economic. Qualified medical care for the dying using modern medical equipment and pharmaceuticals requires a lot of material costs. In European countries, the process of population aging continues, and the promotion of the problem of older people is a priority in medical and social programs of social development. The practice of euthanasia creates pressure on older and vulnerable people who need the support from others.

Since April 2005, a lethal injection kit worth only €60 has been sold in pharmacies in Belgium. Only a practicing family doctor can buy the kit. This innovation was introduced because 40% of those who want euthanasia want to do it at home, with the help of a visiting family doctor, and not in a hospital setting. According to media reports, only in 2012 in Belgium 1.4 thousand people died this way - that is, 2% of all deaths in the country and 25% more than in 2011. The growth dynamics of active euthanasia is obvious. Now, by court order, a person who kills or contributes to the suicide of his patient under certain circumstances is not found guilty. However, many doctors, for ethical or religious reasons, refused to comply with the last request of the patient. Switzerland, Sweden, Luxembourg, and Australia supported the idea of euthanasia and issued bills allowing patients to be disconnected from artificial life support devices or the introduction of drugs, with the help of which the patient will leave this world painlessly. The German Federal Court ruled that euthanasia does not involve intentional killing and there are no contraindications for its implementation. To ensure the complete, in quotation marks, “freedom” of a person, mobile euthanasia teams began to operate in Holland. Dutch law exempts from criminal liability a doctor who, based on several developed indicators, decides to end a patient's life. However, this does not change the essence of this kind of behavior, which remains completely unacceptable from an ethical point of view, and which opens the way for other forms of euthanasia, including involuntary.

What are the arguments for euthanasia? The most frequently cited are: a) a person should be given the right to self-determination, including the right to end his life; b) a person must be protected from cruel, inhumane treatment, from medicine that is incapable of solving the problems of a dying patient; c) an incurable patient has the right to insist on euthanasia to save his loved ones from mental anguish; d) "economic argument" - public resources spent on helping hopeless patients, it is more rational to direct them to other health sectors.

It is known from history that before the start of World War II, the idea of euthanasia was widespread in several European countries. Among famous people, we note Z. Freud, who, due to an incurable form of oral cancer, with the help of a doctor, performed euthanasia in his London house on September 23, 1939, having survived 31 operations to remove tumors under local anesthesia (narcosis was not used in such operations at that time).). Euthanasia and eugenics were popular in European medical circles at the time, but Nazi actions such as the T-4[1] killing program discredited these ideas.

Today we are witnessing the revenge of these ideas, "softened" by certain rules and conditions. The killing of the patient must be carried out in a medically acceptable manner (the committee on the control of euthanasia has introduced forms that must be filled out by doctors to register "mercy killings"). This law was passed by the Belgian parliament and provoked strong objections from the influential Catholic clergy in the country, 75 percent of the 10 million population of Belgium are Catholics. European lobbyists for the legalization of euthanasia believe that when discussing its ethics, it is necessary to abstract from the religious aspect of the problem since faith is a personal matter for everyone. In response to the court precedents indicated by the

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[1] The killing program “T-4” (“Action Tiergartenstrasse 4”) is the official name of the eugenics program of the German National Socialists for the sterilization, and subsequently the physical destruction of the mentally ill, mentally retarded and hereditarily ill. Subsequently, the circle of persons subjected to extermination included disabled persons (disabled people, as well as those who had been ill for more than 5 years). At first, only children under 3 years of age were destroyed, then all age groups

Parliamentary Assembly of the Council of Europe, lobbyists propose to resolve the legal side of the issue by clearly delineating the concepts of murder and medical care and introducing a procedure for considering each case of a hopeless patient.

According to Belgian law, euthanasia is carried out only at the personal written request of a person and only if he is "terminally ill and experiencing unbearable physical or mental suffering." The patient must be of legal age and sound mind. The law specifies control measures to protect vulnerable groups of the population. However, amendments to the euthanasia law are currently being prepared in Belgium, which will lower the age limit for legally requesting medical suicide to 15 years. In addition, it is supposed to allow the use of euthanasia for those suffering from Alzheimer's disease, but only on condition that they draw up a will before the loss of memory indicating the conditions for euthanasia. Today in the Netherlands they have gone further, even a child over twelve years old can ask for euthanasia. However, he does not have to be terminally ill. Sufficient reason - subjectively assessed unbearable suffering of a physical or mental nature, resulting from illness or injury. Recently, for the euthanasia of children from 12 to 15 years old, parental consent is required (previously it was not required), and older teenagers have the right to decide this issue on their own[1]. In February 2012, Belgium became the first country to legalize euthanasia for children: unlike the Netherlands, the law does not define a minimum age after which patients can ask for death.

Has the legalization of euthanasia become a manifestation of humanism, or is it legalized murder? The danger of possible abuses is an important argument among opponents of euthanasia along with other arguments. Thus, in 2005, the members of the Parliamentary Assembly of the Council of Europe (PACE) expressed their concern that medical institutions in several countries practice euthanasia without observing the rules or bypassing the official ban on its use, sometimes on a very large scale. In April 2005, the Council of Europe rejected a draft resolution that proposed to legalize euthanasia as an aid to terminally ill patients in getting rid of suffering and pain. Not the last role in this

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[1] The greatest writer of modern Belgium, Hugo Claus, who was repeatedly nominated for the Nobel Prize, voluntarily passed away at the age of 79, in 2008, although he only had the first stage of Alzheimer's disease

decision was played by the strong position of the church in the countries of Western Europe.

The laws of the Netherlands and Belgium have significant differences regarding the duties of a doctor, the requirements for a patient's medical condition, and the application procedure. Although the law on euthanasia was adopted in these countries almost simultaneously, in the Netherlands it only legalized the widespread practice that existed before, in Belgium, it opened a new version of the relationship between doctor and patient. Every day in Belgium, one person loses his life using the right to euthanasia. In the Netherlands, five or six people a day. In the Dutch-Belgian version (when a doctor injects a patient with a lethal dose of the drug), euthanasia is not allowed in Switzerland. But it is in this country that there is a phenomenon called “suicide tourism” because it is legally allowed to “assist suicide” if the “assistant” does not benefit from what he did. And some organizations provide such assistance. The difference lies in the fact that a person who wants to die must do the last procedure himself - inject or drink the drug. And the employees of these organizations only give the drug and determine the lethal dosage, but do not administer it. For very sick people who are unable to take the medicine, stomach tubes are provided. On February 1, 2007, Swiss federal court declared that mentally ill people were given the right to ask for help to commit suicide. “It cannot be denied that an incurable, long-term, and serious mental illness, like a physical illness, can lead to such suffering that a person does not see further life prospects,” the court said. It turned out that killing painlessly, quickly, and reliably is not such an easy thing. Today, a certain part of the medical community of countries that have adopted a law on euthanasia is working to “improve” this practice, and scientific “research” is underway. Since injections were used for euthanasia, special government commissions have been established to collect data on “how it went”, there are several options for the composition of the lethal injection, protocols are maintained for doctors and pharmacists from year to year, many recommendations have been revised, part was canceled, in other cases the dosages were recalculated. Faced with exceptional cases, they developed special recommendations for patients with renal, and hepatic insufficiency, and began to consider the effect of addiction to previous therapy. You can only commit legal suicide in Belgium from the age of 18. A coalition of several Belgian parties has developed a draft law that will allow resorting to euthanasia to terminally ill children. In addition to the desire of the sick child, the new law says, the permission of his parents is also required. The request will be accompanied by the conclusion of an experienced psychologist, who must make sure that the child fully understands all the consequences of his request and that he does not want to live. For children suffering from diseases that affect the brain and are not able to make decisions, the desire of the parents and the permission of the doctors are enough.

Now any Belgian who is undergoing treatment and has health insurance has the right to euthanasia if at least two doctors support his desire.

Conclusion: the legalization of euthanasia has become legalized murder. We believe that any form of euthanasia is unacceptable for the following reasons:

1) this practice is inevitably fraught with diagnostic errors. In medical practice, there are extremely rare, but real, cases when patients who are hopeless from the point of view of some medical standards recover. In other words, there is a certain percentage of errors associated with the limitations of biomedical science;

2) the danger of intentional abuse cannot be ignored;

3) euthanasia as a form of medical practice can have a demoralizing and iatrogenic effect of hitherto unheard-of scale and force on a huge number of patients;

4) euthanasia is a medical capitulation, and it can have a negative impact on medical personnel.

Euthanasia is not an essential resolution of life's contradictions, since it only eliminates them by force. This is not consistent with either dialectics or understanding of medical humanism. If there is any positive value in this, then this is an ever-expanding discussion of the problem of euthanasia and the heightened attention of scientific medicine and truly humane doctors to a dying person.

Opponents of euthanasia rightly believe that only palliative care - medical pain relief - can be considered humanity in relation to the terminally ill. Everything else they qualify as murder. The legalization of euthanasia, in their opinion, will lead to the devaluation of human life and create favorable conditions for abuse. They give an example when in 2005 a report of 22 cases of euthanasia abuse was submitted[1].

On January 25, 2012, the Parliamentary Assembly of the Council of Europe adopted a resolution (1859) "Protection of the rights and dignity of the person, taking into account the previously expressed wishes of the patient", which states that: “Euthanasia, regarded as intentional killing, through an act, or inaction of an incompetent person in his alleged interests, should be prohibited.[2]" This resolution aims to define the principles applicable in Europe, such as "lifetime will" or "advance notifications". Previously, the Parliamentary Assembly of the Council of Europe in recommendation 1418 (1999) “On the protection of human rights and the dignity of the terminally ill and dying person” insisted on “the prohibition of the intentional deprivation of life of a terminally ill or dying person”. PACE and the member states of the Council of Europe continue to condemn euthanasia and assisted suicide, and only a few countries out of the 47 members of the Council of Europe - Benelux countries and Sweden - practice euthanasia.

Medical, biomedical, and philosophical aspects of modern palliative care

“Ease the path for an old person, help at least a little
Someday you will understand what old age is”.
N. Hosrow

History of Hospice

The word "hospice" is of Latin origin, “hopes" originally meant "stranger", and "guest". In later times, Latin "hospes" was transformed into English word "hospice", which means "shelter", "almshouse", or "hospital house". Usually, the first hospices were located along the main routes of Christian pilgrims. Originating first in the Eastern Mediterranean, the idea of hospices reached the Latin world in the second half of the fourth century

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[1] Site materials: http://www.strasbourg-reor.org/?topicid=1044
[2] Site materials: http://www.strasbourg-reor.org/?topicid=1044

AD, when Fabiola, a Roman matron, and student of Saint Jerom, opened a hospice for pilgrims and the sick. In 1842, Jeanne Garnier, a young woman who had lost her husband and children, opened the first asylums for the dying in Lyon. It was called the hospice, and also "Golgotha". A few more were discovered later in other places in France. Some of them are still active today.

The beginning of hospice movement in the modern world

In 1967, Cecilia Sanders creates the first modern St. Christopher's Hospice in the UK.

The first hospices in England, such as St Christopher's Hospice and Helen House Children's hospice, were established in special houses. These are private hospices; they are completely independent and separate from hospitals. Along with this, the English National Cancer Society creates hospices on the territory of already operating hospitals, where they can use everything that the clinics have.

Palliative care or life-sustaining treatment is any treatment that prolongs life, regardless of the patient's underlying medical condition. One of the first palliative care services was the so-called hospices, which first appeared in England. At first, palliative care was provided to cancer patients, but, gradually, it began to be provided to all terminally ill patients.

Palliative care is a qualified, effective medical care for terminal patients, which is stopping, and, if possible, preventing pain and other painful syndromes, and symptoms that accompany dying. The meaning of the concepts of "palliative medicine", and "palliative care" boils down to the following: painful symptoms associated with dying are taken under control, home a goal of palliative care is to achieve an acceptable quality of life for a dying person, to take care of his comfort, and therefore to realize the patient's right to die with dignity. Hospitals and charitable institutions where only the dying were admitted existed before. But it wasn't until 1967 that the word "hospice" took on the meaning we give it today. The founder of the modern hospice movement, the English woman Sisley Saunders made the whole world take a different look at death, pain, and suffering.

A hospice is an institution where they try to create conditions close to home. Patients are even allowed to keep pets with them, for example, a cat or a dog, to receive relatives, and to arrange celebrations. Hospice never takes away their hope of recovery. There is always a chance - there may be errors in the diagnosis or cases of incredible self-healing of the body. Even if this does not happen, the hospice provides a worthy end to the life path.

In 1990, a hospice was opened in St. Petersburg, then a hospice society was created. Now such institutions are open in Moscow, Kolpino, Ivanovo, Tula, Yaroslavl, and Tyumen. All of them function on a gratuitous basis under the control of the Ministry of Health and Social Development of Russia. In 1996, the journal "Palliative Medicine and Rehabilitation" was founded, which highlights the issues of this problem.

Palliative care, including in hospices, should be based on the following principles: to support life and teach about death as a natural process; not hasten or delay the onset of death; eliminate pain and other painful symptoms; combine physical and spiritual support; offer a support system to help the patient, as far as possible, maintain an active lifestyle until death; offer support to the patient's family. The medical staff providing PC should be able to psychologically influence the patient in order to develop his life attitude toward a “good death”. He must be able to keep the situation under control, ensure the preservation of dignity and the right to privacy; control pain and other symptoms; The patient should be able to choose where to die (at home, in a hospital, hospice); if required, have access to information and expertise; receive any spiritual or emotional support; be able to give last orders and be sure that they will be carried out; do not make senseless attempts to prolong life. At the same time, it is assumed that patients have the following problems: physical suffering caused by the disease; social, caused by the loss of work, a change in social role, the emergence of dependence on others; psychological - depression, fear and anxiety, uncertainty, guilt (before relatives, others); existential - religious, non-religious, assessment of the significance of life, the question "why me?".

At present, PC abroad is provided not only in hospices but also at home by a general practitioner, whose assistant is a nurse who has specialized in this profile. At the same time, there is an opinion that PC is a multidisciplinary function, so it should be provided by a team of specialists. In addition to a doctor and a nurse, the team includes a social worker and, at the request of the patient, a representative of a religious denomination. In terms of modern tactics for managing terminal patients, the provision of medical ethics about "the highest respect for the patient's life" is concretized from the standpoint of the philosophy of palliative medicine. First, doctors and nurses in their work with terminal patients must distinguish between ordinary and extraordinary medical means and methods. Secondly, they must know modern approaches to the treatment of chronic pain, as well as the relief of other painful symptoms that usually accompany dying. Thirdly, the professional duty of all specialists working in the palliative care system also prescribes social, psychological, and spiritual support for terminal patients and their families. At the same time, new approaches to solving the most difficult ethical issue of informing such patients about their condition require reflection. The dying experience fear of death, pain, dependence on others to meet the most basic needs (food, drink, cleanliness, etc.), experience deep sadness, and longing. The founder of modern hospices (organizations for the physical and moral support of dying patients), an English woman S. Saunders, back in 1948, came to a simple idea: a dying patient can and should be helped. The system of so-called “palliative care” for the dying that has developed since then has become the realization of this simple and humane purpose.

The Latin word "pallium" means "sheath", or "covering". When it is no longer possible to interrupt or even slow down the development of the disease when the patient's rather quick death becomes inevitable, the medical professional is obliged to switch to the tactics of palliative treatment, that is, stopping, and mitigating its individual symptoms.

The concept of "palliative care" is not limited to clinical content, it includes new social and organizational forms of treatment, support for dying patients, new solutions to moral problems, and if you like, a new "philosophy of medical business". Various forms of organization of palliative medicine are a home care service, day and night hospitals, an outreach service (“ambulance”) and a hospice hospital, specialized departments of general hospitals, etc. The effectiveness of helping the dying is determined by an integrated approach to solving their problems, the brigade nature of the activities of the medical specialists involved in this matter, nurses, psychologists, as well as representatives of the clergy, and volunteers who have received special training. In this case, the role of close relatives is indispensable for a patient, who, however, needs qualified advice and guidance.

When medical professionals have the full arsenal of tools and methods of palliative care, they have the moral right to say to the dying: "We will help you get through THIS." Of all the problems of the dying patient, the problem of dealing with pain is often the most pressing and urgent. Immediately it should be said that such patients have a legal right to use, in accordance with their condition, available painkillers. The fight against pain is an indispensable condition for the realization of one of the fundamental rights of the patient - the right to die with dignity, which is specifically mentioned in the Lisbon Declaration of the Patient's Rights adopted by the WMA (1981). However, the achievement of this goal sooner or later requires the doctor to prescribe such doses of painkillers, which in themselves can affect the reduction of the patient's life. By prescribing such doses of painkillers, the doctor proceeds from the fact that the quality, rather than the duration of his life, is more important for a patient. Sometimes, in order to alleviate the suffering of a dying person, it may be wiser to abandon some treatment methods that will prolong not so much life as the process of dying. The problem of pain and suffering traditionally occupies a very important place in various religious systems (for example, in Buddhism it is believed that the mind clouded with painkillers is not able to indulge in beneficial reasoning, which is essential for a dying person). Therefore, the WHO Expert Committee, which considered the problems of palliative care at one of its meetings in 1989, concluded that it is necessary to reckon with the decision of a believer to refuse pain relief. A comprehensive assessment of the effectiveness of palliative care for terminal patients is reflected in the concept of "quality of life". The concept of "quality of life" correlates two aspects: objective and subjective. In the situation of a dying patient, the improvement of the objective parameters of his quality of life is not limited only to solving clinical problems and problems of nursing care but is also expressed in creating for him the most comfortable living conditions in general. Ultimately, the quality of life has a subjective expression. A dying patient, relieved of pain with the help of competent palliative treatment, having the opportunity to communicate with his family and friends, capable even in the last days of his life of the highest spiritual manifestations, probably quite sincerely can say that he is happy. It should be noted once again that not only the dying person needs help, but also his relatives, who are suffering from a severe psycho-emotional shock. Therefore, within the framework of the hospice movement, psychological and social support for family members of the dying is given great importance.

In the complex characterization of the quality of life, the moral well-being of the patient occupies a special place. One of the criteria for successful palliative care of the dying patient (and in particular good nursing care) is the expansion of the patient's self-care capabilities, which at the same time increases self-esteem. Any manifestation of normal life (reading, receiving visitors, etc.) should be encouraged. A dying person especially acutely feels the lack of care for him. In this position, a person has the right to whims and even to a feeling of anger. Helping the dying is associated with the strongest stress reactions in nurses, doctors, and in general everyone involved in this work. The main stress factors are the experience of the inevitable loss of those for whom so much care has been shown, to whom so much mental and physical strength has been given; feeling of failure of medical treatment, participation in conflicts that often occur in such a situation. The state of emotional and physical exhaustion of medical personnel involved in helping the dying has received the name "burnout syndrome" in the literature.

The report of the WHO Expert Committee on palliative care, after making recommendations regarding the selection of personnel for such care, states: "Medical personnel is most likely to find emotional support within those communities whose members show a high degree of mutual respect, have clearly defined and universally supported goals, and where power corresponds to responsibility.

Pathosophy (from the Greek pathos - suffering, and Sophia - wisdom) - "wisdom about suffering", which consists of the ability to understand, the willingness to accept suffering, and the ability to overcome suffering. A person's reaction to suffering and the model of his behavior depends on the understanding of suffering and his attitude toward it. As a result, we either run from it or accept it. Pathosophy is the ultimate wisdom for hospice staff and patients. A. Schweitzer drew attention to the fact that a person, “having once begun to think about the mystery of his life and about the connections connecting him with the life that fills the world, can no longer relate to his own life and to all the rest of life, which is in the sphere his influence, otherwise than in accordance with the principle of reverence for life, and this principle cannot fail to manifest itself in the ethical affirmation of the world and life, which is expressed in his actions. His life will therefore be in every way more difficult than it was before when he lived for himself, but at the same time, it will become richer, more beautiful, and happier.

One of the main problems in the development of biomedical ethics in Uzbekistan today is palliative care provided to terminal patients through various services. Such treatment may include mechanical ventilation, artificial kidney extracorporeal dialysis, chemotherapy, antibiotic therapy, artificial nutrition, and hydration. At one time, the term "passive euthanasia" was used to refer to the withdrawal of life-sustaining treatment. However, now many experts refrain from it. This topic was reflected in the elective bioethics course at the Tashkent State Dental Institute. Ethical and legal norms exist in virtually all societies, helping to protect human life, and the Abrahamic religions emphasize the sanctity of life. It seems relevant to consider the ethical basis for making decisions about life-sustaining treatment. Modern medicine has received new extraordinary opportunities to prolong life. In terms of a lesson on this topic, we explore the ethical basis for life-sustaining treatment decisions around which a significant, though hardly universal, a consensus has formed, and contrast it with the distinction between ordinary and extraordinary treatment. We consider situations where the deprivation of life or not prolonging it is ethically justified. Over the past few decades, medical treatments such as kidney dialysis, cardiopulmonary resuscitation, organ transplantation, assisted ventilation, and even the provision of food and water by artificial means have become commonplace in hospitals. Although these new therapies often benefit patients by restoring them to a well-functioning life, they can often be used in circumstances where they may neither benefit nor be desired by patients. Where once pneumonia was "the old man's friend," the way in which "nature" ended a life that had become seriously depleted, now the time and manner of death are more and more subject to human control. In coming close to maintaining, depriving, or not prolonging life, medicine has turned to both its own ethical traditions and society's broader ethical and religious traditions.

In Uzbekistan, the Program for the Development of Palliative Care of the Cancer Service has been approved. The implementation of the program should reduce the death rate from cancer from 38.7 to 35 per 100,000 people. The program for further development of oncological service and the improvement of oncological care for the population of the republic for 2017-2021 was approved by a decree in April 2017, by the President of Uzbekistan Shavkat Mirziyoyev[1]. The cost of the program is $155 million. The document was adopted due to the fact that in the country, as well as throughout the world, there is an increase in the incidence of cancer. "The current stage in the development of medical science requires the solution of priority tasks aimed at further improving measures for the prevention of cancer and improving the quality of oncological care for the population of the republic to the level of world standards," the President's resolution says. As part of the program, it is planned to purchase surgical equipment and build four regional hospices: Tashkent, Urgench, Fergana, and Samarkand. It is also planned to open departments of palliative care in all oncological dispensaries of the country by 2022.

Questions for self-examination.

1. How is the concept of person "death" (clinical, biological) interpreted in modern medicine?

2. Why did the problem of identifying the criteria for a person's death arise?

3. What stages of dying did E. Kübler-Ross distinguish?

4. Why do you think such a natural phenomenon as death of a person gives rise to many ethical and medical aspects?

5. What ideological assessments of the problem of human death do you know (cultural-religious and moral-philosophical aspects)?

6. Ethical problems arising in the curation of terminally ill patients.

7. Name and describe the main types of euthanasia

8. Why is there legal permission for euthanasia only in some countries?

9. What ethical arguments are put forward by opponents of voluntary active euthanasia?

10. List the main principles of palliative care

11. What are the goals and objectives of palliative care?

12. What is a hospice? What is its purpose?

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[1] https://regnum.ru/news/economy/2259120.html

Bibliography

1. V. V. Moroz, I. G. Bobrinskaya, V. Yu. / Cardiopulmonary resuscitation. M.: FNKTs RR, MGMSU, NIIOR, 2017, - p. 60

2. Biomedical ethics: words.-ref. / T.V. Mishatkina, Ya.S. Yaskevich, S.D. Denisov [and others]; ed. T.V. Mishatkina. — Minsk: BSEU, 2007. — 90 p.

3. Kübler-Ross E. About death and dying. - Kyiv: Sofia, 2001.p.110

4. Heidegger M. The law of identity. Conversation on a country road. - M .: Higher School, 1991. - p. 75.

5. Moody Raymond. Life after life. Sofia 2009.

6. Bacon F. Experiments, or moral and political instructions. Works in two volumes. 2nd, rev. and additional ed. T. 2. Comp., total. ed. and enters, article by A. L. Subbotin. M., "Thought", 1978. 575 p. (AN USSR. Institute of Philosophy. Philosophical heritage).

7. Program for the further development of the oncological service and the improvement of oncological care for the population of the republic for 2017−2021. https://regnum.ru/news/economy/2259120.html

CHAPTER VI. THE MORAL STATUS OF THE EMBRYO. ETHICAL ASPECTS OF ABORTION AND NEW REPRODUCTIVE TECHNOLOGIES

> *"Wisdom will not say what is contrary to nature."*
> ***Juvenal***

Key words. *Abortion, Surgical abortion, Abortive contraception, Medical abortion, embryo.*

1. The moral status of the embryo

The term "embryo" usually refers to a fertilized egg up to 8 weeks of gestation. If the moment of zygote formation is taken as the beginning of embryonic development, then in the first days after fertilization, cell divisions form a group of identical cells, in addition, a little later, the formed blastocyst is not yet attached to the uterine wall, which allows some modern specialists to speak not about embryo, but about pre-embryo. At this stage, most cells are neither structured nor individually defined entities, but rather the source of placental growth, and therefore cannot be considered an embryo proper. Approximately on the 14th day, the primary streak appears, after which the nervous system is formed. This served as the basis for the provision, which was included in the legislation of many countries, that the limit of 14 days is the last period when it is possible to conduct research on human embryos.

Further, opinions of different authors begin to diverge, and it is often said that in terms of its status, an embryo is a person (supporters of "saving life"), while others (supporters of "free choice"), that this is only a potential, and not a real personality up to until birth.

The criterion of reaction to stimuli, sensitivity, is understood as the ability to feel pleasure and pain, pleasant and unpleasant. The choice of this criterion as the basis for determining the moral status of the fetus and its right to life makes it possible to develop a rational moral assessment of abortion. The mentioned criterion opens the possibility of solving many other problems, such as the attitude towards animals, children with congenital mental defects, and terminally ill people who are on the verge of life and death, making it possible to establish a morally significant difference between early and late interruption pregnancy.

Considering that human embryo and fetus are potential people, we give them a respectful attitude and right to life, and this right becomes stronger as the fetus develops, and at a certain stage, during the third trimester of pregnancy, it is so strong, that the consequences of the destruction of the fetus are comparable to murder, and the extracted fetus can be considered as a patient. That is why legislators in most cases do not allow the termination of pregnancy in the later stages. However, the reaction of the fetus to stimuli is formed earlier, in the second trimester of pregnancy (3-6 months). Therefore, usually, only the moral assessment of early termination of pregnancy (in its first third) is more tolerant, it is recognized that a woman has the right to be autonomous in deciding how to use contraceptives, and early termination of pregnancy, they seem to be equated to each other. The formulated provisions coincide with the existing and already customary practice but continue to be the object of fierce criticism, both those who advocate the inadmissibility of abortion at any time and those who are ready to allow it.

The ethical legitimacy of embryonic stem cell research depends on the status given to the embryo. While there are other considerations on this ethical issue, such as the consent of the parents or "owners" of the embryo, the question of the status of the embryo is fundamental. Much of the ethical debate in this issue revolves around the question: if the embryo is human, then actions with it are limited to what is allowed to be done with other people. If an embryo is just a bunch of human cells, then there are far fewer restrictions on its use.

One of the key questions is when a human fetus acquires the ability to feel. The first movements of the fetus were recorded in the 6th week of development, at the same time it begins to respond to touch, and synapses are detected in the spinal cord. At week 10, the first neurotransmitters are detected in the nerve fibers of the spinal cord, and the activity of the brain stem is recorded. Based on electrophysiological and immunohistochemical data, some researchers believe that the human fetus begins to feel at the age of 18-19 weeks, but the ability to process the received sensations is not detected until the 30th week of development. Therefore, this period, in their opinion, can be considered the boundary between the fetus and the human being.

In other studies, the ability of the fetus to respond to irritation or pain is found at 7–8 weeks. However, is it possible to consider only the emergence of the ability to feel as a criterion for the formation of a personality? This point of view raises some objections, since unconsciousness and insensitivity to pain, in essence, cannot serve as a basis for refusing to protect the rights of the individual.

Leading embryologists of the world, as a rule, consider the period from the moment of fertilization to the 14th day of embryo development (the beginning of the formation of the primary streak, elements of the nervous system) or up to the 30th day (the beginning of the differentiation of the central nervous system) to be acceptable for manipulation.

The human embryo has a unique status: unlike any other group of living cells, it is able to develop into a complete organism. This property can be called the potential of the embryo, that is the potential to become a fully developed person. This is only a biological fact, but it is he who is the cause of moral "fear". The question is: "Can an embryo be considered a member of the human community with those rights that are allowed exclusively for a person?" It has not yet been possible to reach an agreement on this issue. There are several main opinions:

- individuality of a person begins from the moment of conception;
- individuality of a person begins from the moment when his division into twins is impossible (13th day after fertilization);
- human individuality begins at much later stages of its development (40 or more days after fertilization).

The main subject of debate is the potentiality of the embryo. According to some, the human embryo has the potential to become human, even if it is not yet human. For this reason, it is unethical to deprive him of the opportunity to realize his potential. The other side argues that the potential does not give grounds for such a status. Sex cells are components of the zygote that later becomes an embryo and then a child, but this does not give them the status corresponding to a zygote, embryo, or fetus until this stage of development is reached. If the embryonic status is not granted to sperm, why should human status be granted to the embryo? In addition, an embryo created in vitro, but which will not be implanted in the uterus, has no potential to develop into a human at all. The same applies to embryos created using nuclear transfer technology, which should not be implanted for the purposes of human reproductive cloning.

It is known that individual cells can be removed from early, pre-implantation embryos during artificial insemination without damage. This method may be one of the solutions to the problem of obtaining embryonic stem cells. However, if the removed cells are totipotent (able to develop into any organ and even into an independent organism), then they are, in fact, separate zygotes and embryos, and therefore should be protected to the same extent as the original embryos. If such cells are only pluripotent, then they cannot be considered embryos, and therefore their use will not offend those who consider the embryo to be human. Unfortunately, it is not yet possible to say whether a particular cell is totipotent or pluripotent. This can only be established with certainty retrospectively, by observing what the cells are capable of.

At present, one can distinguish four main ways to artificially obtain embryos:

- an embryo created by in vitro fertilization for implantation in uterus and selected for that purpose;
- an embryo obtained in vitro for implantation, but which is "surplus" (additional embryos must be created to ensure a successful pregnancy);
- an embryo created by artificial insemination for research purposes or for the purpose of creating embryonic stem cells;
- an embryo created by transplanting a cell nucleus into an egg.

When using each of the listed methods, the embryo has its own moral status:

- in the first mode, the special status of a person's probable predecessor, and any attempts to interfere with the fulfillment of this potential must be rejected (with the exception of abortions for moral reasons in legal cases, especially in cases of a threat to the life of the mother);
- an embryo created in a second way does not have the potential to develop into an adult organism;
- Embryos obtained by the second and third methods are intended for certain research purposes or uses that require special consideration.

Both natural and artificial reproduction involves the creation of embryos, some of which are doomed and which can be used to obtain embryonic stem cells. The implantation of two or three embryos in the hope of a successful birth of a child is an accepted practice in this area. Even in Germany, where embryonic stem cell research is now banned and embryo protection is included in the constitution, in vitro fertilization is allowed and three embryos are usually implanted in the hope of producing a single healthy baby.

The ethical standards for creating embryos for specific purposes differ significantly from those for creating embryos for implantation in IVF since even “extra” embryos were created with the aim of carrying out potential development into an adult organism. In many countries, IVF is legal and widely used, and it is ethically acceptable to use "surplus" embryos for therapeutic purposes. In any case, the "extra" embryos will be destroyed, so it is ethical to use them to save the life and health of other people.

Is it possible to create human embryos for specific research or therapeutic purposes? If we consider that the embryo has the status of an individual, then this should be prohibited, since it goes against the universal principle that prohibits the "instrumental" use of people. If the embryo does not have such a status, then is it moral and ethical to subject thousands of people to suffering and death when it is possible to help them using embryonic stem cells? In this case, there can be no objection to the creation and use of human embryos, since the potential benefits of therapeutic cloning outweigh any other arguments.

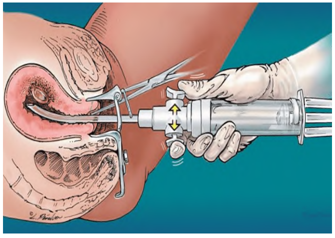
The rejection of the status of the embryo as a human individual should not lead to a reduction in the ethical value of the human embryo as such. The human embryo cannot and should not become a laboratory animal. If we value human life, then we must value it in all its manifestations and reject any abuse of human organs and tissues. However, it would be wrong to argue that the creation and therapeutic use of embryos are incompatible with the principle of value and respect for human organs and human dignity, provided that the purposes of such use are ethical and humane. Medical use falls into this category. Therapeutic cloning using embryos at an early stage of development (usually up to 14 days after fertilization) is compatible with the principle of respect for human life because it aims to alleviate suffering and save the lives of people, the principle of respect for which we advocate.

The creation and use of human embryos must be strictly regulated, be under constant control, and be carried out with the full consent of the parents (donors) of biological material. The donation of such biological material should be more altruistic in nature, not excluding some payment. However, it is necessary to take all measures against the commercialization and financial stimulation of this process. The creation and use of human embryos should only be for humane medical purposes and may not be for trivial, cosmetic, or non-medical purposes.

Every society has the right to discuss this issue and make its own decision based on the ethical and moral grounds of the moment or reconsider its decision if there are other valid arguments. The ethical attitude towards the status of the embryo is based on moral and religious views, which differ quite widely in different categories of society. Therefore, each society (state) must solve this problem for itself. Its solution should be democratic and based on a detailed and comprehensive discussion. There is an example of such a discussion in history - this is the problem of artificial insemination. There were and still are different points of view on this issue, but most of the states were in favor of allowing such a medical service.

Abortion is the process of terminating a pregnancy. There are spontaneous abortion (miscarriage) and artificial, implying medical intervention in the course of pregnancy. According to the term of termination of pregnancy, abortion is classified into early (up to 12 weeks) and late (from 12 to 28 weeks). Termination of pregnancy after 28 weeks is called preterm birth. Depending on the duration of pregnancy and the equipment used, there are several types of abortions:

Medical abortion. This method consists of the use of pills that stop the development of pregnancy. For this purpose, mifepristone is used. The drug inhibits the formation and action of progesterone, which is considered the main hormone of pregnancy, i.e., pregnancy stops. Then the drug misoprostol causes cramping uterine contractions, which helps to reject the fetal egg.



"Mini-abortion" using a special vacuum device, which, by creating negative pressure in the uterine cavity, "tears" the fetal egg from the wall. Subsequently, the embryo is removed from the cavity.

Surgical abortion consists in carrying out curettage. In this case, the embryo is removed along with part of the uterine mucosa. Immediately before curettage, it is necessary to increase the lumen of the cervical canal with the help of special dilators so that the introduction of a curette becomes possible.

The autonomy of a pregnant woman and the right of the fetus to life.

It is obvious that the most acute problem of termination of pregnancy is perceived by a woman. It is the woman who is involved in the decision of the choice of life and death, it is on her that the life of a human being depends. In modern scientific literature, there are three points of view on the right of a woman to make a decision regarding abortion: 1) the liberal point of view on abortion is gradually strengthening its position in European public opinion. Its essence: a woman has the right to dispose of her own body, including the decision to have an abortion; 2) a moderate point of view: the fetus gradually accumulates the quality of humanity, and it is necessary to consider the balance of interests of him and the mother specifically for each trimester; 3) the conservative point of view: abortion is a premeditated murder, and there can be no moral justification. The fetus from the moment of conception is a person who has basic human rights and, above all, the right to life. The most extreme conservative position is that any abortion is unacceptable, there are no exceptions.

The right of a woman to dispose of her own body won a place in European culture with difficulty. First, the so-called medical indications for abortion appear (narrow pelvis, fetal hydrocephalus), then these indications expanded, and heart disease, kidney disease, tuberculosis, mental illness, and hereditary diseases join them. In the first half of the 19th century, the concept of ’’social indications’’ of artificial termination of pregnancy (rape, incest, excessive need) was formulated. Gradually, the volume expands due to - ’’the desire of the husband’’, ’’the desired number of children’’. As a result, many countries were forced to recognize the autonomy of a woman to make a decision to terminate a pregnancy, and not only in its first third.

The preamble to the Convention on the Rights of the Child, adopted by a resolution of the UN General Assembly of November 20, 1989[1],

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[1] Convention on the Rights of the Child. Adopted by General Assembly resolution 44/25 of November 20, 1989 https://www.un.org/ru/documents/decl_conv/conventions/childcon.shtml

notes that the state parties to the Convention take into account that “the child, due to his physical and mental immaturity, needs appropriate legal protection, both before and after and after birth. In accordance with Art. 1 of the Convention, every human being under the age of 19 is recognized as a child. However, the Convention does not establish the starting point from which a human being should be recognized as a child. From what has been said, we can conclude that a child is a human being, both before and after birth.

Part 1 of Art. 4 of American Convention on Human Rights states that every person has the right to respect his life. This right is protected by law and, as a rule, from the moment of conception. No one should be arbitrarily deprived of life.

Obviously, with such an approach to resolving the issue of the legal status of the fetus, one can speak of the priority of public interest over the private interest of a woman in matters of maintaining or terminating a pregnancy.

According to Article 24 (Constitution of the Republic of Uzbekistan, Chapter VII personal rights and freedom), The right to life is an inalienable right of every person. In accordance with this constitutional decision at the moment of the emergence of general legal capacity, there are norms enshrined in the Order of the Ministry of Health of the Republic of Uzbekistan № 312. dated 09/10/2013 "On approval of standards for artificial termination of pregnancy", the right of a woman to artificial termination of pregnancy is considered from the standpoint of private-public interest. On the other hand, in this article, we are talking about the fact that every woman has the right to independently decide on the issue of motherhood. On the other hand, artificial termination of pregnancy is carried out at the request of a woman with a gestation period of up to 63 days of amenorrhea (up to 9 weeks of pregnancy), from 9 to 12 weeks, and with a gestation period of up to 22 weeks only for social reasons. Consideration of the issue of the doctor's right to refuse to perform an abortion deserves attention. The possibility of a doctor's refusal to perform an abortion is provided for by the WMA Declaration "On Medical Abortions" (Oslo, 1970). This Declaration is not a normative legal act, in this regard, it is extremely important to consider the doctor's right to refuse to perform an abortion in a legal sense.

Abortion ban movement.

The terms pro-life, the movement "in defense of life" ("in defense of human life", "for life") are used as translations of the English term pro-life and denote a social movement aimed primarily at the ban on abortion, due to the right to life more unborn children. More broadly, it includes the protection of the human right to life from the moment of conception.

While the term "pro-life" has gained some currency in human life circles, it is not in common use. In some cases, it is quite possible to speak of a struggle for the right to life from the moment of conception, even in the absence of this term.

Among the fundamental principles to which the religion of Islam attaches paramount importance is the protection of the life of a person and his offspring. In this regard, Islam encourages a person to marry and forbids killing without rights. A child living in the womb is called an embryo. Any outside interference committed by a mother or another person that caused a miscarriage or death of the fetus is the subject of study from the point of view of its prohibition or permissibility, as well as from the point of view of the legal responsibility borne by the person who carried out this intervention and his entourage. Islam condemns abortion globally, but many Muslim jurists agree that abortion is permissible in some cases. As such an exceptional case, all schools of Islamic law recognize the threat to the life of a woman. Many legal scholars also admit other significant grounds for abortion, but there is no consensus on this. The status of the fetus in Islam is considered dependent on its age, so abortions, if necessary, are allowed in the early stages. It is generally accepted that abortion is absolutely prohibited after 120 days from the moment of conception, but in the event of a threat to the life of a woman, some jurists allow abortion at a later date. Most jurists allow justified abortions up to 40 days, and many up to 120 days from conception, but between 40 and 120 days, prevailing legal opinions within different schools of Islamic law vary. In different schools of Islamic law, views on the permissibility of abortion develop in different ways and Islam does not represent any monolithic opinion.

Protection of the right to life in the program documents of the Russian Orthodox Church. In particular, the term is not used in the Fundamentals of the Social Concept of the Russian Orthodox Church, but an analysis of the document clearly reveals its correspondence to the goals of the movement (taken in the broadest sense).

In Chapter XII of this document:

- Abortion is regarded as a serious sin, which is equated with murder;
- the actual equivalence between abortion and those contraceptives that have an abortive effect, that is, interrupt an already conceived life, is recognized;
- in vitro fertilization (IVF) (more precisely, all its varieties, involving the preparation, conservation, and subsequent destruction of "excess" embryos) is considered unacceptable.

Also (based on the unconditional value of human life) the following are recognized as unacceptable:

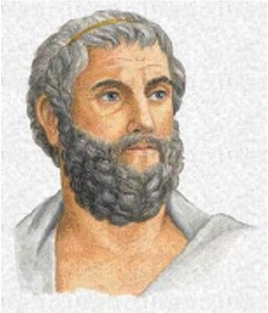
- "fetal therapy, which is based on the removal and use of tissues and organs of human fetuses aborted at different stages of development";
- euthanasia, which is equivalent to murder or suicide.

Abortive contraception.

The de facto equivalence between abortion and abortive contraceptives, mentioned above, leads some supporters of the pro-life movement (pro-lifers) to call for a ban on these methods. As the opponents of these remedies point out, “both in the West and in Russia, doctors, and the whole society are actively forced to falsely imagine the beginning of human life and pregnancy not at the moment of the union of the spermatozoon and the egg and the formation of a unique genetic code of a new human being, but only after implantation - attachment conceived child to the wall of the uterus.

In particular, “along with the contraceptive, all hormonal contraceptives (GCs) available on the markets of Russia and the CIS countries have an abortive effect,” and “different GCs differ among themselves only in the frequency of failures of their own contraceptive (contraceptive) action, which consists in suppressing ovulation - the maturation and release of the egg, as well as an increase the viscosity of the mucus in the cervix, making it difficult for sperm to pass."

2. Ethical aspects of abortion and new reproductive technologies.



"How terrible a mind can be
if it does not serve man."
Sophocles

The concept of "reproductive health", "reproductive choice", and "reproductive rights".

“Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system, its functions, and processes. Therefore, reproductive health means that people have the opportunity to have a satisfying and safe sex life and that they have the ability to reproduce themselves, and that they are free to decide whether to do so when to do so and how often. The latter condition implies the right of men and women to be informed and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of regulating childbearing of their choice that are not contrary to law, and the right to have access to appropriate services in areas of health care that would enable women to navigate safely through pregnancy and childbirth and give couples the best chance of having a healthy baby.”

Reproductive choice is a manifestation of the moral autonomy of the individual in matters of sexuality and procreation.

Reproductive rights - the right of men and women to be informed and to have access to safe, effective, affordable methods of birth control, in accordance with their choice, as well as the right to access appropriate health services that can ensure a safe pregnancy and childbirth for women and to create the best opportunities for couples to have a healthy baby.

Moral aspects of the problem of abortion (types of abortion; the moral status of the embryo and fetus; the autonomy of the pregnant woman and the right of the fetus to life; the movement to ban abortion; abortion and religious morality).

In the 60s 20th century the era of artificial insemination began, which posed new ethical problems, for example, surrogate motherhood. There are two types of surrogate motherhood: 1) another woman bears a child produced from genetic mother and genetic father; 2) a woman bears her child from an anonymous father. In the first case, a dilemma may arise if the surrogate mother does not want to give up the child. In the second case, the problem of anonymity of donors arises, threatening marriages between blood relatives. Some prolifers denounce the use of in vitro fertilization (IVF) and surrogacy as treatments for infertility. IVF is considered unacceptable due to the death of "excessive" embryos, and surrogacy, in their opinion, destroys the deep emotional and spiritual closeness that is established "between mother and baby already during pregnancy."

Here arises a truly philosophical problem of a new understanding of the family, a new understanding of motherhood and fatherhood, because the modern medical practice of childbearing is changing the entire system of the traditional family, based on special relationships between a man and a woman, as well as between parents and children.

And there is one more lesson to be learned from the discussions related to human cloning. As already noted, an additional protocol adopted by the Council of Europe establishes a ban on the cloning of human beings. The Protocol is accompanied by an explanatory report stating: "... it is decided to leave to domestic law the definition of the scope of the expression "human being" for the purposes of the application of this Protocol." Such a decision raises the question of the need for a legal interpretation of the concept of "human being", and thus the concept of "man". It is known that the definition of this concept is a long-standing philosophical problem. Philosophers of different times offered a variety of definitions - from "a bipedal without feathers" to "an animal that produces tools" and "the totality of all social relations." To most people, however, such definitions seemed nothing more than the idle whims of sophisticated minds. The rapid progress of modern biology and medicine has led to the fact that this definition has not only an abstract philosophical but also a directly practical meaning.

Thus, the problem, the acuteness of which until recently was clear only to a fairly narrow circle of specialists in philosophical and ethical issues, is becoming relevant for everyone. This is another of the most important lessons of the cloning debate. Modern biomedicine expands the technological possibilities of intervention in the natural processes of the origin, course, and end of human life. Various methods of artificial human reproduction, replacement of worn out or damaged organs and tissues, neutralization of harmful genes, and much more have become common practices.

This leads to situations where it is difficult to determine whether we are already (or still) dealing with a living human being or only with an aggregate of cells, tissues, and organs. The limits of our intervention in life processes and functions are determined not so much by expanding scientific and technological capabilities, but by our ideas about what a person is, and, consequently, about what actions and procedures in relation to him are permissible and which are unacceptable. But nothing less than the prospect of human cloning clearly demonstrates the need to legally clearly and unambiguously define the concepts of “human” and “human being.” Perhaps it is the absence of such definitions, and hence the unambiguous concept, ultimately explains the emotional intensity that accompanies these discussions. We must develop this definition ourselves, on the basis of our morality and new knowledge of modern biology and medicine.

History knows prohibitions on science: the prohibition of genetics and cybernetics in the 1940s and 1960s. 20th-century scientific thought cannot be banned. Historically, the choice of people who sought to turn back the clock of history and restrict or prohibit the use of already existing technologies has never been either realistic or productive. It is necessary to regulate the application of scientific achievements, as it is done with nuclear energy, genetically engineered organisms, and other aspects of human activity. Prohibitions have never solved anything - let's remember the "Prohibition" introduced in many countries. Only education and upbringing can solve moral and ethical problems.

Each country, based on its moral and religious foundations, must decide whether it is ready to accept the modern achievements of science and medicine. The discussion should be democratic in nature, with the right to express any point of view, and the decision should be made on the basis of knowledge, not emotions. Both the level of morale of citizens and the preparedness of specialists should be taken into account. If society is not ready to accept a new one, it is necessary to introduce a moratorium and return to this issue after a while, having carried out appropriate work to enlighten and educate society.

In Uzbekistan, within the framework of the Action Strategy for the five priority areas of development of the Republic of Uzbekistan in 2017-2021, a unified state policy is being pursued in the field of strengthening the institution of the family, maternal and child health, and promoting a healthy lifestyle among the population. This work reached a new level with the adoption of the Law “On the Protection of the Reproductive Health of Citizens”[1], signed by the President of the country Shavkat Mirziyoyev on March 11, 2019. The law establishes the main directions of state policy in the field of protecting the reproductive health of citizens, including the development and improvement of the reproductive health protection system, the education of a conscious and responsible attitude to the birth of healthy children, the creation of equal opportunities for men and women in the exercise of their reproductive rights, and the improvement of medical culture citizens in this area. In our society, the family retains the status of the most important social institution that ensures the upbringing of a worthy younger generation, children remain one of the main values of life and a necessary condition for the existence of a happy and strong family. Monitoring of public opinion revealed positive changes in the minds of Uzbeks in matters of family planning: citizens understand that planning is a necessary and positive measure for the formation and strengthening of a family, which makes it possible to have healthy and desirable children, provide them with a high quality of life and give them a good education. During the study period, there was an increase in the number of respondents who are convinced of the importance of family planning: in 2019, 72.5 percent of survey participants stated this (in 2018 - 63.8 percent). According to the Law, the protection of the reproductive health of citizens provides for:

- obtaining reliable and complete information about the reproductive health of citizens;
- activities, procedures, and services during pregnancy, childbirth, and after them, ensuring the bearing and birth of a child without complications;
- prevention and treatment of diseases of the reproductive system, as well as sexually transmitted diseases;

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[1] Law of the Republic of Uzbekistan On the protection of reproductive health of citizens. No. ZRU-528 03/11/2019. https://lex.uz/docs/4233888

- safe artificial termination of pregnancy, which contributes to the prevention of possible complications and dysfunctions of reproductive system;
- getting information about contraceptive methods and accessibility to them.

It is determined that citizens have rights to:

- make independent decisions about the birth of their children using safe and effective reproductive technologies;
- receive reliable and complete information about their reproductive health;
- access to safe methods of birth control and use of contraception;
- use health and preventive services and be protected from products that pose a threat to health, including from the use of scientific experiments;
- receive medical and social, as well as psychological assistance and information in the exercise of their reproductive rights;
- be involved in the use of assisted reproductive technologies.

The Law outlines the principles, directions of state policy, and state guarantees for the implementation of the reproductive rights of citizens.

The issues of the application of preventive measures to protect the reproductive health of citizens, contraception, and artificial termination of pregnancy are also spelled out. Article 15 of the Law is devoted to the use of assisted reproductive technologies. It states that these include treatments and procedures aimed at achieving pregnancy, in which some or all of the stages of conception are carried out outside the woman's body. The procedure for using these methods is determined by the Ministry of Health.

It has been established that all services in the field of reproductive health care are provided with the preservation of medical secrecy and confidentiality of information when using assisted reproductive technologies

Questions for self-examination

1. What is the problem of the right to life at initial stage of human existence?
2. Does an embryo with developmental deviations have the right to life?
3. What is the ethical aspect of the problem of using embryonic stem cells (ESCs)?

4. How can you prevent unwanted pregnancy?

5. How to explain that there are organizations in society that demand a legal ban on medical abortion?

6. What modern methods and means of family planning can provide / or contain demographic problems?

7. What modern normative and international documents in the Republic of Uzbekistan regulate the use of reproductive technologies?

8. What ethical problems are generated with the development of reproductive technologies?

9. There is a kind of scientific fundamentalism in the new technological spirit - the view that science is omnipotent and has all the answers. Can this rise in technology and rapid changes in science be controlled?

10. Scientifically proven that "each method of artificial insemination increases the risk of perinatal pathology and severe neurological disability since childhood." Is it possible in this situation to consider that the risk of participants in the process of using reproductive technologies will be justified? It is necessary to reveal different points of view (moral and ethical, state, religious).

Bibliography

1. Belyaletdinov, R. R. Risks of modern biotechnologies: socio-humanitarian analysis: monograph / R. P. Belyaletdinov - Moscow: 4 Print LLC, 2019. – p.212.

2. Human Genome Project, HGP — international research project , *Robert Krulwich*. (Cracking the Code of Life) PBS. ISBN 1-5375-16-9. the largest international collaboration ever undertaken in biology https://www.theguardian.com/environment/2015/mar/16/what-is-the-wellcome-trust

3. Biotechnology. Biosecurity. Bioethics / ed. A. P. Ermishina. - Minsk, 2005

4. Ethical and legal aspects of the project "Human Genome": Intern. Doc. and analytic materials. - M., 1998.

5. Universal Declaration on the Human Genome and Human Rights. - UN, 1997. URL: www.unesco.com

6. Hen, Yu. V. Eugenics: founders and successors / Yu. V. Khen // Man. - 2006. - № 3.

7. *Sgreccia E., Di Pietro M. L.* Manipolazioni genetiche e procreazione artificiale: orientamentici e giuridiconsiderazioni etiche // Il diritto di Famiglia e delle Persone. - 1987. - No. 3, 4. - P. 1351-1447.

8. Social bioethics through the prism of global bioethics / Intern. state ecologist. in-t C69 under the name A. D. Sakharova Bel. state university; T. V. Mishatkina, S. B. Melnov, T. N. Tsyrdya [and others]; ed. cand. philosophy sciences, prof. T. V. Mishatkina, Doctor of Biol. sciences, prof. S. B. Melnova. - Minsk: Information Center of the Ministry of Finance, 2018. - p.518.

CHAPTER VII. MORAL ISSUES IN GENETICS

"Humanity needs a combination of biology
and humanistic knowledge,
from which the science of survival is to be forged
and
with its help to establish a system of priorities."
V.R. Potter

The study of the genome has reached such a state that both the humanities involved in philosophy, sociology, law, and religious figures, and general public, should finally come to grips with issues of bioethics.
A. A. Baev

Key words. *Medical genetics, "Human Genome","generational egoism", "genetic risk", Modern genetics.*

Modern genetics, and especially human genetics, is one of the most rapidly developing areas of scientific knowledge. It is characteristic that many of its achievements very quickly find their practical applications, in particular, in the field of medicine and public health. There are certain grounds for assertions of those who believe that in the future biology and medicine will increasingly rely on the foundation of genetics.

This rapid progress in medical genetics is inevitably accompanied by the incessant emergence of new moral and legal problems[1]. Some of them, such as those associated with the possibility of obtaining genetically identical copies (clones) of living or already deceased people, attract the attention of the widest sections of society; others, perhaps no less important and acute, are discussed mainly among specialists.

Of course, these problems require not only discussion but also the making of responsible decisions, both at the level of both societies as a

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[1] Belyaletdinov, R. R. Risks of modern biotechnologies: socio-humanitarian analysis: monograph / P. P. Belyaletdinov - Moscow: 4 Print LLC, 2019. - 212 p.

whole and the scientific and medical communities and even at the level of an individual family and an individual person.

Specifics of moral problems in medical genetics

Traditionally, medical ethics focuses primarily on the relationship between two individuals - a doctor and a patient. One of the main features of ethical problems of medical genetics is different: it is related to the fact that hereditary diseases (although they appear in individuals) are transmitted to descendants as a result of reproductive processes. Problems being studied in medical genetics have a familial (or generic), and not just an individual character, as is the case with ordinary diseases.

Another feature of medical genetics, which also manifests itself in the specificity of its moral problems, is that for only a very small number of hereditary diseases, there is a more or less successful treatment. Predominantly it is necessary to be limited to measures of prevention and diagnostics of these disorders. It is the latter circumstance that determines the presence of such specific problems as the ethics of diagnosing a particular pathological condition if there is no sufficiently effective method of its treatment. There are great doubts as to whether a person would want to know his fate without being able to avoid it. As reported in one special study, out of 150,000 individuals at risk for Huntington's disease, only 200 agreed to undergo a diagnostic procedure. The rest chose not to know the diagnosis of an incurable disease.

According to one of the authoritative experts in this field, W.McKusick, the rapid progress of modern human genetics contains at least two risks: firstly, new information will increase the gap between what we can diagnose and what we can treat. Already now it is an acute problem concerning the same Huntington's disease and a number of other hereditary diseases. Second, the gap between what we (physicians, scientists, and the public) think we know and what we actually know will widen considerably. The latter circumstance, according to McKusick, is connected with the involuntary enthusiasm that grips the scientific community about the expected benefits from the implementation of the international project "Human Genome", and reassessment due to the degree of influence of genetic factors on the formation of human behavior.

The specificity of ethical problems of medical genetics also lies in the fact that the subject of genetic practice is the main concern for the health of unborn children - future generations. Therefore, as a kind of medical care, medical genetics can only develop in a social situation where both individual citizens and society as a whole recognize responsibility for the health of not only living fellow citizens but also those who is yet to be born. Recognition of this responsibility makes us think about the problem of justice in relation to the distribution of social resources between the generation already living and those who will replace them.

Ignoring the interests of medical genetics, in fact, would become a form of "generational egoism" - unfair redistribution and withdrawal of development resources from descendants. At the same time, justice will not be able to prevail even if unjustified advantages are received by “future people”. However, some experts defend "the principle of unconditional priority of the rights and interests of the future person over the rights and interests of already living people", the present is a set of possibilities for future development. If the present generation of people is not sufficiently developed and healthy, then little will be redistributed to them in favor of their descendants. Perhaps intergenerational justice is to be found in a more difficult balance of interests.

So, the specificity of the subject of medical genetics and its methods predetermines the specificity of its moral and ethical issues. According to the South American researcher L.Walters, the main ethical problems of modern medical genetics are such problems as the preservation of medical secrecy (confidentiality of genetic information), voluntariness in genetic testing of individuals and population screening, the availability of medical genetic assistance (testing, counseling, etc.) for different segments of the population, the ratio of potential benefits and harms in the implementation of various genetic interventions.

2. Medical genetic information: moral problems of obtaining and using

Medical genetics uses numerous methods, but in connection with the problems we are discussing, genealogical analysis, testing and screening for detection of genetic pathology are of greatest interest. The application of each of these methods is associated with certain moral problems. One of the central places, in this case, is a problem of confidentiality of genetic information.

A classic way to establish the genetic nature of a particular human disease is to make a genealogy. This practice of genealogical analysis is inherently controversial. To help an individual or a couple, the geneticist must obtain information about the somatic and mental characteristics of a whole group of people - their relatives. If, however, relatives also become the object of research, is it necessary to ask their permission as well?

Should the patient (proband) ask the consent of his parents to transfer to the doctor data about their diseases, bad habits, character traits, and everything that a medical geneticist may consider related to hereditary traits of interest to him? Does a geneticist have the right to work with the medical records of the patient's relatives without informing them?

Now let's assume that the genealogy is made. Does the patient have the right to know all the information that an experienced geneticist can extract from the study of the pedigree, or only what concerns himself and his descendants? Can he get a copy of the genealogy from the doctor? Do his relatives have the right to receive this information without his consent or, moreover, contrary to his prohibition? There are serious differences of opinion on all the issues identified.

The root of the problem is that the ethical standards of medical practice have traditionally been based on the model of individual interaction "doctor-patient". Do rules such as privacy fully apply to genetics? Information about diseases, mental and somatic characteristics, habits, and lifestyle - all this is information related to the private life of the patient. But within the framework of the genealogy, the same information may have medical and genetic significance for other relatives. Having it, the patient's relatives can take a more responsible approach to the issue of the birth of offspring, consult in time, conduct the necessary examinations, take preventive measures if there is a predisposition to the development of a certain disease, etc.

Respect for confidentiality, as well as the principle of respect for the autonomy of the patient, are the most important moral principles of healing. The duty to “help a person” follows from the principle “do good”, which is also an obligatory moral requirement in the activities of a medical worker. It is almost impossible to develop a universal approach to resolving such a moral dilemma. Each case requires an individual, situational analysis, during which it should be remembered that all the principles and rules of bioethics may not be applicable, only after a thorough assessment of the consequences of making a particular decision.

However, the situation can be somewhat simplified when it comes to two extreme cases: if the information concerns signs that do not have significant clinical significance, or, conversely, if the information concerns the likelihood of a severe mental or somatic illness. In the first case, it is usually possible to attach decisive importance to the requirement of confidentiality and refrain from sharing information with the patient's relatives.

In the second case, when there is a clear danger of the development (appearance in descendants) of a severe hereditary disease that threatens life or leads to severe disability, the duty of the geneticist will be to prevent trouble, if possible, by informing and consulting the patient's relatives. However, in this case, every effort should be made to obtain permission for the release of information from the patient. If this fails, then it is necessary to inform him that the information, due to its special clinical significance, will be transferred to the relative, despite the prohibition. Of course, when presenting information to a relative, one should limit oneself to only that part of it that concerns the likelihood of him or his descendants developing this particular serious disease.

Making a moral decision in complex cases that cannot be classified as extreme, is more expedient to carry out within the framework of the so-called "ethical committee" (ethical commission), which can be organized in a medical institution engaged in medical genetic counseling. A joint discussion of a morally difficult situation allows you to find a more balanced solution. Moreover, it is during such discussions that a group of professionals organizes itself, forming a community with its moral values and traditions. In this case, of course, it follows the possibility of avoiding the impact on the nature of the decision made by the financial or research interests of the medical geneticists themselves, as well as considering the sociocultural characteristics of patients.

Depending on religious, national, or personal characteristics, patients may prefer a more paternalistic attitude or, on the contrary, an attitude based on the principle of respect for the autonomy of the individual. It should also be considered that clan relations still play a decisive role among some ethnic groups. In this case, the mediation of an authoritative representative of the clan (an elder or simply an older common relative) will probably be useful.

Similar problems arise with genetic testing of patients, which can be carried out both at the request of the patient and on a mandatory basis, for example, for certain professional groups. In recent years, the ability to test for hereditary diseases has increased rapidly due to the introduction of DNA diagnostic methods into practice. Previously, the identification of a particular gene was based on the detection of certain metabolites that are controlled by it. DNA diagnostics allows the direct detection of genes in any nucleated cells.

Unauthorized use of the patient's genetic information concerning him can be a danger to him. For example, the genetic information obtained as a result of a mandatory medical examination can be used by the administration of an enterprise as a means of discrimination, a reason for dismissal, and an obstacle to career advancement.

It should be borne in mind that the employer has quite rational and understandable motives for using genetic information. After all, by not hiring people with a genetic predisposition to develop a certain disease, he reduces the risk of financial losses associated with the illness or disability of an employee. Of course, this rationality of the selfish behavior of the administration by no means removes questions about its morality and compliance with labor legislation. Nevertheless, as soon as the subject is found to have a genetic predisposition to a disease, the development of which can be provoked by working conditions at the enterprise, the problem turns out to be difficult in moral terms.

Genetic screening of the population is carried out to determine the carriers of genes for severe hereditary diseases. A classic example is the screening program to identify newborns with phenylketonuria (PKA), a severe hereditary disease that primarily affects the brain and spinal cord. Timely diagnosis of a genetic defect and the subsequent use of a special diet that excludes phenylalanine, in combination with psycho-corrective therapy and methods of social adaptation, in some cases leads to a good overall result. The simplicity and relative reliability of the screening method for detecting PKA contributed to its widespread use.

As with testing, there can be a moral conflict in the use of screening programs, based on the collision of the rule of confidentiality with the duty to prevent the occurrence of serious illness. Along with this, a special moral problem that arises in the screening of hereditary diseases is the need for effective financial support not only for the screening procedures themselves but also for full-fledged subsequent treatment, including diet therapy and psycho-corrective work. The underfunding of the program, which is so characteristic of modern Russian conditions, often leads to the fact that instead of an extremely severe mental pathology leading to the death of a child in the first years of life, a less severe, but also disabling pathology is formed, stretching the suffering of the patient and his family for decades. A reasonable question arises - does such a medical practice reduce the "volume of suffering" of a person or, on the contrary, even increase it?

Serious moral problems arise in the development and implementation of new screening programs. None of the existing diagnostic methods is absolute. There is always a certain percentage of misdiagnosis. Some patients are diagnosed as healthy (false-negative result), and some healthy ones are diagnosed as carriers of pathological genes (false-positive result). The relationship between the number of false positive and false negative diagnoses is dynamic. The more we strive to minimize the number of false negatives, the more false positives we get, and vice versa. False-negative diagnosis has quite obvious consequences - the patient does not receive the necessary treatment. A false-positive diagnosis can cause serious mental harm to a healthy child and his parents, and unjustified treatment can harm his health.

Given that the concentration of genes for severe hereditary diseases in the population is low, then even with very accurate diagnostic methods, the number of healthy, erroneously diagnosed as carriers of a pathological gene can be commensurate with the number of identified real patients. To cure some children, physicians must agree that a certain number of healthy children will be harmed. Therefore, when deciding on the use of screening programs, one should carefully “weigh” not only (and not so much) financial, but also a purely human “price”.

Similar problems can arise with testing, but because it is usually done for certain medical conditions, including a family history of a hereditary disease, as well as on an individual basis, the likelihood of misdiagnosis during testing is less, although it cannot be excluded completely.

Specific problems arise when the medical genetic testing procedure itself carries a risk of harm. For example, several hereditary diseases can be diagnosed in utero using amniocentesis, which, however, is associated with the risk of unintentional termination of pregnancy. If there are medical genetic indications that indicate a significant likelihood of having a child with a genetic pathology, then it is usually considered that this risk can be neglected.

If, however, a practically healthy woman does not have the appropriate indications, and therefore, the risk of hereditary pathology is minimal, then a serious moral problem arises in this case. Although the unborn fetus is not protected by law, from a moral point of view it has the right to life, and its interests must be taken into account.

The “neutral” position of some doctors who are ready to fulfill the “customer's order” for appropriate remuneration is hardly morally justified. The fetus, although not fully human, must still be protected following the principle of "not harm", which should not be outweighed by unreasonable concerns of the parents.

Ethical problems of the international project "Human Genome"[1]

Since its inception, bioethics and the problems developed by it have generated different opinions and approaches related to modern biotechnologies and biosafety[2]. The greatest number of ethical problems and disputes is associated with such areas of scientific research as human genetics, genetic engineering, and cloning. The rapid development of human genetics gives rise to many questions:

- Can the genome be a criterion for assessing personality?
- Can biogenetic inequality (ability, health) become the basis of social inequality?
- Should genetic testing be made available to everyone and cover the entire population?

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[1] The Human Genome Project, or HGP, is an international research project whose main goal was to determine the sequence of nucleotides that make up DNA and identify the 20-25 thousand genes in the human genome. This project is called the largest international collaboration ever carried out in biology.

[2] Biotechnology. Biosafety. Bioethics / ed. A. P. Ermishina. - Minsk, 2005

- Will science limit itself to deciphering pathological genes or will it go further - to the search for genes responsible for human behavior?
- Is it possible to improve or “harmonize” a person and the human race by providing marriage advice based on medical genetic testing?
- Can a person (geneticist-researcher, politician) become a "co-author" of biological evolution?
- Should the state and society regulate the process of scientific research, and if yes, how?

Most of these and other questions that arise in this area of scientific knowledge can be reduced to two binary oppositions. First, do we have the right not to interfere with the long-established order of life to change it?[1] Second - do we have the right to carry out any manipulations and apply the products of such manipulations, if the long-term consequences of such actions are unknown? Moreover, each of these questions is not just an exercise in rhetoric, but a natural consequence of the existing scientific and legal practice.

Today, the basis for regulating specific ethical problems of genetic research is, first of all, the Universal Declaration on Human Genome and Human Rights, adopted by the General Conference of UNESCO in 1997[2]. The merit of this document lies in the balance between guarantees of human rights and the need to ensure freedom of research. There are several groups of genetic studies:

1) determination of the localization and origin of genes;
2) gene diagnostics and screening studies;
3) search and research new methods of gene therapy.

The main aspects of the ethical review of each of these groups are the significance of the study, the scientific prerequisites for its conduct; research design; analysis of the admissibility of using certain procedures in the study; choice of research objects; risks and benefits; providing information to participants; considering commercial interests.

American specialists J. Annas and S. Elias identify three levels at which it is advisable to monitor the social and ethical consequences of the Human Genome Project. Firstly, this is the level of the individual

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[1] Ethical and legal aspects of the Human Genome Project: Int. Doc. and analytical materials. - M., 1998.

[2] Universal Declaration on the Human Genome and Human Rights. - UN, 1997. URL: www.unesco.com

and the family, and secondly, the level of societies and, thirdly, the level of a person's fundamental philosophical understanding of himself.

Consider the level of the individual and the family. Thousands of new diagnostic methods that will be developed shortly will make people the owners of unique information about their genetic characteristics, which will constantly accumulate. In this case, a natural asymmetry of the rights of ownership and disposal of such “property” arises. Parents, as legal representatives of minors, have the right to access their genetic information. However, the law does not provide for the right of children to possess genetic information about their parents. Since the child's genome was received partly from the father and partly from the mother, the restriction on the right to access the genetic information of the parents means that it is sometimes impossible to obtain vital information about oneself. This is a clear form of injustice in relations between generations within the family.

In this situation, it is necessary to supplement the foundations of traditional ethics with such concepts as “confidentiality”, “privacy” and “personal autonomy”, which should no longer concern an individual, but a family or even a kind of group of families related by kinship. Only intra-family solidarity, justice, and mutual responsibility can protect each family member from unwanted intrusion by third parties, and from the "transparency" of the genetic characteristics of individuals for employers, insurers, or government agencies.

At the level of society, there is a need for qualitative improvement in the general biological and, especially, genetic education of the population. Possession of genetic information implies responsible disposal of it. The latter is impossible without mastering the basics of modern genetic knowledge, without understanding the language of probabilistic patterns that describe the features of the manifestation of hereditary traits. The habit of using simplified, unambiguously deterministic descriptions, widespread in the mass consciousness, can have the most negative impact on the behavior of an individual who manages his genetic information. The genetic ignorance of the population was, given the experience of eugenics, and will be a fertile environment for unscrupulous political speculation and unscrupulous commercial activities in the field of genetic testing and medical genetic counseling. Another social problem faced by society during the implementation of the Human Genome Project is the issue of fair access to genetic diagnostic methods, medical genetic counseling, and appropriate methods for the prevention and treatment of hereditary diseases,

Since significant public resources have been invested in Human Genome Project, in a certain sense the right to enjoy the benefits that will be received as a result belongs to everyone. Justice requires the creation of public mechanisms to ensure universal access to medical genetic services. At present, like any other technological advances, innovations arising from the implementation of Human Genome Project primarily benefit those who, following the inequality in the distribution of power and money, have advantages over others. So, for example, a test for the diagnosis of Huntington's disease costs about 8 thousand dollars in the USA, not counting the cost of the necessary medical genetic counseling.

In a certain sense, problems similar to those just described arise when genes (nucleotide sequences) are patented. In 1983, the DNA sequence responsible for the control of the plasmogen-activating protein was patented; in 1987 - erythropoietin was. Thousands of laboratory-derived sequences are currently up for patenting. A patent protects the right of ownership and disposal. If something is patented by someone, then the other person has no right to use the patented thing without paying a certain amount to the owner.

When it comes to technical inventions, everything is more or less clear with them. Sequences are "parts" of the human body. How can a part of the body of each of the people be the property of one person? Can a product derived from significant public resources be subject to private patenting and ownership? These questions are far from being resolved. The lack of patent rights for developers deprives them of the opportunity to recoup their costs and reduces the attractiveness of their activities for private investment in this area. At the same time, patenting limits the availability to all members of society of those benefits that are obtained to a large extent at the expense of public resources.

It is also necessary to take into account what some experts call the "social power of biological information." Since the distribution of certain genetic properties (including pathological genes) is uneven among different social and ethnic groups, there is a real threat of their discrimination as "animals” according to the results of genetic testing. Now there are opinions that the homeless and unemployed are "genetically defective" individuals and that the solution to this social problem can eventually be carried out by genetic engineering methods. If we consider that each person has a significant number of genes that deviate from the average "norms", then the threat of a "dictatorship of normality" is quite real. History shows how easily genetic information (usually misinterpreted) is connected to racist stereotypes to justify discrimination and the different treatment of different individuals and social groups.

At the level of a general philosophical understanding of human nature, Human Genome Project can somehow contribute to the spread of the reductionist approach[1]. The danger lies in the fact that as a result, a person begins to be seen as a certain way organized collection of molecules. The ancient myth of the homunculus, recreated by the genius of Goethe, is given new life.

Today it is already obvious that genetic engineering and biotechnologies have a huge potential and opportunities to influence bioethics, humans, and society. However, these perspectives are twofold. Thus, noting the scientific and economic prospects of genetic engineering, it is necessary to keep in mind its potential threat to man and mankind, in particular, the dangers that may arise with further penetration of the human mind into the natural forces of nature. If everything possible today in genetic engineering with microorganisms and individual cells is in principle possible to do with the human egg and somatic cells, then the following become real: a directed change in hereditary material; identical reproduction of a genetically programmed individual (cloning); the creation of chimeras (man-animal) from the hereditary material of different species, etc. Man becomes the object of genetic technology. Therefore, from the point of view of bioethics, the question should be asked: is it always possible to do in a given area what can be done? This is not about saying "yes" or "no" to genetic technology but highlighting the positive and negative aspects of the problem. Genetic technology has given man an advantage that he did not have before purposefully and quickly change the natural environment and himself. At the same time, some scientists believe that their

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[1] Reductionism (from the Latin reductio “return, bringing back”) is a methodological principle according to which complex phenomena can be fully explained using laws characteristic of simpler phenomena (for example, sociological phenomena are explained by biological or economic laws).

activities should not be limited to anything: everything they want and know how to do, they can also do. However, if the rearrangement of the genome of an adult individual for medical reasons or at his request is ethically acceptable, then a completely different situation arises when the genome of germ cells is changed[1]. Concerning the problems of genetics within the framework of bioethical methodology, two approaches have been formed, which can be conditionally called "liberal" and "conservative". Adherents of the "liberal" approach see great prospects opening in the field of gene therapy and biotechnology, and any restrictions on these prospects are considered a stop to scientific progress. As a rule, scientists confess such an attitude: molecular biologists, and geneticists, that is, direct participants in research work. This position is based on the principles of pragmatism and utilitarianism. The "conservative" point of view is more common among lawyers, theologians, and some philosophers, but also among scientists. Its essence is concern about the possibility of genetic transformations, which, once begun, can change the genetic portrait of humanity so much that, concerning the consequences of this revolution, the consequences of wars and catastrophes may seem insignificant. The ethical arguments of this position are connected with the expectations of catastrophic consequences of violation by a person (scientists, researchers) of traditional moral norms.

The most adequate and most relevant to the current state of science and society is, from our point of view, a combined approach, in which it is recognized that genetic engineering undoubtedly contributes to the social and technological progress of society, but is subject to unconditional adherence to the principles and norms of ethics of biomedical science, as well as global and social bioethics[2]. Using the methods of genetic engineering, in vitro fertilization, surrogacy, diagnostics, which can be carried out not only in the prenatal period, but also before conception, a person more and more begins to, as if “manufacture” embryos, fetuses and children "on order" - i.e. focusing

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[1] *Sgreccia E., Di Pietro M. L.* Manipolazioni genetiche e procreazione artificiale: orientamentici e giuridiconsiderazioni etiche // Il diritto di Famiglia e delle Persone. - 1987. - No. 3, 4. - P. 1351-1447.

[2] Социальная биоэтика сквозь призму глобальной биоэтики / Междунар. гос. эколог. ин-т С69 им. А. Д. Сахарова Бел. гос. ун-та ; Т. В. Мишаткина, С. Б. Мельнов, Т. Н. Цырдя [и др.] ; под ред. канд. филос. наук, проф. Т. В. Мишаткиной, д-ра биол. наук, проф. С. Б. Мельнова. - Минск : ИВЦ Минфина, 2018. - 518 с.

on obtaining children with certain desirable genetic properties for parents (and, perhaps, for the ruling elites). Recently, methods of cloning have been actively developed - the creation of genetic copies of living beings. So, the natural process of the generation of man by man is gradually being technologized, turning into a kind of laboratory production.

Should parents be held accountable to their children if the latter is not satisfied with the parent's choice of desirable traits? In foreign practice, there are cases when disabled people suffering from severe hereditary diseases filed lawsuits against parents who at one time refused to have an abortion and thereby doomed them to torment.

If the world of culture is defined as the totality of what is made by man, in contrast to the world of nature - what happened due to natural necessity, then “test-tube” children with an “improved” genotype at the request of the “customers” (parents or rulers) should be considered, with from the point of view of the canons of modern civilization, to a greater extent by people than those who were born in a natural, "uncivilized" way. Back in 1971, the American biologist B. Glass wrote that modern biology could guarantee the quality of all newborns so that none of the parents has the right to burden society with the birth of a deformed or mentally retarded child.

The enthusiasm with which the public perceives progress in the study of the human genome entails an exaggeration of the role of the genetic determination of human qualities and, above all, human behavior. The exaggeration of the role of genes ultimately means the removal of personal responsibility. Talent or, on the contrary, limited abilities, deviant behavior, etc. - all this and much more is considered as predetermined by heredity.

Therefore, as J. Annas and S. Elias rightly point out; “The second danger lies in the tendency to believe that genes are more powerful than environmental influences, and therefore our actions should be considered as “genetically determined” and not as the result of free will. We are already witnessing this kind of thinking in connection with cases of "47, XYY defenses". There is an assumption that carriers of 47, XYY karyotype are genetically predisposed to committing crimes. Accordingly, some individuals with an extra Y chromosome who have been accused of crimes have argued that they should not be held responsible because their genetic makeup predisposes them to commit criminal acts. Courts generally do not accept such reasoning, and in the rare cases where it was taken into account, defendants were sentenced to compulsory psychiatric treatment.

The problem of genetic predetermination of human behavior revives the paradox that our thought has been facing for many centuries when a person tries to understand himself. How can one think of the free will of a person if everything that happens in the world is predetermined by the will of God? What is the meaning of ideas of freedom, responsibility, and morality in the modern world, if everything happens due to natural necessity? After all, on the one hand, at each moment of time, the state of the human body is genetically determined and through certain physiological, biochemical, and other biological patterns, it is causally connected with previous states. This is the foundation of scientific knowledge. But, on the other hand, our society is built on a fundamental basis of the idea that a person has free will. Whatever he does, everything can be considered as his act, that is, as something for which he is responsible: it can be rewarded or condemned, approved or blamed. According to this position, the social world is, as it were, marked by oppositions of good and evil, and the interaction of people in society is impossible without a moral and legal orientation.

The emergence of new possibilities for manipulating genetic material in order to improve the hereditary qualities of an individual and prevent the spread of genetic diseases contributes to the revival of the ideas of eugenics, which were widespread among biologists and politicians at the end of the 19th and the first half of the 20th century.

Questions for self-examination

1. List five ethical principles of human genome research.

2. What is the “genetic risk” of gene therapy procedures?

3. Under what conditions can a "genetic passport" limit a person's freedom?

4. Describe the ethical issues of the Human Genome Project

5. What regulatory documents regulate the introduction of bio and genomic technologies into practice?

Bibliography

1. Belyaletdinov, R. R. Risks of modern biotechnologies: socio-humanitarian analysis: monograph / R. P. Belyaletdinov - Moscow: 4 Print LLC, 2019. – p.212.
2. Human Genome Project, HGP — international research project , *Robert Krulwich*. (Cracking the Code of Life) PBS. ISBN 1-5375-16-9. the largest international collaboration ever undertaken in biology https://www.theguardian.com/environment/2015/mar/16/what-is-the-wellcome-trust
3. Biotechnology. Biosecurity. Bioethics / ed. A. P. Ermishina. - Minsk, 2005
4. Ethical and legal aspects of the project "Human Genome": Intern. Doc. and analytic materials. - M., 1998.
5. Universal Declaration on the Human Genome and Human Rights. - UN, 1997. URL: www.unesco.com
6. Hen, Yu. V. Eugenics: founders and successors / Yu. V. Khen // Man. - 2006. - № 3.
7. *Sgreccia E., Di Pietro M. L.* Manipolazioni genetiche e procreazione artificiale: orientamentici e giuridiconsiderazioni etiche // Il diritto di Famiglia e delle Persone. - 1987. - No. 3, 4. - P. 1351-1447.
8. Social bioethics through the prism of global bioethics / Intern. state ecologist. in-t C69 under the name A. D. Sakharova Bel. state university; T. V. Mishatkina, S. B. Melnov, T. N. Tsyrdya [and others]; ed. cand. philosophy sciences, prof. T. V. Mishatkina, Doctor of Biol. sciences, prof. S. B. Melnova. - Minsk: Information Center of the Ministry of Finance, 2018. - p.518.

CHAPTER VIII. AIDS AS A GLOBAL PROBLEM OF THE MODERN WORLD

Life is not about living, but living
creating and being healthy
M.V. Martial

Key words: *HIV/AIDS (UNAIDS), antibodies to HIV-1, HIV -2 and HIV antigen*

In Political Declaration on HIV/AIDS, adopted on June 2, 2006 at 87th plenary session of the UN General Assembly[1], Heads of State and Government stated: “We reaffirm that HIV prevention should form basis of national, regional and international action aimed at combating this pandemic, and therefore commit to intensify efforts to ensure that all countries, especially the most affected countries, have a wide range of prevention programs tailored to local conditions, ethical and cultural values, including information, education in the languages most understood by the population, and respecting cultures that reduce risky behavior and encourage responsible sexual behavior, including abstinence and fidelity; expanding access to essential supplies, including male and female condoms and sterile injectables; reducing the harm associated with drug use; expanding access to psychological assistance services and testing on a voluntary basis and subject to the principle of confidentiality; security of donated blood supplies; and timely and effective treatment of sexually transmitted diseases.”

The UN has established a specialized structure - Joint United Nations Program on HIV/AIDS (UNAIDS). The implementation of the UNAIDS Strategy 2011-2010 has now begun. This strategy aims to accelerate

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[1] Political Declaration on HIV/AIDS, Adopted by General Assembly resolution 60/262 of 2 June 2006 https://www.un.org/ru/documents/decl_conv/declarations/aidsdecl.shtml

global progress towards country-set targets for universal access to HIV prevention, treatment, care, and support, and to halt and reverse the spread of HIV and contribute to development of millennium goals by 2015. Adopted by the Program Coordinating Board in December 2010, this strategy provides for the implementation of the HIV response in the new global environment. The AIDS response is a long-term investment, and the strategy itself aims to revolutionize HIV prevention, accelerate the next phase of treatment, care, and support, and promote human rights and gender equality.

Moral problems related to HIV/AIDS are the focus of attention of scientists (Ivanyushkin A.Ya., Ignatiev V.N., Korotkikh R.V., Siluyanova I.V., Tishchenko P.D., Yudin B.G., Yarovinsky M.Ya.)[1] since these problems focus on all the ethical problems of modern medicine, giving some of them a uniqueness, due solely to HIV infection.

Many traditional principles and norms of bioethics are often tested for strength precisely in accordance with HIV infection.

This applies to the oldest principle “First of all, do no harm!”. Previously, the medical context of possible harm to the patient has been considered. In particular, such a form of harm is the failure to provide assistance to the patient. HIV infection has posed an acute problem of mass refusal of doctors in many countries of the world to provide assistance to people infected with HIV. The leading motive for such refusals of medical workers is their personal safety. This problem has not yet found an adequate solution.

In the case of HIV/AIDS, there is a problem with implementing the principle "Do good!". We are talking about the fact that the spread of HIV infection causes a kind of bifurcation in the professional thinking of a medical worker. In a specific clinical situation, the implementation of the principle "Do good!" does not focus only on the HIV-infected. The doctor's professional thinking here is not focused only on treatment, it has a wider range and captures the issues of necessary prevention of HIV infection among those who make up the patient's inner circle. It turns out that the principle "Do good!" in the case of HIV infection,

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[1] Introduction to bioethics: Proc. allowance / A.Ya. Ivanyushkin, V.N. Ignatiev, R.V. Korotkikh and others - M.: Progress-Tradition, 1998. - 381 p. ;Siluyanova I.V., Biomedical Ethics.M.2016;Yudin B.G., Tishchenko P.D. (ed.). Introduction to bioethics. M.: Progress-Tradition; 1998;. Yarovinsky M.Ya. Medical ethics (bioethics): Proc. allowance. – M.: 2006.

involves many objects of its implementation, not only the life and health of one patient, as is often the case, for example, in surgical practice. In this case, the active benefit of a medical worker should also be aimed at preserving the life and health of other people. This is only one side that generates the internal conflict of a medical worker who is aware of the need to follow the principle "Do good!". There is another equally important aspect of the moral and ethical issues of HIV/AIDS. This is a question about the expediency of providing assistance to HIV-infected and AIDS patients. It is important to emphasize that this question arises not only among medical professionals who are professionally aware that the treatment of AIDS is currently does not lead to the desired result. This question is raised by insurers, economists, and, finally, members of the public.

In this regard, there is an acute question about the implementation of the principle of justice in relation to HIV-infected and AIDS patients. It is important to emphasize the legal and moral aspects of fair treatment of HIV-infected and AIDS patients. In the legal (formal) aspect, this category of patients, in accordance with international law and national legislation, has equal rights to health protection and medical care in comparison with other citizens. In the moral (substantive) aspect, when it comes to equality based on the recognition of each HIV-infected and AIDS patient, like any other person, as the only, indispensable, inexhaustible in their claims and aspirations, then we must state the problem of the unconditional implementation of the principle of justice. In the medical community, there is a differentiated approach to the personality of an HIV-infected person and an AIDS patient. First of all, this is due to the specifics of the contingents of HIV-infected persons.

There are several groups of increased risk of HIV infection: 1) homosexuals and bisexuals; 2) drug addicts using intravenous drug administration; 3) prostitutes; 4) patients and persons episodically undergoing blood transfusion. Given that HIV-infected people are dominated by people who lead a lifestyle that traditionally causes negative public assessment, medical workers often have the feeling that AIDS is, as it were, a punishment for “wrong behavior”. Having such an attitude, medical workers begin to treat patients from different risk groups differently, which often creates an ethical conflict. It is clear that such differentiation of patients is contrary to the principle of justice.

In the case of HIV/AIDS, there is a bioethical problem in implementing the principle of respect for patient autonomy. The scope of autonomy of an HIV-infected patient and an AIDS patient is limited by a number of external conditions that affect the course and result of his actions. Such an external condition is, first of all, a potential social danger to the patient. Therefore, the moral choice of the patient and the doctor, of course, is determined by the awareness of this social danger. The degree of freedom of behavior of an HIV-infected and AIDS patient is limited by a high level of moral and legal (up to criminal) responsibility. Finally, at a certain stage of the disease, due to a severe physical and mental condition, an AIDS patient may not be able to act autonomously.

In such clinical situations, the question of the implementation of the principle of human dignity is acute. In particular, there is an ethical problem associated with the provision of medical care to AIDS patients who are in an agonal state. To what extent is it acceptable to depart from the classical approaches when conducting clinical trials in relation to AIDS patients? It is known that with the classical scheme in clinical trials, there should be a group of patients receiving a placebo. For AIDS patients, this may mean that a number of test patients lose hope of receiving a treatment that could theoretically affect their life expectancy. In this regard, the problem of selecting groups of test participants arises. In a number of countries, for this reason, it is allowed to test the effectiveness of therapeutic drugs for HIV infection without the use of a placebo.

In the aspect of the application of new medical technologies in the treatment of AIDS, the problem of implementing the principle of integrity may arise. This problem is related to the fact that until now HIV/AIDS remains a little-studied area of medicine. Therefore, the number of scientific and exploratory research in this direction significantly exceeds the number of positive or relatively positive practical results achieved. It cannot be ruled out that any of the scientific research will lead to the creation of a new, hypothetically very effective medical technology for the treatment of AIDS, but the use of it in clinical practice poses a potential threat to the bodily and mental integrity of the individual. It is clear that in any case, the risk of using such medical technology must be justified.

With regard to HIV-infected and AIDS patients, the problem of compliance with the principle of vulnerability arises. The UN Declaration of June 27, 2001[1], determined that vulnerable groups should be given priority attention. At the same time, it is emphasized that the empowerment of women is essential to reduce vulnerability. The Declaration calls for the establishment in all countries of strategies, policies, and programs to identify and begin addressing the factors that make individuals vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or goods for self-defense, all types of sexual exploitation of women, girls, and boys, including for commercial purposes; such strategies, policies, and programs should address the gender dimension of the epidemic, prescribing measures to be taken to reduce vulnerability. The Declaration specifically addresses the development and/or strengthening of strategies, policies, and programs that recognize the importance of the family in reducing vulnerability, in particular in the education and life orientation of children, and take into account cultural, religious, and ethical factors that aim to reduce the vulnerability of children and young people through: ensuring that both girls and boys have access to primary and secondary education, including HIV/AIDS programs for adolescents; providing a safe environment, especially for young girls; scaling up youth-friendly high-quality information services, sexual health education, and counseling; strengthening reproductive and sexual health; involve families and young people in the planning, implementation, and evaluation of HIV/AIDS prevention and care programs to the greatest extent possible.

The next bioethical problem is related to the observance of the rule of truthfulness in the process of treatment and observation of patients with HIV/AIDS.

Since modern medicine does not have sufficiently serious arguments that it can oppose HIV infection and AIDS, a medical professional is obliged to critically assess the extent of his knowledge in this area and truthfully inform the patient of the available information. From a psychological point of view, it is important to remember that AIDS patients, as a rule, are aware of the inevitability of an unfavorable

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[1] Declaration of Commitment on HIV/AIDS Adopted by resolution S-26/2 of the special session of the General Assembly on 27 June 2001

outcome of the disease, therefore they are most sensitive to any information, especially regarding the use of new drugs. Thus, the emergence of new foreign drugs - "HIV protease inhibitors", the treatment of which costs at least 20,000 dollars a year, at the initial stage entailed the ethical problem of informing patients about this group of drugs. The problem is due to the fact that not every patient is able to purchase these drugs.

The above material on the conflict between personal and public interests allows us to state the problem of compliance with the rule of privacy and the rule of confidentiality in relation to HIV-infected and AIDS patients.

It should be emphasized that on this issue there is probably the widest range of judgments: from strict observance of medical secrecy to its full disclosure. It is clear that the system of arguments for extreme opposing judgments is built depending on the recognition of the priority of the interests of the individual or society. Supporters of different points of view on confidentiality are unanimous in only one thing, in the first place it is necessary to ensure that the patient himself informs other people about his illness and stops all actions that may endanger the health of others.

It is important to emphasize that the guarantees for the observance of the rights and freedoms of HIV-infected people are formulated in the Law of the Republic of Uzbekistan “On counteracting the spread of the disease caused by the human immunodeficiency virus (HIV infection)”, adopted by the Legislative Chamber on June 7, 2013, in Articles 20, 21[1]

Article 20. Social Protection of HIV-infected People

Free specific treatment is provided to HIV-infected people. HIV-infected persons who have not reached the age of eighteen are entitled to receive monthly social benefits, regardless of the stage of the disease, and benefits for disabled children established by law. Parents of HIV-infected children or persons replacing parents have the right to stay with their children in a medical institution in stationary conditions with

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[1] Law of the Republic of Uzbekistan On countering the spread of the disease caused by the human immunodeficiency virus (HIV INFECTION) Adopted by the Legislative Chamber on June 7, 2013 Approved by the Senate on August 22, 2013 No. ZRU-353 09.23.2013 https://lex.uz/docs/2240472

temporary release from work and payment of temporary disability benefits in the manner prescribed by law.

Article 21. Prevention of restriction of the rights of HIV-infected

It is not allowed to terminate an employment contract, refuses to hire, with the exception of certain types of professional activities provided for in the list established by the Ministry of Health of the Republic of Uzbekistan, refuses to admit to educational institutions, with the exception of certain types of educational institutions established by law, and to institutions providing medical care, as well as restriction of other rights and legitimate interests of HIV-infected people on the basis of their HIV infection, as well as restriction of housing, other rights and legitimate interests of their family members.

Often, medical professionals and the media present a global and really serious problem associated with HIV / AIDS, in such a way that it causes fear and confusion in many, especially young people, which often leads to AIDS phobia - an obsessive state of fear of getting AIDS.

From fear of AIDS, as a rule, a person begins to seek protection in alcohol, drugs, and immoral sex, thereby “starting a vicious circle”, which greatly increases the risk of HIV infection. A person is obsessed with fear - the world is collapsing, and fear undermines faith, above all faith in oneself, in tomorrow. The loss of faith gives rise to the most insidious and dangerous disease - the erosion of the soul.

The fear is based on three important factors: the absence or lack of information about HIV / AIDS, the awareness of the fatal outcome in the case of AIDS, and the predominance of an extremely negative attitude towards HIV-infected and AIDS patients in society. These patients irritate, they are considered guilty of all troubles, and they become outcasts and therefore often begin to sink to the level where society dooms them. Stigma, silence, discrimination, and exclusion, as well as a lack of confidentiality, undermine prevention and care efforts and increase the impact of the epidemic on individuals, families, communities, and nations.

Consequently, the fight against AIDS phobia is possible in three directions: education, changing negative social attitudes, and deepening scientific research aimed at treating AIDS.

At present, indeed, there are more scientific problems in the study of HIV infection than real practical results. But are there any achievements in the fight against AIDS? Undoubtedly.

In recent years, new diagnostic test systems have been created that make it possible to isolate antibodies to HIV within 1-5 minutes and are not inferior in their qualities (primarily in sensitivity and specificity) to standard enzyme immunoassay.

Four genetically engineered vaccines are already in phase I clinical trials in humans. More than 50 new chemotherapy drugs with high activity against HIV are undergoing clinical trials.

"10 commandments" about AIDS:

1) AIDS is a completely new disease spread throughout the world.

2) How AIDS virus spreads are already well known.

3) Knowing the ways of spreading a causative agent of AIDS means knowing how to prevent it.

4) Sexual transmission of AIDS virus can be prevented.

5) There are various, reliable ways to prevent transmission of infection through the blood.

6) It is very important to know how the AIDS pathogen does not spread.

7) You should not be afraid of communication in everyday life with people infected with the AIDS virus.

8) Since there are no vaccines against AIDS and reliable drugs, truthful information and health education play a crucial role in preventing infection.

9) At present, all countries of the world are rising to fight the global threat of AIDS.

10) Together we can stop the spread of AIDS!

In the fight against HIV/AIDS, expanding access to voluntary and confidential counseling and testing is essential; ensuring the supply of safe donated blood; early and effective treatment of sexually transmitted diseases.

At present, selective checks of the quality of diagnostic test systems for the detection of antibodies to HIV and the work of screening laboratories are systematically carried out in Russia.

Screening tests are of particular importance in the operation of blood transfusion stations. Thus, by the decision of the Council for Cooperation in the Field of Healthcare of CIS dated April 2, 2004[1], it was recommended for use in practice the Procedure for medical examination of a blood donor and its components, according to which screening of donor blood is carried out according to certain indicators, including antibodies to HIV-1, HIV -2 and HIV antigen .

An important element of an effective response is the care, support, and treatment of patients with AIDS. The highest achievable standard of care is urgently being developed, including effective use of antiretroviral therapy with careful quality control, increased efficiency, and reduced risk of developing resistance.

Questions for self-examination

1. What are AIDS and HIV?
2. Who are AIDS phones?
3. Ethical issues of HIV, and AIDS?
4. Confidentiality rules for HIV-infected and AIDS patients.

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[1] Decision of the Council for Cooperation in the Field of Healthcare of the CIS dated April 2, 2004 http://base.spinform.ru/show_doc.fwx?rgn=6865

5. Compliance with the rule of truthfulness in the process of treatment and monitoring of patients with HIV / AIDS

6. What are the main phases of the course of HIV?

7. How do you know if a person has HIV infection?

8. What are the ways of transmission of HIV infection

9. Implementation of the principle of justice concerning HIV-infected and AIDS patients.

Bibliography

1. Political Declaration on HIV/AIDS, Adopted by General Assembly resolution 60/262 of 2 June 2006 https://www.un.org / ru/documents/decl_conv/declarations/aidsdecl.shtml
2. Introduction to bioethics: Proc. allowance / A.Ya. Ivanyushkin, V.N. Ignatiev, R.V. Korotkikh and others - M.: Progress-Tradition, 1998. - 381 p. - Bibliography. p. 381
3. Siluyanova I.V., Biomedical ethics. M.2016
4. Yudin B. G., Tishchenko P. D. (ed.). Introduction to bioethics. Moscow: Progress-Tradition; 1998.
5. Yarovinsky M. Ya Medical ethics (bioethics). Ed.manual – M.: 2006.
6. Declaration of Commitment on HIV/AIDS Adopted by resolution S-26/2 of the special session of the General Assembly on 27 June 2001
7. Law of the Republic of Uzbekistan On combating the spread of the disease caused by the human immunodeficiency virus (HIV INFECTION) Adopted by the Legislative Chamber on June 7, 2013 Approved by the Senate on August 22, 2013 No. ZRU-353 09/23/2013 https://lex.uz/docs/2240472
8. Decision of the Council for Cooperation in the Field of Healthcare of the CIS of April 2, 2004 http://base.spinform.ru / show_doc.fwx?rgn=6865

CHAPTER IX. ETHICS IN PSYCHIATRY AND PSYCHOTHERAPY

Define meanings of words and you will save mankind
from half of his delusions.
Rene Descartes

Key words: *Human rights, Antipsychiatric movement , Psychotherapy, Psychiatry.*

Human rights.

According to the World Health Organization, about 450 million the person suffers from a mental or behavioral disorder. Many of them suffer silently and alone without any treatment. There are obstacles between suffering and the prospect of help, which are expressed in stigma, prejudice, shame, and alienation. Mental disorders account for 12% of the global burden of disease, while budgets for mental health care in most countries do not exceed 1%. By dedicating The world health report 2001 to calling it "New Understanding, New Hope", the WHO simply and unequivocally states: "Mental health, which has long been neglected, must be seen everywhere in a new light[1]. There is no justification for people with mental illness or brain disease to be excluded from society - there should be a place for everyone in society." The etymology of the word "psychiatry" (from the Greek "psyche" - soul, "iatros" - doctor) adequately reflects the main goal of the professional activity of a psychiatrist - the treatment of mental disorders, competent and skillful assistance, first of all, to mentally ill people, but also to any person in need of such assistance. Of all the medical disciplines, psychiatry deals most with the whole person, taking into account his biological, mental, spiritual, and social components.

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[1] Mental Health: New Understanding, New Hope World Health Report 2001 https://www.who.int/publications/list/whr01/ru/ ; WHO, Context of mental health. Compendium of guidelines on mental health policy and service delivery / Geneva, 2003.

Antipsychiatric movement

Psychotherapy (from other Greek ψυχή - “soul”, “spirit” + θεραπεία - “treatment”, “recovery”, “medicine”) is a system of therapeutic effects on the psyche and through the psyche on the human body. Often defined as an activity aimed at ridding a person of various problems (emotional, personal, social, etc.). It is carried out, as a rule, by a specialist psychotherapist by establishing deep personal contact with the patient (often through conversations and discussions), as well as using various cognitive, behavioral, medication, and other techniques. However, this definition is not complete.

It is necessary to distinguish the concept of psychotherapy from both psychiatry and psychology. Psychotherapy may be a subset of or part of psychiatric treatment (described in psychiatry textbooks, recommended for use by psychiatrists), but psychiatric treatment is often not limited to it (or, in some cases, such as in acute psychosis, can generally be reduced to medication only).

Psychiatry (ancient Greek ψυχή (psychḗ), soul + ἰατρεία (iatreía), treatment) is a branch of clinical medicine that studies mental disorders through the prism of medical methodology, methods for their diagnosis, prevention, and treatment. This term also refers to the totality of state and accredited non-state institutions, in some countries having the right to involuntary isolation of persons who pose a potential danger to themselves or others.

The definition of psychiatry proposed by German psychiatrist Wilhelm Griesinger (1845) as the doctrine of the recognition and treatment of mental illness has received wide recognition. According to several modern authors, this definition "contains the most significant features of this medical discipline", and "exactly formulates the tasks facing psychiatry", given that: recognition means not only diagnosis but also the study of the etiology, pathogenesis, course, and outcome of mental disorders. Treatment, in addition to the therapy itself, includes the organization of psychiatric care, prevention, rehabilitation, and social aspects of psychiatry.

Among medical disciplines, psychiatry is the most social in its subject matter, research methodology, and practice. The state of mental health is greatly influenced by social factors, the study of which is necessary for psychiatry as a medical science. It was the social orientation of psychiatry that often turned it into an arena for a sharp struggle between various ideologies, public opinions, and social, ethical, and legal concepts and placed on psychiatrists a great moral responsibility to society[1].

There are reasons for this:

1. Psychiatry deals with the socially functioning individual in a complex set of personal and social relationships. The range of persons and phenomena of mental life that have become the subject of diagnostic assessments, and therapeutic and therapeutic interventions has expanded enormously. There are practically no strict criteria for delimiting the norm from pathology. Under these conditions, the danger increases not only of erroneous judgments but also of deliberate distortions, and false diagnoses under the pressure of circumstances or prejudices. Since the price of such distortions is too great, professional ethics require the utmost honesty, objectivity, and responsibility from the psychiatrist.
2. The diagnosis of a mental disorder, like no other, carries a huge moral burden on the Republic of Uzbekistan. Persons recognized as mentally ill, no matter how humane society treats them, inevitably lose some measure of social trust, and therefore experience different restrictions. This implies one of the important tasks of psychiatric ethics - increasing the tolerance of society towards people with mental disorders and overcoming bias, and alienation.
3. A feature of psychiatry is the possibility of using measures of coercion and violence against certain categories of patients. Thus, the task of psychiatric ethics is to limit the scope of coercion in the provision of psychiatric care to the limits determined by medical necessity, which serves as a guarantee of human rights.
4. Psychiatric patients form a wide continuum, from patients with severe mental disorders to individuals with a high degree of personal autonomy, personal responsibility, and intellectual development. Concerning the first category of patients, the paternalistic model of relations is adequate. At the same time, the paternalistic approach does not mean a complete disregard for the patient's opinions and preferences, suppression of his will, and unlimited coercion. The second category of patients is quite capable of self-determination, expressing their interests,

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[1] Sokolov M.P., Sumarokov L.A. Problems of bioethics in psychiatry https://studfiles.net/preview/2248214/

and distinguishing between benefits and harms. In this case, the doctor-patient relationship is built based on partnerships.

Three different concepts are distinguished: "abuse of a psychiatrist", "abuse in the field of psychiatry", and "abuse of psychiatry"[1].

The first concept characterizes the legal and (or) ethical assessment of the actions, actions of a psychiatrist as a doctor in general, as a specific person, and as a subject of consciousness and will. The second concept implies the use of the positions, powers, and abilities of a psychiatrist and staff of psychiatric institutions to the detriment of the patient or his relatives. The use of psychiatry for evil in this case refers to the improper use by professionals of special knowledge, as well as special methods and means, such as a special system of social institutions. The third concept - "abuse of psychiatry" as a clinical discipline and the existing system of medical care for the mentally ill - can have a variety of aspects. These include incorrect, erroneous diagnoses of mental disorders and the appointment of unindicated or excessive treatment.

Any abuse by a psychiatrist of his knowledge is incompatible with professional ethics. A psychiatrist has no right to use his professional knowledge and abilities contrary to medical interests or to distort the truth, without sufficient grounds and without the need to apply medical measures. The misuse of psychiatry as a clinical discipline and the existing system of medical and social care for the mentally ill can have a variety of aspects. The most serious forms of abuse of psychiatry are associated with the establishment of a psychiatric diagnosis or with an infringement on the mental integrity of a person, his rights, and his freedoms. It should be noted that an incorrect, erroneous diagnosis of mental disorders may be allowed by doctors for reasons related to a lack of information about the patient or insufficient professional competence of a psychiatrist. Such diagnostic medical errors are difficult to attribute to abuse: they are usually understood as "conscientious errors".

As a result of this practice, a situation has developed in which any patient who applied at least once to a psychoneurological dispensary could be subjected to social discrimination, restriction of rights, and often prejudiced attitude from society.

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[1] Tikhonenko V.A., Ivanyushkin. AND I.,. Evtushenko V.Ya. Kondratiev. F.V 1997

The attitude towards those young people who showed interest in philosophical problems, tried to comprehend the social processes taking place in the country, and searched for the key to life in the so-called "bourgeois literature" became especially illiterate and unceremonious in this regard. The term "philosophical" or "metaphysical intoxication", used by the German philosopher Karl Jaspers to characterize the formation of personality in adolescence, not associated with illness, became in Soviet psychiatry a synonym for the early-onset schizophrenic process.

We are talking about the abuse of psychiatry in cases where, for example, incorrect diagnostic conclusions are due to non-medical factors and are made by doctors under pressure from other people. Regardless of whether this is accompanied by an internal conflict of the doctor with his conscience or not, he, as a specialist, inevitably becomes the main source of the admitted abuse, since it is carried out in life according to his conclusion, recommendations, and advice. This group of cases of misdiagnosis of mental disorders cannot be considered medical errors in the strict sense (as "conscientious errors"). The Principles for the Protection of Persons with Mental Illness prescribe in this regard: “No one will be declared mentally ill, diagnosed ... as such for political, economic, social, cultural, racial or religious reasons. , for reasons of family conflict or any other reasons that are not irrelevant means of relating to the state of mental health.

Unreasonable intervention of a psychiatrist or his professional passivity, and self-elimination can become manifestations of abuse of psychiatry.

Refusal of active psychiatric intervention should be considered ethically justified only when the harm from it is obviously greater than the benefit. If psychiatric care is necessary for the patient and is able to bring him good, and the doctor, realizing this, deliberately does nothing, guided by unprofessional considerations, then such behavior belongs to the category of abuse of psychiatry and violation of the “do no harm” principle, which entails deliberate lies (including the number in medical records). Therefore, it is fair to believe that the abuse of psychiatry is the intentional infliction of moral, physical, or other harm to a person by applying to him medical measures that are not indicated and necessary, or by not using medical measures that are indicated and necessary, based on the state of his mental health.

The possibility of abuse is quite high in cases where a psychiatrist enters into domestic or financial relations with a patient or his relatives. Therefore, a psychiatrist is not entitled, when providing psychiatric assistance to a patient, to enter into property transactions with him, use his work for personal purposes, enter into an intimate relationship, take advantage of his position as a doctor, or the mental incompetence of the patient.

When conducting a forensic psychiatric examination of prisoners facing death sentence charges, psychiatrists face a difficult ethical dilemma, since their conclusion almost entirely determines whether a person's life will be saved or he will be executed. The deepest contradictions contained in the very phenomenon of the death penalty doom doctors who conscientiously fulfill their duty to the violation of the ethical principle "do no harm". A similar dilemma may arise for physicians in many other specialties when they must provide medical care to convicts so that the state of health of the latter is not an obstacle to the execution of a death sentence.

Ethical and legal regulation in the field of psychiatry.

It is important to emphasize that the content of the principles and many norms of modern ethics in psychiatry has international recognition. Documents such as "Set of Principles and Guarantees for the Protection of Mentally Ill Persons and Improvement of Mental Health Care", prepared in 1990 by one of the UN human rights commissions, as well as "Hawaiian Declaration", adopted in 1977 and revised in 1983 by the World Psychiatric Association (WPA), etc., define the minimum ethical standards in the work of each psychiatrist[1].

The first of the main ethical and legal principles for the protection of persons suffering from mental disorders, formulated in the above-mentioned UN document, states: "All persons suffering from a mental illness should be treated humanely and with respect for the dignity of the human person." The mentally ill are a particularly vulnerable social group. In the context of human rights ideology, people with mental disorders have something in common with volunteers on whom new drugs are being tested, with "test-tube babies", with donors and recipients in transplantation practices, and so on. - respect for their

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[1] Hawaii Declaration (Approved by the WPA General Assembly, Vein. Austria, July 10, 1983 http://www.psychepravo.ru/law/int/gavajskaya-deklaraciya.htm

personal dignity, protection of their civil rights requires special social (legal, professional and ethical, etc.) guarantees. Let's try to ask this question: what should be prohibited in a civilized society in relation to mentally ill people? In the most general form, the answer will be as follows: stigmatization (that is, the use of an offensive label in relation to this individual, such as “crazy”), social exclusion, unjustified restriction of rights, contempt or neglect, any other forms of humiliation of the human dignity of the mentally ill not only immoral but in many cases subject to legal assessments and sanctions.

"Geneva Declaration" of the WMA (1948)[1] instructs every doctor not to allow any discrimination against patients. Among all possible types of discrimination against certain groups of patients (due to gender, age, religion, ethnicity or nationality, etc.), it is necessary to single outpatient discrimination associated with the disease itself or incapacity, which is especially important in psychiatry. Manifestations of discrimination against the mentally ill in the provision of medical care to them can be predominantly moral and predominantly social. In the context of the stigmatization of the mentally ill that persists in modern society, the requirement of the strictest observance by doctors and medical staff of medical secrecy when providing psychiatric care (Article 45 of the Law of the Republic of Uzbekistan “On Protection of Public Health”) [2] is especially urgent. The application of the confidentiality norm in psychiatry has many peculiarities. The subjects of medical secrecy, that is, persons who are subject to the obligation not to disclose confidential information when providing medical care, are doctors, psychologists, nursing staff, orderlies, in general, all employees of psychiatric institutions (for example, ambulance drivers), as well as medical students who may become aware of medical confidentiality in the educational process. The protection of medical secrecy by law is an objective requirement that does not depend on whether the patient himself cares about the protection of information about his health.

3. Involuntary hospitalization of the mentally ill. The greatest moral and ethical tension in the provision of psychiatric care is characterized by situations where a psychiatrist makes a decision to apply medical measures on an involuntary basis. Up to the middle of the 20th century.

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[1] Decl-of-Geneva-v1948- https://www.wma.net/policies-post/wma-declaration-of-geneva/

[2] Law of the Republic of Uzbekistan On protecting the health of citizens. National database of legislation, 1996-2019 https://www.lex.uz/acts/41329

involuntary hospitalization of the vast majority of the mentally ill was considered a generally accepted social norm. As English psychiatrist T. Models wrote in the 20th century: “Those who are obsessed with general voice of society are excluded from the environment of mankind.”

A modern approach to the involuntary treatment of mentally ill was outlined in 1954 when the WHO committee of experts on mental health determined hospitalization of socially dangerous persons with mental disorders through the courts as humiliating for them and their relatives. The fact is that the legislation that existed then in many countries, regulating involuntary treatment, copied the model of criminal proceedings.

In 1959, England passed a law on mental health, which, in fact, fully introduced the modern principle of voluntary provision of psychiatric care, including the abolition of legal procedures before the hospitalization of mentally ill. According to this law, the principle of hospitalization in psychiatry should be the same as in other areas of medicine. Involuntary hospitalization is just a "special case" in medicine. By 1987, in most European countries, as well as in the United States and Canada, more than 90% of the placements in psychiatric hospitals were carried out on a voluntary basis.

Obtaining the consent of the patients in each case of prescribed psychiatric treatment is a cornerstone of the entire modern system of care for people suffering from mental disorders. Already the legal side of obtaining informed consent for psychiatric treatment distinguishes this discipline from a number of other clinical disciplines. First, in psychiatry, the patient's consent to treatment must be in writing. Secondly, the basic ethical requirements for obtaining consent for the treatment of a patient in psychiatry were enshrined in the law "On Psychiatric Care", adopted in August 2000.[1] In this law, the rights and legitimate interests of citizens of the republic in providing them with psychiatric care are protected by special rules and procedures. The main meaning of the Law of the Republic of Uzbekistan "On Psychiatric Care" is a desire to make psychiatric care as humane and democratic as possible, to bring it closer, and even equalize it legally with other types of medical care. The law is aimed at solving four main tasks:

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[1] Law of the Republic of Uzbekistan On Psychiatric Care. T.2000 https://lex.uz/mobileact/14460

1. protection of the rights and legitimate interests of citizens in the provision of psychiatric care from unreasonable interference in their lives;

2. protection of persons with mental disorders from unjustified discrimination in society on the basis of a psychiatric diagnosis, as well as the facts of applying for psychiatric help;

3. protection of society from possible dangerous actions of persons with mental disorders;

4. protecting doctors, medical personnel, and other professionals involved in the provision of psychiatric care, providing them with benefits as employees operating in especially dangerous, difficult working conditions, as well as ensuring the independence of a psychiatrist when making decisions related to the provision of psychiatric care, from the possible influence of third parties, including representatives of the administration and management bodies.

Thus, Article 4 of the Law states that psychiatric assistance to persons suffering from mental disorders is guaranteed by the state and is carried out on the basis of the principles of legality, mercy, humanity, and respect for the rights and freedoms of man and citizen. The humanity of mental health care means that it is provided for the benefit of a person suffering from a mental disorder in order to treat and alleviate his suffering.

Article 5 of the Law determines the guaranteed volume of psychiatric care and social protection at the expense of the state budget.

The protection of the rights of the mentally ill is also reflected in Article 6 of the Law, which states that “Psychiatric care is provided upon the voluntary application of a person or with his consent, with the exception of cases provided for by this law. A minor under the age of fourteen, as well as a person recognized incapable in accordance with the procedure established by law, is provided with psychiatric assistance at the request or with the consent of their legal representatives in the manner prescribed by this Law. It should be noted that it is not so much the specificity of mental illnesses as the stigmatization of mentally ill people that creates such a framework in which the voluntariness of applying for psychiatric essay help needs legislative consolidation.

Despite the fact that in the practice of a psychiatrist, the element of a paternalistic attitude towards patients is much more pronounced than in other clinicians, obtaining the patient's voluntary consent to treatment should never be accompanied by deceit, threat, or, even more so, violence. In order for the patient's consent to the proposed treatment to also meet the criterion of awareness, the psychiatrist must sometimes resolve the most diverse moral and ethical conflicts. Given some of these conflicts, experts recommend that when informing patients about the nature of their mental disorders, they must take into account the psychotherapeutic moment.

A special issue is communication to the patient of information about the diagnosis. The law does not oblige the psychiatrist, when obtaining consent to treatment, to inform the patient of his diagnosis without fail. If the diagnosis does not cause categorical rejection or pronounced negative emotions in the patient, then the doctor may well discuss this issue with the patient. Discussing another very important issue for the patient - the duration of treatment, the doctor must be truthful with him, avoiding excessive categoricalness.

The principle of voluntariness in the provision of medical care includes patient's right to refuse medical intervention.

Restriction of the right of the patient or his legal representatives to refuse treatment is allowed only in strictly and clearly specified cases. Giving to mentally ill the legally guaranteed right to refuse treatment creates new moral and ethical dilemmas. There are discussions in the literature about the "specific limitation" of the legal capacity of persons suffering from mental disorders when the patient can be recognized as retaining other civil rights, but at the same time - having lost the "right to refuse treatment".

The Law of the Republic of Uzbekistan "On Psychiatric Care" defines necessary and sufficient conditions that allow the hospitalization of certain categories of persons suffering from mental disorders without their voluntary consent. First, we are talking about psychopathological conditions, which the law defines as “severe mental disorders”. Secondly, there are cases when the examination and treatment of a patient are possible only in a hospital (that is, outpatient treatment is excluded). Thirdly, the patient's condition must have at least one of the following three characteristics: a) the patient poses an immediate danger to himself and/or others; b) the patient is helpless, that is, unable to independently satisfy the basic needs of life; c) the mental state of the patient is such that leaving him without psychiatric care will cause significant harm to his health.

In a strict sense, the concept of "involuntary psychiatric measures" should be distinguished from the concept of "coercive measures of a medical nature" ("compulsory psychiatric treatment"). The latter concept also reflects the use of treatment without the consent (against the consent) of the patient. However, we are talking about the mentally ill who have committed socially dangerous acts. According to the definition of the Council of Europe, admission and retention for treatment of a person suffering from a mental disorder in a hospital or other medical institution, not at his request, is involuntary psychiatric hospitalization. The concept of involuntary hospitalization and other involuntary psychiatric measures should be distinguished from the concept of compulsory medical measures. Compulsory measures of a medical nature are usually carried out in relation to persons who have committed socially dangerous acts, but in the case of involuntary measures, this condition is not necessary. In other words, coercive measures are applied to those persons who would have been convicted in a criminal case if they had not been declared insane, and involuntary hospitalization is most often carried out in relation to persons who have not committed illegal acts.

The introduction into medical practice of the results of fundamental research in the field of genetics and molecular biology has exacerbated discussions about the permissible limits of intervention in the vital processes of the human body. Psychiatry is the area of medicine in which ethical issues were articulated at a different level - the socio-psychological one. This level marked at its extreme points the most acute moral problems associated with the observance and protection of fundamental human rights. The history of human rights in their modern sense is usually counted from the Great French Revolution, after which the “Declaration of the Rights of Man and Citizen of 1789” was adopted. Therefore, it seems no coincidence that the emergence and development of the humanistic approach in psychiatry are associated with the names of French doctors, primarily with the name of Philippe Pinel (1745-1826), who in 1792 freed patients from chains in the Bicêtre hospital. A follower of F. Pinel, psychiatrist Jean-Etienne-Dominique Esquirol (1772-1840) was the creator of the first law on the mentally ill, known as the "Law of June 30, 1838". It reflects various medical, legal, and administrative issues relating to a) the protection of society from wrong actions on the part of the mentally ill; b) the provision of mentally ill medical care in specially trained institutions; c) protecting the rights of the mentally ill. In 1977, almost two hundred years after the Pinel reform, the General Assembly of the World Psychiatric Association (WPA) adopted the Declaration of Hawaii (its text was revised in 1983), which became one of the main international documents of medical ethics in psychiatry. The preamble to the Declaration of Hawaii states: “From time immemorial, the ethical principles of culture have been an integral part of medicine. And in modern society, more than ever, due to the particularly delicate relationship between the doctor and the patient, it became necessary to establish high ethical standards for all those involved in psychiatry, so that there was no possibility of abuse of it, its concepts, knowledge, methodology in order to commit actions contrary to the laws. humanity. Like every physician, as every member of society, the psychiatrist must regard the ethical norms specific to psychiatry as a reflection of the general ethical requirements applicable to physicians in general and the social responsibilities of each individual. Deep conscience and personal responsibility are the essences of ethical behavior.”

In the above text, attention is drawn to the desire of psychiatrists to establish high ethical standards. At the same time, the ethical status of a psychiatrist is formed at two levels - general (ethical requirements relating to doctors in general) and special (ethical norms specific to psychiatry).

The specificity of bioethical problems in psychiatry is due to the peculiarities of this field of medicine. These features are comprehensively analyzed in the study by V.A. Tikhonenko, A.Ya. Ivanyushkina, V.Ya. Evtushenko, and F.V. Kondratiev (1997). The authors note: firstly, psychiatry deals with a socially functioning personality, the concept of the pathology of which includes its deformed social relations, and the number of pathogenic factors including complex social situations that are perceived and comprehended by this personality; secondly, the diagnosis of a mental disorder carries such a negative social and ethical burden of the Republic of Uzbekistan, which no other clinical term of any other medical specialty has. Persons recognized as mentally ill, no matter how humanely society treats them, fall into a special category of people who are completely deprived of social trust and therefore morally infringed upon and experience various social restrictions. However, the size and nature of the social restrictions to which patients are subjected must correspond to the severity of their mental disorders; thirdly, an essential feature that distinguishes psychiatry from other medical disciplines is the application of involuntary measures to certain categories of patients - coercion and even violence. The psychiatrist may, under certain conditions, not voluntarily, i.e. without the consent of the patient or against his will, conduct an examination, establish mandatory dispensary observation, place him in a psychiatric hospital and keep the patient in isolation, use psychotropic drugs and other methods of treatment that affect the psyche; fourthly, psychiatrists work with patients who make up a heterogeneous population in terms of their ability to express their will. It is represented both by patients who, due to severe mental disorders, cannot not only protect themselves, but also express their interests, and by patients who, in terms of their personal autonomy, personal responsibility, intellectual development, and legal and moral consciousness, correspond to a psychiatrist. despite the presence of borderline mental disorders. Intermediate between these extremes, the "zone" is a set of mixed, transitional options; fifthly, a feature of psychiatry as an object of ethical regulation is its dual function of protecting the interests of the patient and the interests of society. The general moral basis from which any medical, including psychiatric, practice proceeds is the positive value of human health and life. It is assumed that the preservation and promotion of mental health are in the interests of each individual and society as a whole. Psychiatric ethics seeks to achieve a balance between the interests of the patient and society based on the values of health, life, safety, and well-being of citizens.

A humanitarian model of psychiatry, without denying or belittling the medical aspect, organically includes morality and law through the subjective attitude towards the patient. This opens up the possibility of a genuine integration of legal, ethical, and medical norms within the framework of legislation.

All models of doctor-psychiatrist relationship and tpatient have the right to exist in psychiatric practice. The task of psychiatric ethics is to establish the optimal relationship between the doctor and the patient, contributing to the realization of the interests of the patient, taking into account the specific clinical situation.

President of the World Psychiatric Association M. Maj (2008), noting that antipsychiatry is still a reality in some countries, emphasizes the uniqueness of psychiatry, which can create "its own antibodies".

Indeed, recognized leaders of antipsychiatric movement D. Cooper, R. Laing, F. Basaglia, and T. Sas are psychiatrists. This movement also includes M. Foucault, who was not a psychiatrist. The formation and development of antipsychiatry are comprehensively and fully disclosed in the studies of O.A. Vlasova (2006), who notes that the term "antipsychiatry" has a number of meanings at present. So, it can be understood as the school of psychiatry (led by R.D. Laing), which proposed an alternative concept of the origin and development of mental illness; a radical trend in psychiatry in the 1960s. (headed by D. Cooper); the countercultural movement of the 1960s; the totality of any theories and concepts that oppose "official" psychiatry; a radical political movement defending the rights of mentally ill people, etc.

D. Cooper, who is considered to be a radical wing of antipsychiatry, proposed the term "antipsychiatry" in 1967. He believed that insanity is always revolutionary, and undermines the foundations and power structures of bourgeois society. D. Cooper called for the study of mental illness within the framework of the human sciences, using dialectical rationality, in which the distinction between external and internal disappears and mental illness is presented not as a violation of the behavior or a flaw in the character of a particular individual, but as a consequence of the interaction between people.

R. Laing describes being mentally ill using the language of the humanities. To more visually describe what happens in schizophrenia, Laing uses the terms "out of order" and "of course". He compares society to the formation of aircraft, which can be traced from an observation point on the ground. An aircraft may be "out of order", and then it may be declared insane or crazy. But the plane can also "go off course", just like all planes. Or it may happen that an aircraft that is moving "out of formation" is, nevertheless, "on course". Laing emphasizes that the criterion of "out of order" is a clinical positivist criterion, while the criterion of "off course" is an ontological criterion.

F. Basaglia made a revolution in psychiatry, which D. Cooper spoke about. In 1968, he advocated the elimination of the state system of psychiatric care and against the forced treatment of patients. He founded the movement "Democratic Psychiatry", the result of which is the law adopted in Italy in 1978 to abolish psychiatric hospitals.

T. Szas expounds his anti-psychiatric views in the books "Factory of Madness", and "The Myth of Mental Illness". So, in the Madness Factory, T. Szasz writes: “Those who, like me, believe that the doctor should be the protector of the individual, even when the individual comes into conflict with society, are particularly dismayed by the generally accepted medical practice of painting birds and the fact that that among the paints used, the most fashionable is a psychiatric diagnosis. In the book “The Myth of Mental Illness”, T. Szas summarized his main theses, which he outlined in the “Manifesto”. In the first paragraph of this “Manifesto”, in particular, it is said that “mental illness is a metaphor (metaphorical illness). The word "disease" means a detectable biological process that affects the bodies of living organisms (plants, animals, people). The term "mental illness" refers to unwanted thoughts, feelings, and behaviors of people. To classify thoughts, feelings, and behaviors as illnesses is a logical and semantic error, just like classifying a whale as a fish."

M. Foucault in books "Mental Illness and personality", "History of Madness in the classical era", "Abnormal", and "Psychiatric Power" considered various aspects of psychiatry. Z. Sokuler (1997) notes that M. Foucault introduced the term "power knowledge". This is such knowledge that directly serves the goals and objectives of power and its inherent aspect of seeing its objects. If it is true that any knowledge itself shapes its object, so does power. It studies people subordinate to it not as things in themselves, but as them in certain disciplinary institutions.

In the book "The History of Madness in the Classical Era", M. Foucault points to a key date - 1656, when the decree on the founding of the General Hospital in Paris was signed. In its functioning and even in its design, according to the author, the General Hospital has nothing to do with medicine. This is one of the instances of order, of that monarchical bourgeois order that was taking shape in France precisely during this period. A whole motley tribe - venereal not sick, depraved, spendthrifts, homosexuals, blasphemers, alchemists, libertines - in the second half of the 17th century. suddenly found themselves outside the mind, within the walls of shelters, which after one or two centuries will turn into a closed field of madness. Starting from the 17th century. an unreasonable person is a specific person, an individual, withdrawn from the world of social reality, and it is the society, of which he is a particle, that judges him and sentences him. This is the most important thing: the fact that madness has suddenly been transferred to the social sphere and will henceforth manifest itself predominantly and almost exclusively here.

The above basic provisions of antipsychiatry require a critical assessment.

First, the shift of the vector of psychiatry from the field of natural sciences to the field of the humanities can lead to a methodological dead end. It seems that at the present level of development of science, methodological monism is more promising, the essence of which is to overcome the split between the natural sciences and the humanities. V.G. Borzenkov (2010) notes that “the very course of the development of science in the 20th century prepared that decisive breakthrough to overcome the split between the two cultures – natural science and the humanities – which emerged in the very last decade of this century. Before our eyes, a new type of science is being born (or, in any case, a new type of scientific activity, successfully symbolized by the metaphor "bridge to the future" and in need of its precise logical and logical-methodological explication. ” This type of scientific activity was originally inherent in bioethics. Here it is appropriate to recall that the seminal work of VR Potter was called Bioethics: A Bridge to the Future.

With regard to psychiatry, it should be pointed out that the most fruitful ideas and impressive practical results can be achieved on the path of convergence between medicine and philosophy, and not on antipsychiatric barricades. This is confirmed by the life and professional activities of R. Assagioli, L. Binswanger, M. Boss, J. Lacan, W. Reich, Z. Freud, K.G. Jung, and K. Jaspers. Positive examples of such a constructive approach can be found in the works of M.E. Burno (2010), O.A. Vlasova (2010), V. Leybin (2009), and V.P. Rudneva (2010).

Secondly, at present, compulsory treatment of the mentally ill has a strict legal and ethical justification.

At the 75th Plenary meeting of the UN General Assembly on December 17, 1991, the Principles for the Protection of Mentally Ill Persons and the Improvement of Mental Health Care were adopted (resolution 46/119). In this international legal act, principle 16 "Involuntary hospitalization" is formulated, in accordance with paragraph. "a" of paragraph 1 of which any person may be hospitalized in a psychiatric institution as a patient involuntarily only when a qualified specialist in psychiatry authorized for this purpose by law establishes that this person suffers from a mental illness and determines: "that, as a consequence of this mental illness, there is a serious risk of imminent or imminent harm to that person or others."

In clause 5. Hawaiian Declaration, approved by the General Assembly of the World Psychiatric Association in 1977, noted that none of the examination procedures and none of the treatment methods should be used against the will of the patient, except in cases where the patient loses the ability to express his own desire, or because of mental illness, cannot determine what is best for his own interests, or, for the same reason, is dangerous for others. In these cases, compulsory treatment can or should be carried out primarily in the interests of the patient within a reasonable period of time, if there is appropriate consent to this, preferably from someone close to the patient.

Thirdly, establishing a diagnosis of a mental illness is not an arbitrary discretion of a psychiatrist, but a serious procedure that has a serious legal and ethical basis.

At the 75th Plenary meeting of the UN General Assembly on December 17, 1991, the Principles for the Protection of Mentally Ill Persons and the Improvement of Mental Health Care were adopted (resolution 46/119). This international legal act formulates principle 4 "Diagnosis of mental illness", which, in particular, notes that the diagnosis that a person suffers from a mental illness is made in accordance with internationally recognized medical standards (paragraph 1). A diagnosis of mental illness is never made on the basis of political, economic, or social status, or membership of any cultural, racial, or religious group, or for any other reason not directly related to mental health (item 2). The ideologists of antipsychiatry called the movement they initiated the "third revolution in psychiatry", considering the first movement against the "witch trials" in the 16th-17th centuries, and the second the "Pinel reform". Antihospital and antipsychiatric This movement foreshadowed a truly radical change in psychiatry in the 1970s and 1980s when the social context of mental health care became largely determined by the idea of protecting the civil rights of people with mental disorders. In Uzbekistan, these positive changes were reflected, first of all, in the adoption in August 2000. at the third session of the Oliy Majlis of the Republic of Uzbekistan, the Law "On

Psychiatric Care”, in which the rights and legitimate interests of citizens of the republic in the provision of psychiatric care to them, are protected by special rules and procedures. The main meaning of the Law of the Republic of Uzbekistan "On Psychiatric Care" is the desire to make psychiatric care as humane and democratic as possible, to bring it closer, and even equalize it legally with other types of medical care.

Fourthly, the problem of stigmatization of patients with mental illness is complex and, in this regard, it is a big mistake to consider it only on the scale of “power-subordination” in isolation from the social, cultural, and individual psychological context.

The mental health of the population of Uzbekistan is one of the priorities of the Ministry of Health of the Republic of Uzbekistan.

The problems of the mental health of the population go far beyond medical problems, being more of a social and economic problem that needs to be addressed, taking into account various factors and living conditions of the population of Uzbekistan. Creating a humane, patient-centered mental health organization requires improvements in professional training, changes in professional attitudes and values, and structural changes in the health care system.

The European Declaration on Mental Health signed in Helsinki (2005)[1] can be considered a positive development in this direction. This was the first stage of the "Biennial cooperation agreement between the Ministry of Health of the Republic of Uzbekistan and WHO". The signing of the declaration obliges to monitor of the commitments made by the Ministry of Health of the Republic of Uzbekistan to ensure the implementation and compliance with mental health legislation.

The next step in this direction is the implementation of the National Mental Health Program developed and approved by the Ministry of Health of the Republic of Uzbekistan, where, of course, the principles of bioethics concerning the mentally ill must be observed.

Questions for self-examination

1. List the main forms of psychotherapy?
2. What impact did the anti-psychiatric movement have on the development of psychiatry?

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[1] European Declaration on Mental Health Problems and solutions. Helsinki, Finland, January 12–15, 2005. https://www.euro.who.int/__data/assets/pdf_file/0011/88598/E85445R.pdf

3. How did the features of historical eras manifest themselves in the ethics of psychiatry (the status of the mentally ill)?

4. List the main provisions of the Code of Professional Ethics for a Psychiatrist

5. What principles and rules of bioethics are applied in psychiatry?

6. What regulations are designed to prevent possible cases of abuse and violations in psychiatry?

Bibliography

1. Sokolov M.P., Sumarokov L.A. Problems of Bioethics in Psychiatry https://studfiles.net/preview/2248214/

2. Tikhonenko V.A., Shishkov S.N., Ivanyushkin A.Ya., Pokulenko. Legal and ethical problems of psychiatry // Bioethics: problems and prospects / Ed. editor: S.M. Malkov, A.P. Ogurtsov; RAN. Institute of Philosophy. - M.: IFRAN, 1992. - pp.78-90.

3. Mental health: new understanding, new hope. World Health Report, 2001https://www.who.int/publications/list/whr01/ru/

4. WHO, The Mental Health Context, A set of guidelines for mental health policy and service delivery / Geneva, 2003

5. Declaration of Hawaii (Endorsed by the WPA General Assembly,Vein. Austria, July 10, 1983 http://www.psychepravo.ru / law/int/gavajskaya-deklaraciya.htm

6. Decl-of-Geneva-v1948- https://www.wma.net/policies-post/wma-declaration-of-geneva/

7. Law of the Republic of Uzbekistan On the protection of the health of citizens. National Legislation Database, 1996-2019 https://www.lex.uz/acts/41329

8. A. Ya. Ivanyushkin. Bioethics and psychiatry
/Questions of Philosophy, 1994 №3/

9. Law of the Republic of Uzbekistan On Psychiatric Care.
№ 123-II 08/31/2000
https://www.lex.uz/docs/14460

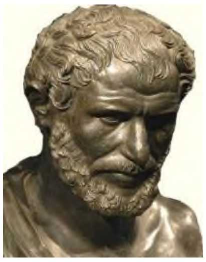
10. Vlasova O.A. Antipsychiatry: formation and development. Moscow: Publishing house of RSSU "Soyuz", 2006. - 221 p.; Antipsychiatry: social theory and social practice Nat. research University "Higher School of Economics". — M.: Ed. house of the Higher School of Economics, 2014. - p.432

11. Borzenkov V.G. Unity of science and the problem of reduction. Vestnik Mosc. Philosophy .2010 4. Borzenkov V.G. The unity of science and the problem of reduction. Vestnik Mosc.7. Philosophy .2010 №4.

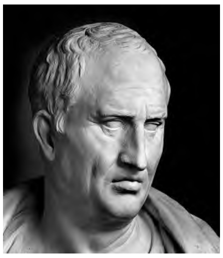
12. Principles for the protection of mentally ill persons and the improvement of mental health care Adopted by General Assembly resolution 46/119 of 17 December 1991 https://www.un.org/ru / documents/decl_conv/conventions/mental_helth_care.shtml

13. European Declaration on Mental Health Problems and ways to solve them. Helsinki, Finland, January 12–15, 2005 https://www.euro.who.int/__data/assets/pdf_file/0011/88598/E85445R.pdf

CHAPTER X. MORAL ISSUES IN TRANSPLANTATION



"Many who do shameful deeds speak beautiful words."
Democritus



"It is not enough to have wisdom,you have to know how to use it."
Cicero

Key words: *donor, organ transplant, "presumption of consent", "presumption of disagreement".*

Transplantation is certainly one of the most promising areas of medical science and practice: it accumulates the latest achievements of modern surgery, resuscitation, anesthesiology, immunology, pharmacology, and other biomedical sciences and relies on a whole set of high medical technologies.

Until the early 1960s, transplantation remained, in fact, an area of experimental surgery, without attracting much attention from the public. While transplant surgeries were counted in units and were experimental, they aroused surprise and even approval. The turning point came in 1967 when the South African surgeon Christian Bernard performed the world's first heart transplant from a person who died in a car accident to a patient who was on the verge of death. A heart transplant from one person to another caused a huge public outcry. Heart transplantation, is like no other achievement of modern culture, but before this culture a whole block of philosophical and anthropological problems: What is a person? What defines personality? What is human self-identity?

The successes of transplantology have shown that a new, extremely promising opportunity has opened up for mankind to treat patients who were previously considered doomed. At the same time, a whole range of legal and ethical problems arose, the solution of which requires the joint efforts of specialists in the field of medicine, law, ethics, theology, psychology, and other disciplines. Moreover, these problems cannot be considered solved if the approaches and recommendations developed by specialists do not receive public recognition.

Legal and Ethical Criteria for Acceptance of Organs from Living Donors

The ethical issues of transplantation differ significantly depending on whether it is a question of organ harvesting for transplantation from a living person or a corpse[1].

Kidney transplantation from living donors was the first direction of transplantology in practical medicine. Currently, this is a rapidly developing worldwide direction of providing medical care to patients with irreversible disorders of the kidneys. Kidney transplantation not only saved hundreds of thousands of patients from death but also provided them with a high quality of life. In addition to the kidney, a lobe of the liver and bone marrow is transplanted from living donors, which in many cases will also save the life of the patient. However, this raises several difficult moral problems. Is it moral to prolong life for some time at the cost of deteriorating health, conscious trauma, and shortening the life of a person?

Oro donor? The humane goal of prolonging and saving the life of the recipient may lose the status of humanity if harm to the life and health of the donor becomes a means of achieving it.

An organ transplant from a living donor carries a high risk for the latter. Taking an organ or part of it from a donor is a deviation from one of the fundamental ethical principles of medicine – “do not harm”. A

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[1] Mukhamedova Z.M. Ethical problems of biomedical cultural research in the field of organ and/or tissue transplantation. Materials of the First National Congress on Bioethics in Uzbekistan. T. USAID. 2005, pp.39-41.

surgeon who takes an organ or tissue from a donor quite deliberately injures him and puts his life and health at significant risk. This is the risk associated with the surgical operation itself, which is always a significant injury for any patient. Numerous cases of severe complications (and even deaths) during and after the removal of a kidney from a donor have been described. Having lost one of the paired organs or part of an unpaired organ, the donor becomes more vulnerable to the effects of adverse external factors, which can lead to the development of various pathologies.

To minimize damage to the donor's health, for example, Russian legislation guarantees his free, including medication, treatment in a healthcare facility in connection with the operation. However, it must be noted with regret that the scope of providing free services in health care is rapidly shrinking. After discharge from the hospital where the organ was harvested, the donor may be left alone with their problems, directly or indirectly caused by the mutilation operation to remove the organ. It arises, as we see the conflict between the two fundamental principles of medicine: “do no harm” and “do good”. To "mitigate" this problem, it is probably necessary to provide for the protection of the interests of the donor through health insurance.

The circumstance that ethically justifies the violation of the “no harm” principle is the right of a potential donor out of compassion, love, for one’s neighbor and altruism to donate one of the organs or part of an organ to save the patient’s life. However, not every sacrifice can be made. The law prohibits organ transplantation if it is known a priori that the result may be an irreversible deterioration in the health of the donor. Parents who love their children do not have the right to sacrifice their lives by giving them an unpaired vital organ. The administration of several surgical centers where heart transplantation is performed has repeatedly received proposals of this kind from the parents of sick children.

For a mentally and morally healthy person, helping one's neighbor is not only a right but also a moral duty. However, if the child's life is in danger, and the father, for example, refuses to act as a bone marrow donor, then the law does not oblige him to fulfill his moral duty and does not give third parties the right to coerce in this regard. All that remains is a moral condemnation of selfishness, but this does not make it any easier for a child in need of a transplant.

From an ethical point of view, the donation should be a voluntary, consciously committed, and disinterested (altruistic) sacrifice. Voluntariness is possible in the absence of coercion to donate, based on tribal, administrative, and financial dependence (directly or through third parties). Altruism involves the exclusion of a commercial transaction, that is, a sale, in the relationship between the donor and the recipient. Awareness of the victim should be based on the completeness of the information provided by the doctor about the possible risk concerning the health and social well-being (working capacity) of the potential donor, as well as the chances of success for the intended recipient. In this regard, disabled citizens who, due to their age or intellectual abilities, are not able to consciously make a decision, cannot act as donors. Society cannot recognize the right of a child or a patient with a severe mental disorder to make a sacrifice in favor of a loved one.

Currently, all countries of the world have adopted the practice of transplanting organs and tissues from a living donor only to persons who are closely related to him, designed to ensure the principles of voluntariness and altruism. True, the possibility of allowing such transplants not to relatives is being discussed, but under the supervision of authorized independent bodies (ethical committees). However, it should be noted that allowing such forms of donation carries a serious threat to its commercialization, even extortion of organs and tissues, a danger that will be very, very difficult to cope with.

When transplanting organs to close relatives, the rule of voluntary, informed consent is of particular importance. In Russian medicine, instead of informed consent, they usually use a somewhat similar, but essentially different procedure - obtaining written permission from the donor. This document does not contain detailed information about the risk of adverse consequences, both medical and social (for example, the possibility of limiting performance or even disability), as well as the likelihood of a favorable outcome for this particular recipient.

The doctor can manipulate information to incline to donation due to financial interest, his scientific interests related to the testing of new surgical techniques, or medications. In such cases, physicians can provide information to a potential donor only with silence, for example, about unsuccessful transplants that ended in death or disability, low chances of success for the recipient, and the availability of alternative methods of treatment.

Another problem that may arise in obtaining consent to donate is the difficulty in establishing whether it is voluntary.

In Russian healthcare, medical information about patients is traditionally transferred to family members, so there is a possibility of overt pressure from family members on a potential donor and even coercion. Such coercion may have the character of an indirect, veiled psychological or moral impact. In this regard, it can be considered justified the practice of those transplant centers in which any medical information about a potential donor (or recipient) is transferred even to relatives only with his direct consent. In other words, the rule of confidentiality is enforced.

Another group of complex moral problems arises in connection with the ban on the sale of organs for transplantation. The trend towards commercialization has its objective reasons. First, it is due to the situation of a chronic shortage of donor organs. This forces patients to search for extraordinary sources of obtaining organs for transplantation. Secondly, the impoverishment of a significant part of the population can push people to seek income even by selling their organs. Such facts can be cited: in Kazakhstan (in Shymkent) there was a criminal gang organized by foreigners. Citizens of Uzbekistan, Kyrgyzstan, and Ukraine were involved as organ donors, who, due to financial problems, sold their kidneys. These organs were transplanted to wealthy citizens of other countries, mainly Israel[1].

Thirdly, the crisis of budgetary funding and the weakness of funding through compulsory health insurance encourage medical institutions to fight for survival by commercializing their activities.

What is the moral evil of organ trafficking? First of all, it consists of the fact that the human body turns into a commodity thing, equated through the mechanism of sale and purchase with other things. This destroys his special social status. Through the bodily integrity of a person, one way or another, in a variety of different forms, his potentialities and aspirations are realized. Therefore, manipulations with the body are nothing more than forms of influence on the personality. The transformation of the body into a thing and a product depersonalizes a person and causes moral damage to him.

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[1] What problems in transplantology were revealed by the doctor’s case of illegal organ transplantation? https://informburo.kz/stati/kakie-problemy - v - transplantologii-vskrylo-delo-vracha - o - nezakonnoy-peresadke-organov.html

Permitting organ trafficking will exacerbate social injustice - the rich will survive at the expense of the poor. This newest form of exploitation of man by man is capable of destabilizing social life to no small degree. It should be noted that in fact, the commercialization of the human body has already begun since it is possible to sell and buy blood, sperm, and eggs. Therefore, from the point of view of supporters of market mechanisms in the procurement of organs for transplantation, the only question is to put the real emerging market for human organs from living donors (and from corpses) on a solid legal basis.

It should be taken into account that a simple ban on commercialization in the presence of objective interests and weak legal control creates conditions for the formation of a shadow market for these services. The latter may hurt the entire public life, as the social space in which power belongs to criminal structures will expand. This is bad for donors and recipients, as they are deprived of legal mechanisms to protect their interests in case of non-compliance with the terms of the transaction (poor quality of the “goods”, poor medical care, late or incomplete payment of remuneration, etc.). This will also hurt doctors, as it will lead to the criminalization of part of the medical community, which will cast a shadow on the profession as a whole.

To avoid such negative consequences, society should either go in the direction of legalizing the trade of organs from living donors (which is hardly acceptable) or develop a set of measures capable of:

1) effectively control the prohibition of commercialization;

2) ease the pressure of objective factors by improving the financing of transplantation programs, creating a national system for the procurement and distribution of cadaveric organs for transplantation;

3) to strengthen measures of social protection of the population.

As a "third" way, some authors propose replacing the mechanism of selling an organ with a mechanism of material compensation for the donation. in the organ. The operation of such a model can be represented as follows. Financially and administratively independent of transplant centers, a medical organization engaged in the procurement and distribution of organs for transplantation (which are considered in this case as public property), compensates the donor for the damage caused in the form of a cash payment, the provision of medical insurance in case of treatment of complications, and also other social benefits. In its organization, this system may resemble the system of blood procurement and transfusion in force in the USSR.

The authors of the compensation model are trying to mitigate some morally negative aspects of direct commercialization, take into account the objectively emerging motivations for donation and provide certain quality assurances for both donors and recipients. But it should be borne in mind that any non-profit bureaucratic organization has its morally weak sides. In particular, it is predisposed to the usual corruption among state structures that distribute public resources.

In connection with the increasing commercialization of transplantology, the World Medical Assembly has adopted several declarations on the ethical issues of transplantation. In particular, in October 1985, the 37th World Medical Assembly (Brussels, Belgium) adopted the “Statement on the Trade in Living Organs”. It says:

“Having considered the evidence of the recent flourishing of living donor kidneys from underdeveloped countries for transplants in Europe and the United States, the World Medical Association (WMA) condemns the buying and selling of human organs for transplantation.

The WMA calls on governments of all countries to take effective measures to prevent the use of human organs for commercial purposes.”

In 1987, the 40th World Health Assembly, concerned about the commercial trade in human organs, launched an initiative to prepare the first WHO Guidelines on Transplantation, which were approved by the Assembly in 1991 in resolution WHA44.25. These Guidelines have had a major impact on the profession's code of conduct and practice, as well as legislation around the world, for nearly two decades. Following a consultation process that took several years, the World Health Assembly adopted resolution WHA63.22 on 21 May 2010, by which it approved an updated version of the WHO Guidelines and identified directions for progress to optimize donor and transplant practices.

Because of the urgent nature of the problems caused by growing transplant tourism and illegal trafficking of donor organs against the background of their global shortage, from April 30 to May 2, 2008, a representative forum (Istanbul Summit) was held in Istanbul, bringing together more than 150 representatives of government and medical organizations, public figures, philosophers and sociologists, scientific and medical communities around the world. The Istanbul Declaration expresses the common point of view of experts in the field of donation and transplantation, as well as their colleagues in related fields, that transplantation should be as accessible as possible to all those in need around the world without resorting to the practice of exploiting the poor and powerless people that is contrary to ethics. The purpose of the Declaration is to be an ethical guide for professionals and officials who follow these principles. Thus, the Declaration complements the efforts of professional societies, national health authorities, and intergovernmental organizations such as the World Health Organization, the United Nations, and the Council of Europe to support the development of ethical programs in the field of organ donation and transplantation, as well as to prevent organ trafficking and transplant tourism... These efforts have contributed to the significant progress made in countries around the world since 2008. In 2010, TTS and ISN established the Istanbul Declaration Trust Group (DICG) to promote the Declaration and respond to new challenges in organ trafficking and transplant tourism. Between February and May 2018, DICG held a wide range of consultations with all stakeholders to update the Declaration in connection with clinical, legal, and social changes in this area. The results of this work were presented, reviewed, and presented in the form of a new edition in Madrid in July 2018 at the TTS International Congress.

High-tech operations are carried out only in countries with developed medicine, such as the USA, Germany, Norway, Switzerland, and India. Today, medicine in Uzbekistan seeks to take its place among these states. Previously, patients were forced to go for such operations to foreign countries (medical tourism), spending fabulous money on this. But not everyone had this opportunity. Moreover, the other hand Ony, after surgery abroad, patients experienced severe consequences. Because such patients must be under the constant supervision of doctors, they will be required to undergo a medical examination, to comply with certain conditions in everyday life. It is to prevent such problems that a transplant service is being established in our republic. Let us turn to history: in Uzbekistan, the Tashkent Kidney Transplant Center was organized in 1972. The Center was established on the initiative of Academician U. A. Aripov, a pioneer in clinical transplantology, who performed the first kidney transplant in Uzbekistan in 1972. The Kidney Transplantation Center has gone through the entire development path, which is typical for transplantation in general. 1970 - 1973 - years of the formation of the Center. At that time, a nephrological service was created with hemodialysis and an appropriate diagnostic base, primarily immunological. A donation service was organized to remove a kidney from a corpse. At the same time, the technology of kidney transplantation began to be actively mastered with 6-8 operations per year. In the next decade (1973-1983) the scope of the Center's work expanded. The technical re-equipment of the dialysis laboratory was carried out with the performance of 3 - 3.5 thousand hemodialysis procedures during the year. The number of kidney transplants has grown to 20-25 per year. A three-component immunosuppression regimen has been introduced. Transplant survival has improved significantly. In 1994, in connection with the adoption of the law "Criminal Code of the Republic of Uzbekistan", which allowed the removal of organs from a corpse only with the permission of relatives or the consent of the deceased during his lifetime, kidney transplantation in Uzbekistan was stopped. In 2002, the Ministry of Health of the Republic of Uzbekistan issued an order authorizing a kidney transplant from a living-related donor. At the end of 2006, the Ministry of Health withdrew this order. Since 2007, kidney transplant operations have not been performed at the Center. In 2010, kidney transplant operations resumed. Until 2007, 358 kidney transplants were performed at the center. In 311 cases, cadaveric kidney transplantation was performed, and 47 patients underwent kidney transplantation from a living-related donor. The Academician Vakhidov Surgery Center is the flagship of surgery of the abdominal organs and blood vessels, as well as the chest, including the heart. Many operations in Central Asia are performed only in this Center. These include several complex high-tech operations on the liver, pancreas, lungs, and heart. Adopted in 2017, the Law of the Republic of Uzbekistan “On Transplantation of Human Organs and (or) Tissues” clearly stipulates: “Human organs and (or) tissues cannot be the subject of sale and purchase.” Also, a form of opposition to the commercialization of transplantation is the ban on the transplantation of donor organs from living unrelated individuals prescribed in this law. The adoption of the law "On transplantation of organs and tissues" will serve as an additional impetus to the development and intensive research in the field of operative surgery, immunology, and transplantology. The document is aimed at the legal regulation of the issues of transplantation of human organs and tissues, the development of transplantology as a clinical discipline, and creates a legal basis for the transplantation of human organs and tissues. of the Law on closely related transplantation of the kidney and (or) lobe of the liver” was adopted for high-tech specialized medical care for patients with end-stage chronic diseases of the kidneys and liver, as well as the organization of closely related transplantation in the republic. The regulation defines the procedure for transplantation of kidneys and (or) liver lobe from living closely related donors, indications and contraindications for performing closely related transplantation, and the rights and obligations of the donor and recipient. Such high-tech operations, which are carried out in some countries of the world, are now also carried out in the following three major institutions of the republic:

- Republican Specialized Scientific and Practical Medical Center for Surgery named after Academician V. Vakhidov
- Republican Scientific Center for Emergency Medical Care
- Tashkent City Nephrological Hospital.

The document also clarified the question of who may or may not be a donor. Living closely related donors can be: persons who are related or related, that is, parents, blood and half-siblings, spouses, children (including adopted children), grandparents, grandchildren, as well as parents and half-siblings of spouses following the law. However, it is not allowed to remove the kidneys and (or) a lobe of the liver to perform transplantation from close relatives: under the age of 18, recognized in the prescribed manner as incompetent, - held in places of detention, disabled people of groups I and II, pregnant women, people suffering from drug addiction, chronic alcoholism, substance abuse. The final decision on the need for transplantation is made by approved by the Ministry of Health by a special commission. To operate, it is necessary to obtain the fully free and conscious consent of the donor, set out in writing, for the removal of one kidney and (or) a lobe of the liver from him. At the same time, he must undergo a comprehensive medical examination. After transplantation, the donor and recipient will be provided with a preventive medical examination for at least three years. In addition, patients under outpatient control will be provided with medicines in the manner prescribed by law. Establishing a transplant service is of great importance. After all, now the patient will be under the supervision of doctors, and even the slightest changes in the state of his health will be under the control of specialists. This will prevent post-operative consequences. It is also important that the patient's time and money will be saved. In the future, the scale and capabilities of this unique service will be expanded. For this purpose, scientific, technical, and legal conditions continue to be created in the country.

On May 12, 2022, the “Law of the Republic of Uzbekistan

On transplantation of human organs and tissues”

Moral and legal problems of organ transplantation from a deceased person.

The use of a human corpse as a source of organs for transplants raises a whole range of moral questions and concerns. Among them, it is worth highlighting the following problems:

1. Reliability of diagnosing brain death, about the legitimacy of identifying the concepts of "biological death" and "brain death";
2. The problem of the moral and ethical status of a deceased person. Is it possible to speak about the preservation of a person's right to his body after death;
3. Moral problems of the organ harvesting procedure for transplantation: routine sampling, “presumption of consent”, “presumption of disagreement”.

The concept of brain death has been developed in neuroscience regardless of the goals and needs of transplantology. However, it is for transplantologists that the concept of brain death has opened up the widest possibilities that are inaccessible when using traditional cardiopulmonary death criteria.

The question of the reliability of diagnosing brain death occupies a central place. It almost entirely falls within the scope of the professional competence of neurologists and becomes a moral issue when it comes to the public's confidence in the reliability and quality of the practical use of these procedures before making a decision on organ retrieval for transplantation.

Lack of public awareness of the measures taken by health authorities to ensure the reliability of the application of procedures for diagnosing brain death, according to many supporters of transplantation, creates fertile ground for unfounded accusations, rumors, etc. in general, undermines public confidence in the activities of physicians in the field of transplantology.

The most important principle that protects the procedures for diagnosing brain death from the influence of the selfish interests of organ procurers and thereby ensures their reliability is the organizational and financial independence of medical institutions that carry out diagnostics and organ retrieval from transplantologists. The latter is possible only if there are federal or regional systems for the collection and distribution of organs and tissues for transplantation.

Such systems should be funded from the budget, regardless of transplantation programs. Without this, there is always the danger of intentional or unintentional "overdiagnosis" in the diagnosis of brain death due to the presence of a serious material interest.

There is another vision of the problems that arise in connection with the concept of brain death. A number of authors in Russia (N.V. Tarabarko, I.V. Siluyanova) believe that the gradual convergence, and then the identification of the concepts of "biological death" and "brain death" occurred precisely under the influence of the goals and objectives of transplantology. The concept of brain death as the biological death of an individual in relation to the tasks of transplantation was legally enshrined in many countries. In 1993, in the Appendix to the Order of the Ministry of Health of the Russian Federation dated 10.08.93 No. 189 - Instructions for ascertaining the death of a person based on a diagnosis of brain death - it says: “Brain death equivalent to the death of a person. I.V. Siluyanova believes that it is difficult to disagree with a specific assessment of such a very conditional identification, as with "an exclusively pragmatic statement of the end of life." If society accepts "pragmatic brain death", then there is no reason not to follow a similar logic when deciding on the issue of artificial maintenance of the deceased in all his vital functions until his organs become necessary, and only after "fence" or "seizure" (again artificially) ensure death, now biological. The "pragmatic" outcome of transplantation to a large extent contributes to the formation of a new function in medicine, along with the traditional healthcare function - death support. And this, according to the author, is tantamount to a fundamental reassessment of the attitude of society to medicine and healthcare, the patient to the doctor, and a rethinking of the traditional social trust in the ethical impeccability of healing.

All world religions prohibit inflicting damage to the body of a deceased person and prescribe a careful and respectful attitude towards him. In the Abrahamic religions, the dead body remains the space of the personality. Respect for the dead is directly related to respect for the living. Loss of respect for the deceased, in particular, infliction of damage to the body, entails a loss of respect for the living. From a secular, secular point of view, the death of a person does not interrupt the effectiveness of his will in relation to what belongs to him. A will is a special form of will, which, as it were, is extended beyond the line that separates a person's life from death. It is also recognized that any act of desecration of the body of the deceased is a reprehensible act that offends the memory. In other words, for both religious and secular consciousness, a dead body has a certain moral status and presupposes certain norms governing its handling.

In the former Soviet Union, when solving these problems, for a long time, expediency considerations were placed above moral and ethical considerations. For example, from 1937 to 1993, the Decree of the Council of People's Commissars of the USSR (No. 1607 of September 15, 1937) “On the procedure for conducting medical operations” was in force. Where it is recorded that the People's Commissariat of Health was granted “the right to issue orders binding on all institutions, organizations, and individuals on the procedure for carrying out medical and surgical operations, including transplantation of eye corneas from the dead, blood transfusions, transplantation of individual organs, etc. »

Following the permission to remove from the corpse without the consent of the relatives of the cornea of the eye, blood, followed by instructions for extracting the pancreas, individual bone fragments, and then other organs and tissues. This is how the routine sampling of organs and tissues of a deceased person was carried out and, unfortunately, is often carried out to this day. His body in this case is treated as state property, which doctors can use in the public interest.

Here, the initial setting of utilitarian ethics is fully realized, according to which an action is morally justified if it produces the greatest amount of good for the greatest number of people. It is believed that the restriction of the right to autonomy of the individual, who is deprived of the right to control the fate of remains that are already useless to him, is outweighed by the obvious benefit to society in the person of potential recipients, whose lives can still be saved as a result of transplantation.

Such a practice and such an attitude, however, is morally detrimental, since it deprives a person of being the master of his body, exercising control over it directly - through the mechanism of a will or indirectly - through the will of his relatives. The moral commandment "Thou shalt not steal!" warns not only against the violation of the head law, which may be absent but also against any appropriation by a person of what does not belong to him. As the American philosopher R. Witch rightly states, “In a society that values the dignity and freedom of the individual, we should be able to control what happens to our bodies not only during life but also, within reasonable limits, after it ends.”[1]

Routine organ harvesting for transplantation also affects the moral values of the deceased's family. The tradition goes back centuries, prescribing to the relatives of the deceased, as a moral duty, his worthy burial. At the same time, the inviolability of the remains and a respectful attitude towards them are strictly mandatory. Manipulations with the body of the deceased without the permission of the family can be perceived by many people as a personal insult and moral damage.

Currently, there are two main legal models for regulating the procedure for obtaining consent for the removal of organs from deceased people: “presumption of consent” and “presumption of disagreement”.

In 1992, Russian legislation in the field of medicine was brought into line with the principles of protecting human rights and dignity, developed by the World Health Organization (WHO). The main position of the WHO on the issue of a person's right to his body after death is to recognize this right, by analogy with a person's right to dispose of his property after death.

Based on WHO recommendations, the Law of the Russian Federation "On Transplantation of Human Organs and (or) Tissues" introduces a presumption of consent (unsolicited consent), according to which the collection and use of organs from a corpse are carried out if the deceased did not object to this during his lifetime, and if there are no objections say his relatives. The absence of a refusal is interpreted as consent, i.e. each person can almost automatically turn into a donor after death if he did not express his negative attitude towards this.

The current law on transplantology provides the right to refuse both the person himself - in advance, and his relatives - after his death. It is important, however, that this right can be exercised in practice. The public must be informed of their right to refuse, understand the content of this right and know how it can be exercised. The fact that the refusal

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[1] Ivanyushkin A. Ya., Ignatiev V., Korotkikh R. V. et al. Introduction to bioethics // M.: ProgressTradition, 1998.

mechanism is explained only in the departmental instructions of the Ministry of Health is a significant obstacle to the implementation of the positive aspects of the presumption of consent and the violation of the rights of citizens. In turn, since the refusal mechanism is not formalized legally, an additional risk of complaints and even lawsuits from relatives falls on doctors who remove organs and tissues for transplantation.

The second model for regulating the procedure for obtaining consent for organ harvesting is the so-called “solicited consent” or the presumption of disagreement. “Solicited consent” means that prior to his death, the deceased explicitly stated his consent to the organ removal, or a family member expressly consents to the removal in the case when the deceased did not leave such a statement. The doctrine of “solicited consent” presupposes some documentary evidence of consent. An example of such a document is the "donor cards" received in the United States by those who express their consent to donate. In some countries, consent to organ harvesting is written into driver's documents. The doctrine of "requested consent" is adopted in the health legislation of the United States, Germany, Canada, France, Italy, and Holland.

At the heart of the approach based on "requested consent" lies the fundamental right of the individual to self-determination, and autonomy. A person should be able to dispose of his own body after death. At the same time, the “requested consent” does not contradict the public interest in obtaining organs and tissues for transplants.

The specificity of the realization of the public interest, in this case, consists in the voluntary delegation by individuals of certain rights to dispose of their own bodies after death to society or, more precisely, to certain structures authorized to represent this interest. “Solicited consent” is a more democratic mechanism than a routine fence, in which doctors seem to arrogate to themselves the right to dispose of the body of the deceased without his permission.

At the same time, the approach based on the presumption of disagreement, according to many experts, significantly complicates the procurement of organs and tissues for transplantation, gives doctors a psychologically very difficult duty to contact the relatives of the deceased at a difficult time for them to lose a loved one. Many doctors consider this immoral.

It should be noted, however, that the world medical practice has accumulated a certain amount of experience in communicating on this topic with the families of the deceased. In some US states, for example, the law obliges physicians in designated cases to apply to the relatives of the deceased with a proposal to remove organs or tissues for transplantation. Thus, to some extent, doctors are relieved of the moral and psychological burden associated with discussing this most difficult topic with the relatives of the deceased. The legal norm in this case acts as a kind of "support": after all, it is one thing to say these words on your own behalf, and quite another - on behalf of the Law.

The successful implementation of the “requested consent” mechanism presupposes, firstly, that the population is sufficiently well informed about the concept of brain death and about the public utility of transplants. Secondly, the need for a high level of public trust in medical professionals who are responsible for the diagnosis of brain death. Strictly speaking, such conditions must be observed both in routine sampling and in the operation of the presumption of consent, however, in an approach that requires the informed consent of the donor, these factors decisively determine the very possibility of obtaining donor organs and tissues for transplantation. Today, in order to make a legislative transition in the field of transplantation of human organs and tissues, not only from living donors but also to various models that are used in other countries, a huge amount of explanatory work is to be done, taking into account national traditions, religious views, mentality among the population.

Questions for self-examination

1. Describe the legal aspect of transplantation in Uzbekistan?
2. What are the presumption of consent and the presumption of disagreement of the donor?
3. What is xenotransplantation?
4. What moral issues might arise if the development of artificial organs and xenotransplantation become widely used in medical practice?
5. What ethical problems arise when deciding on organ transplantation?

Bibliography.

1. What problems in transplantology have been revealed by the doctor's case on illegal organ transplantation.

https://informburo.kz/stati/kakie-problemy-v-transplantologii-vskrylo-delo-vracha-o-nezakonnoy-peresadke-organov.html

2. Medical associations, medical ethics and general medical problems. Collection of official materials. Ed. V.N. Uranova. M.: PAIMS, 1995.–p.96
3. WHO GUIDELINES FOR HUMAN CELL, TISSUE AND ORGAN TRANSPLANTATION Adopted by the Sixty-third World Health Assembly in May 2010, resolution WHA63.22https://www.who.int/transplantation/Guiding_PrinciplesTransplantation_WHA63.22ru.pdf?ua=1
4. Steering Committee of the Istanbul Summit. Organ trafficking and transplant tourism and commercialism: the Declaration of Istanbul. The Lancet. 2008 Jul 5;372(9632):5-6.
5. Decree of the Cabinet of Ministers of the Republic of Uzbekistan dated October 23, 2017№ 859 On approval of the temporary regulation on the procedure for related transplantation of the kidney (or) lobe of the liver. Decree of the Cabinet of Ministers of the Republic of Uzbekistan dated December 25, 2019 No. 1035 - National Legislation Database, 12/26/2019, № 09/19/1035/4226) № 859 10/23/2017
6. Academic Notes of the Faculty of Law. Issue. 18 (28) / Ed. A. A. Liverovsky. - St. Petersburg: Publishing House of the St. Petersburg State University of Economics and Finance, 2010. – p.117.
7. Ivanyushkin A. Ya., Ignatiev V., Korotkikh R. V. et al. Introduction to Bioethics // M.: ProgressTradition, 1998.

CHAPTER XI. ETHICAL PROBLEMS AND CATEGORIES IN DENTISTRY

Key words: *dentistry, Ethical problems in dentistry, Ethical categories in clinical dentistry.*

Ethical problems in dentistry

Demand for solutions and discussion on bioethical problems gave rise to the appearance in the world of special journals, international, regional, and local committees, textbooks on bioethics courses, and encyclopedias. However, in terms of ethical issues associated with dentistry, there is a lag of about 15-20 years. If hundreds of books have been written on medical ethics, there are literally only a few on ethics in dentistry. The only book on the topic of ethics in dentistry has been reduced to issues of informed consent.[1] The spectrum of ethical issues in dentistry and how to address them, however, is defined. Interest in ethics, in the ability to teach real ethical thinking in dental education in the West, is in demand and continues to grow. Today it can be said that about 80% of American dental schools and all schools of hygiene provide training in professional ethics.[2] However, the ability to teach real ethical thinking seems questionable, as the number of staff with formal training in ethics is limited, and at least in dental schools most of the courses are legally oriented. In clinical dentistry, interest in ethics differs significantly from trends in general medicine. For example, it has nothing to do with the ethics of consultation or ethical committees that are becoming common in general medicine hospital practice in the West. The main issue in dentistry cannot be a specific clinical issue, such as disconnecting from a life support machine. Rather, it targets the profession's ethical standards for excellent service and the need to maintain overall trust.[3] The increased number of ethics-oriented education courses has been a reflection of

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[1] Warner R, Segal H. Ethical Issues of Informed Consent in Dentistry. Chicago. III: Quintessence Publ Co; 1980:115

[2] Odom JG. The status of dental ethics instructions. J Dent Educ 1988;52:306-308; Jong A, Heine CS. The teaching of ethics in the dental hygiene curriculum. J Dent Educ 1982; 46:699-702.

[3] www.pucrs.br/bioetica/cont/joao/anoverview.pdf

these needs. Costly innovations such as computer-assisted restorative procedures, along with the increasing use of implants and lasers, not only serve to improve the quality of care but also make these services unaffordable to the less well-off part of the population[1].

Rising prices for dental care raise ethical concerns in terms of effectiveness and efficiency. In medicine, an increase in costs does not directly mean an improvement in morbidity or mortality statistics. What constitutes an ethical problem as distinct from a clinical, scientific, or legal problem? Some problems may appear to be purely clinical or scientific in nature. However, this view is erroneous if by this we mean that clinical or scientific decisions can be made without a discussion of values. Every clinical, scientific, or legal problem includes an evaluation component. Evaluation can often be manifested by the words "good", "bad", "right", "wrong", "should", and "should". Sometimes these words don't show up explicitly, but they convey the idea of evaluation nonetheless. By stating that the result is "positive", or the treatment is "indicated", or that the result is "negative", or that there are side effects, an element of evaluation is already implied. Of course, not all assessments are moral in nature. Some scores are aesthetic, cultural, or simply personal preference. Regarding ethical assessments: Many of us rely on common sense to determine ethical and other types of assessments. Solutions can be obvious if the difference between positive and negative is unambiguous. In other situations, decisions can be difficult and a choice must be made between good and evil or the lesser of two evils.

The use of local anesthesia in dentistry provides a good example of the role of judgment in decision-making. The dentist is trained to administer local anesthesia to ensure patient comfort. Frequent use of local anesthesia is not the main issue in dentistry, but it shows the importance that dentists place on its capabilities. Evaluation can become an ethical issue when the dentist understands that evaluation involves a trade-off between the benefit of anesthesia and other benefits that the patient may claim. For example, the patient may fear the side effects of anesthesia, may object to the duration of action of the drug, or may

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[1] Mukhamedova Z.M. Current problems of ethics in dental education. Scientific journal “Humanitarian Treatise” No. 14 www.gumtraktat.ru 2017; Mukhamedova ZM. Ethical categories in clinical dentistry. . Scientific journal Humanitarian treatise. 15. From 22-26. 2017. www.gumtraktat.ru

simply have a physiological constitution that allows him to tolerate toothache. It is clear that there is no single correct value judgment in this matter. Value judgments of the doctor and the patient may not coincide. A dentist who believes that he is acting for the good of the patient may end up violating his rights.

Another set of issues involves patient autonomy.

Issues of informed consent and the need to put the best interests of the patient first are certainly important. Informed consent is an important ethical issue for the dentist because of the variety of materials and technologies that are possible when performing the same procedures. In such circumstances, how much information the patient needs to know in order to make the right decision and decides informed consent?

Conflicts between a dentist and a patient and ways to resolve them also represent an important ethical problem. One category concerns conflicts on the part of the dentist. For example, does a patient who is unable or unwilling to comply with the procedures prescribed at home cause the physician to consider whether it is necessary to continue treatment at all? Another problem is child abuse, when the doctor's actions are aimed at helping a small patient, but on the part of the parents this looks like cruel behavior towards their child. The problem of using control techniques for rebellious children who require dental treatment can also be a source of ethical conflict. A final example is the question of how much preparation for the use of new technology, such as implant placement, is needed before moving on to practical implementation in patients.

Another category of conflicts includes conflicts on the part of the patient. The most common situation is when a patient requires a procedure that is not consistent with the training and principles of the dentist. As an example, this is a request from a patient to extract a tooth that, in the opinion of the dentist, needs to be treated rather than removed. Another example is a patient who requires anesthesia, but the dentist believes that this is not necessary in this case.

There are also issues of fairness. How is the doctor obliged to act when it comes to the queue, whom to take first? A patient who is in severe pain, a patient with AIDS, or a patient who has not been helped by previous treatment? Should the doctor stop treatment if the payment system does not cover his expenses, or the payment is completely stopped? Should a dentist treat special patients, such as the handicapped, the homeless, and nursing home patients, when their treatment could affect a successful practice? Is the dentist obligated to provide free care, and if so, to whom and to what extent?

A serious problem is relationships within the profession among dentists. For example, the discovery of a pathology that was not noticed by colleagues when installing a temporary crown and other situations with criticism of colleagues when communicating with a patient is very important. Referral practices based on factors, not in the best interest of the patient may be a source of concern. Among the most difficult is the problem when physicians are faced with the incompetence of their colleagues and this incompetence should be reported.

The human right to health in most countries of the world is protected by relevant laws and documents of medical organizations. The principal feature of professional medical ethics is its universal, supranational, universal character. Undoubtedly, as medical advances continue, new ethical and legal issues will arise. Regardless of what ethical attitudes the society in which the doctor performs his mission has, regardless of the socio-economic formation, he must be guided by the principle of “do no harm”. The doctor is obliged to follow all the logical stages of performing diagnostic measures, starting with the analysis of the information received. Firstly, it does not expose the patient to the risk of unnecessary examinations, and secondly, it provides him with diagnostic and therapeutic assistance using the safest means. Professional and legal responsibility from the point of view of deontology is a doctor's constant demands on himself. Compliance with moral and ethical principles allows the protection of the interests of the patient and society as a whole, contributes to the progress of medical science, and stimulates the useful initiative of the doctor in the interests of the patient. The study of the discipline "Biomedical Ethics" is necessary for: the implementation of the initial and ultimate goal of healing is the healing of a person, the requirements for the ethical and psychological factors at the present stage of development of practical healthcare, to preserve the mental and somatic health of the medical worker himself. To neglect ethical knowledge is to inevitably distort the essence and purpose of medicine.

Thus, the general purpose of ethics in dental education is to provide an introduction to ethical considerations and the methodology of ethical analysis in order to enable future professionals to justify their moral choices. Accounting for teaching at the preclinical and clinical levels must be subordinated with particular attention to a specific goal. The general conclusion that can be drawn is the priority of respect for patient autonomy and informed consent in the relationship between the dentist and his patient. The international practice of developing dental education and the formation of the relevant competencies of a dentist that meet the requirements of the time today cannot be formed outside a special bioethics course.[1]

Ethical categories in clinical dentistry.

Clinical research in dentistry is included in the broad term "biomedical research". For biomedical research involving humans, there are internationally accepted guidelines set out in the Declaration of Helsinki and other documents. It should be noted that the professional ethics of a dentist within the framework of deontology is still more common today not only in the republics of Central Asia and Kazakhstan but also in other republics of the CIS. Actualization of the inclusion of bioethics and biomedical ethics in the educational, everyday practice, and clinical research of dentists would be a worthy response to the challenges of the time, would meet the requirements of the State Standard of Uzbekistan for good clinical practice and the Decree of the President of the Republic of Uzbekistan "On measures for the further development of the higher education system".

Biomedical principles in the dental profession are that the dentist must act in such a way as to enhance the prestige and reputation of the profession in the face of the progress of the latest technologies. The principles of biomedical ethics are the goals set for the dental profession and provide guidance and rationale for a code of professional conduct and advisory opinions. The main ethical principles are: to avoid causing any harm to the patient (the principle of do no harm); the principle of doing good to the patient; the principle of patient autonomy; the principle of informed consent of the patient, etc. These principles are supplemented by other ethical rules, such as altruism, fairness, confidentiality, loyalty, truthfulness, and others.

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[1] Mukhamedova Z.M. The role of bioethics in educational, everyday practice and clinical research of dentists. STOMATOLOGYA No. 4(69) 2017.P.80-82.

For clinical decision-making in dental research, and in everyday practice, in addition to guidelines, and principles, there are values. In 1988, the authors of Ozar D.T. and others published a report that presents 7 categories of values recognized by the profession in its approaches to treatment.[1] The authors propose a ranking of values to help clarify the decision-making process when these categories are in conflict. The values in their hierarchical order are as follows:

1. Life and health,
2. Proper and painless oral functioning,
3. Patient autonomy,
4. Preferred practice,
5. Aesthetic values,
6. Cost,
7. Other external factors.

The very existence of these values, as well as their ranking, is controversial both within dentistry itself and outside it. For example, there is some risk to a patient's life every time local anesthesia is used in the name of painless dentistry, but most dentists feel the risk is worth it. Others may prioritize patient autonomy over dental health and proper functioning. Patients may prioritize extrinsic (non-dental) factors over all other listed values. According to some ethical systems (for example, religious, and legal), many of the listed values must be subordinated to other ethical issues that have nothing to do with these values. For now, however, it will be useful to summarize one version of a possible list of values to provide a basis for further discussion.

Ethical categories "Life and health". Vitality and the development of general health is a central concerns for all dental practitioners and patients. Under normal circumstances, dentists should not perform treatment that endangers the life and health of the patient. Occasionally, in a patient with malignant hyperthermia who has sustained a severe facial injury, the risk of death during general anesthesia may exceed the expected aesthetic outcome. Therefore, in this case, the oral surgeon uses local anesthesia.

The complex and important category "Proper and painless oral functioning" has two broad aspects. First, the prioritize actions that take

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[1] Ozar DT, Schiedremayer DL, Siegler M. Value categories in clinical dental ethics. *J Am Dent Assoc* 1988;116:365-368

into account factors such as age, health status, and ability to care for themselves. These categories include the basics of disease prevention and maintaining oral health. In the event that the patient has periodontal disease and does not maintain oral hygiene, the need for more thorough self-care at home should be emphasized before starting any treatment. In the case of a patient who is physically handicapped and unable to perform the procedures prescribed by the doctor at home, the dentist may consider it unethical to initiate any treatment, since its success depends on the patient's activities.

The second aspect concerns the convenience of oral functioning. Some dentists and patients prioritize long-term performance over other categories. These doctors value the prevention of dental health and the practice of high-quality dentistry. For example, if a patient asks for fixed dentures to be installed on damaged teeth and there will be problems with them in the near future, it is considered unethical to perform this procedure, even if the patient requires and is willing to pay for it.

In the context of healthcare, the category "patient autonomy" refers to the ability of competent patients to make decisions that reflect their best interests. An example of a patient who refuses further treatment of the tooth and requires its extraction, even though several procedures have already been performed and now a root canal treatment and a crown are required. The dentist believes that the tooth can be saved and does not agree with the patient's choice. In this situation, the tooth is already damaged, and although the dentist does not agree with the extraction, the patient's request is reasonable and can be fulfilled.

During training, dentists gain knowledge regarding the choice of treatment. For example, preference for restoration of a damaged tooth over-extraction (when possible), use of crowns over amalgam restoration, and use of fixed restorations over partial restorations in a situation where both methods are possible. The category of practice preference in the minds of many dentists is higher than aesthetic value, but these preferences are less important than patient autonomy. Those who agree with this hierarchy of preference appreciate that the patient is fully aware of the existing alternative methods. In many situations where the patient chooses a treatment that the dentist disapproves of, the concept of the practice of preference suggests that the doctor should give in to the patient's demands.

Dentists are aware that appearance is important to the patient, and they usually take aesthetic factors into account during treatment recommendations. On the other hand, dentists are usually reluctant to prioritize aesthetics over pain-free functioning when the two are incompatible.

The role of values in ethical decision-making in dentistry is a complex and controversial issue. It is generally accepted that cost is primarily a concern for the patient, but it can also affect the dentist's recommendations. A doctor may not be able to recommend a particular treatment because he knows, or at least thinks, that the patient can afford to pay for his work. However, dentists usually do not consider cost as a particularly important category in their recommendations to the patient. For example, the treatment of a damaged central incisor that is discolored and hypoplastic is being considered. The dentist is more likely to recommend a composite resin crown, purely in terms of better aesthetics, even if the crown is significantly more expensive. Of course, for a patient whose financial situation may be very different from that of a doctor, the issue of cost will be more important.

Factors outside of dental considerations often enter the decision-making process on the part of the dentist. This broad category includes social and cultural influences, public welfare, social justice factors, and even the personal responsibilities of a dentist. Some external factors may deserve a higher place in the hierarchy, and at times may be more important than, for example, cost or ethical factors. To clearly understand the role of values in ethical decision-making in dentistry, their role, as well as to understand more systemic alternative ways of solving ethical problems, it is necessary to study the foundations of ethical theories.

So, the overall goal of ethics in clinical dentistry is to provide not only an introduction to ethical considerations but also a methodology for ethical analysis to enable future professionals to justify their moral choices. Accounting for teaching at the preclinical and clinical levels must be subordinated with particular attention to a specific goal. It is important to note that in the international practice of the development of dental education and the formation of the relevant competencies of a dentist that meet the requirements of the time, a special priority is given to the category of respect for the autonomy of the patient and informed consent in the relationship between the dentist and his patient.

Questions for self-examination

1. Ethical aspects of the use of local anesthesia in dentistry
2. Why may the doctor's and patient's value judgments not coincide?
3. Ethical categories "Life and health" in dentistry
4. What will be the preference in the dental practice - the aesthetic component or painless functioning?
5. What categories in the international practice of dental education are of particular priority?
6. What is the general purpose of ethics in clinical dentistry?

Bibliography.

1. Warner R, Segal H. *Ethical Issues of Informed Consent in Dentistry*. Chicago. III: Quintessence Publ Co; 1980:115

2. Odom JG. The status of dental ethics instruction. *J Dent Educ* 1988;52:306-308; Jong A, Heine CS. The teaching of ethics in the dental hygiene curriculum. *J Dent Educ* 1982; 46:699-702.

3. Source http://www.pucrs.br/bioetica/cont/joao/anoverview.pdf

Mukhamedova Z.M. Actual problems of ethics in dental education. Scientific journal "Humanitarian treatise" No. 14 www.gumtraktat.ru 2017; Mukhamedova ZM. Ethical categories in clinical dentistry. . Scientific journal Humanitarian treatise. 15. pp. 22-26. 2017.

4. Mukhamedova Z.M. The role of bioethics in the educational, daily practice and clinical research of dentists. DENTISTRY № 4(69) 2017.pp.80-82.

CHAPTER XII. HISTORICAL AND MODERN ASPECTS OF PHILOSOPHICAL-RELIGIOUS AND ETHICAL TRADITIONS IN MEDICINE

The sacred fire in the heart is not extinguished,
The mind burns, renewing the spirit.
Everyone has their breath, feeling,
And in that, the Creator is a wise art.
Abu Ali Ibn Sina

Key words: *Avesta, Ayurved, Buddhism, Confucianism, Taoism, Euthanasia, Embryo, Abortion, Contraception, Sterilization, Fertilization in vitro*.

Modern biomedical ethics is based on rich philosophical and religious traditions and retains historical continuity with traditional professional medical ethics.

Eastern ethical traditions in medicine.

A) Avesta

Videvdat (Law Against the Devas) is the only book of the Avesta which contains prescriptions related to medicine. Although Herodotus (5th century BC) reported on prescriptions similar to those contained in Videvdat, the first mention of Videvdat itself is contained only in the Pahlavi Denkart, written already in the 9th century AD.[1] Videvdat, the most fully preserved text of the Avesta, presents the religious, legal, and political ideas of the ancient cultures of Central Asia and Iran. Videvdat says about the first doctor Trita: “Trita was the first of the healers; he received the instrument of healing from Hshatra-Vairya, to overcome illness and death, to overcome pain and fever, and all the demons of disease, the evil eye, and other evil creations of Angra Mainyu[2]. Avestan magicians were known to the ancient world as healers. Under the division of all things into the spiritual world (testing) and the material

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[1] Here and further Rtveladze E.V., Saidov A.Kh., Abdullaev K.V. Avesta “The Law against the Devas” (Videvdat). St. Petersburg: Polytechnic University Publishing House, 2008. 301 p.

[2] Rtveladze E.V., Saidov A.Kh., Abdullaev K.V. Avesta “The Law against the Devas” (Videvdat). St. Petersburg: Polytechnic University Publishing House, 2008. 301 p.

world (moment), medicine was also divided into spiritual (treatment with the Holy Word - mantra) and carnal (treatment with medicines and surgical intervention). "mantra treatment is the best in spiritual medicine: in case of a particularly serious illness, injury or injury that is not treated in the usual way, the best way was recommended - the use of mantric formulas (arson). "

The appearance of prescriptions for doctors in the part of Videvdat devoted to the laws of purification is not accidental - doctors, by their very profession, are associated with carnal impurity, and by their actions they can both heal and kill the patient. Naturally, there was no question of any practice on corpses in Zoroastrianism. Therefore, Videvdat instructs the novice healer to "practice" on representatives of other religions. Trita is mentioned in the Avesta as one of the first priests of Haoma. In medicine, there are three types of healing: with a knife, herbs, and the Holy Word. Healing with a knife is implied in the mention of Hshatra Vairya - one of the Immortal saints, healing with herbs - in the mention of the Gaokeren tree (producing seeds of medicinal plants); healing with the Holy Word - in exorcisms that drive out disease-causing demons. If there is a choice and several healers offer their help: a healer who heals with a knife, a healer who heals with herbs, and a healer who heals with the Sacred Word, then the last one is chosen; for the healer who heals with the Holy Word is the best of healers; he will best drive sickness out of the believer's body.

In ancient times, in many religions, the idea of the superiority of the priest over the doctor in the matter of healing was widespread, and the hierarchy of "patients" was listed. For example, the cure of the householder's heir was valued not only above the cure of the householder's wife, but also of the householder himself, and was equal in payment to the cure of the ruler of the city.

Videvdat has regulations, including those related to the protection of motherhood - both concerning a pregnant woman and a dog expecting offspring. The concept of law has been an essential part of Zoroastrianism from its earliest stages. Based on the texts of Videvdat, a crime against a person was a deliberate attack or an attack in a state of passion, threats, harmful actions of a doctor, abortions, crimes against a woman's health during the regulation and pregnancy;

Crimes against morality: homosexuality, prostitution, adultery. In the hierarchy of crimes against morality, the ethical dualism of

Zoroastrianism manifested itself especially clearly. So, homosexuality was considered the most difficult act - "serving the devas" and was the only crime punishable by death.

If a woman gave birth to a dead child, then she had a rite of purification. Drinking a woman who gave birth to a dead child before the time of purification (before the expiration of three days) was considered a sin of water defilement, therefore the punishment for it was similar to the punishment for watering the land on which someone died (before the expiration of 1 year). if this offense was committed by a child under the age of seven, then the punishment should be borne by his father. Children under seven years of age were considered in early medieval Central Asia and Iran to be legally incompetent.

B) Ayurveda.

The collection of Hindu medical writings known as Ayurveda [Ayur-veda] was probably created at the beginning of the first millennium BC. and contains a code of ethical conduct for the physician.

Ayurveda is the oldest medical system that originated in India. The word Ayurveda consists of two Sanskrit roots: Ayur - which means life or a segment of life, and Veda - knowledge, or science. Thus, Ayurveda is the science of life. In the main textbooks of Ayurveda - Charaka Samhita and Sushruga Samzita - the directions that have in general the same names as in traditional medicine are considered. In addition, these textbooks contain treatises on medical ethics and the relationship between doctor and patient.

Biological individuality is a central principle in diagnosis and treatment from the point of view of Ayurveda. The doctrine considers the imbalance that occurs in the body due to the breakdown of links between homeostatic or immune mechanisms as the main cause of the disease. Emotional and mental factors have a great influence on the development of imbalance. According to the teachings of Ayurveda, the regulation of times is based on The personal functions of the mind and body that lie within the 3 doshas [doshas] (physiological principles). In Sanskrit, the 3 doshas are called Vata [vata], Pitta [Pitta], and Kapha [Kapha]. Each person is gifted with all three doshas from birth, but their exact proportions vary from individual to individual. They determine the psychophysiological type of the organism. There are 10 classical types, consisting of a combination of 3 doshas. Doshas are divided into many sub-doshas with different locations and functions in the body. Instability in the doshas and sub-doshas disrupts the normal functioning of the body and leads to the emergence of diseases.

The main goal of therapy, from the point of view of Ayurveda, is to restore the physiological balance, which corresponds to the restoration of the balance of the doshas. Balance is a condition under which homeostatic and self-regulating mechanisms are maximally enhanced. This concept extends to 4 main areas - consciousness, body, behavior, and environment.

The treatises on medical ethics by Charaka Samhita (2nd century AD) and Sushruta Samhita (5th century AD) reflect the ethical norms that a doctor must follow in his professional activities. They concern the competence of the doctor, his moral qualities, and the rules of behavior of the doctor with the patient, colleagues, and students.

Charaka Sangeeta states that "medicine is indeed not so easy to learn, so let everyone study it diligently and constantly." With all his heart, the doctor “should take care of the treatment of the patient, and even if he risked his own life, he had no right to cause any suffering to the patient and should never have thought to offend the wife of another, and also trample on his property with his feet.” Entering the home of the sick person, accompanied by a person who is familiar and has the right to enter, "his word, thought, and feeling should be directed to nothing else, but to the treatment of his situation." A place is given to medical secrecy: “One should not talk about incidents in the house, it is also impermissible to report anything regarding the threatening premature death of the patient, where this could harm him or anyone.”[1]

The Sushruta Samhita points out the rules of behavior of a doctor and the high moral and physical qualities required of him. The Physician was required to be compassionate, and benevolent, never lose his temper, and be patient, and calm. When helping a patient, one should show respect for him, and be kind and humane. Humanity should become, as it were, the doctor's religion. The doctor is warned against arrogance, and increased conceit. A separate section is devoted to the behavior of a doctor with a seriously ill and dying person: to fight to the end for the life of a person, to be careful in his judgments in the presence of a patient, to assure him of recovery.

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[1] Shepotyev N. Scientific notes of Kazan University. B. III, book 4. - Kazan, 1890. - P. 57.

Buddhism, Confucianism, and Taoism have contributed to the development of other Eastern medical ethical traditions.

1) Fundamentals of Buddhist thought.

From the time of his Enlightenment until his death (about 480 BC), the Buddha preached a single thought: getting rid of suffering through its recognition. The spiritual path that constitutes the content of his teachings were called Buddhism.

According to Buddhist teachings, suffering and getting rid of it are determined by the state of the spirit, on which the continued existence of beings in one of the six planes of samsara depends. Liberation from the state of dissatisfaction and suffering presupposes, first of all, the knowledge of the true nature of the phenomenal world. It is characterized by the impermanence and disappearance of everything that arises from causes and conditions, and it is he who lies at the basis of universal suffering. The person himself is connected with the rest of the environment, with nature and other living beings, people, and animals. The Buddha calls for enlightenment and personal responsibility. Passions determine actions, the sum of which determines the fate of people following the law of Karma, which covers not only a given segment of life but also its continuation in the stream of successive rebirths.

Negative actions are generated by ignorance of the true nature of phenomena. Envy and hatred flow from ignorance, which inevitably entails grave consequences that prevent the one who is seized by them from getting rid of suffering. Positive deeds associated with the highest knowledge - understanding the impermanence and non-substantiality of phenomena - create happy living conditions and lead to liberation from the bonds of samsara. As for the actual practice, enlightenment follows the spiritual path described by the Buddha, the path of justice and balance. Spiritual development is achieved through the practice of concentration and contemplation, which are at the center of the Buddhist tradition.

Freed from passions and spiritual filth, a person leaves the cycle of being, ceases to be reborn, and gets rid of suffering.

The main elements of Buddhist thought. The human personality rests on five psychophysical pillars called skandhas: form (rupa), sensations-emotions (vedana), perceptions-imaginations (Sanjaya), karmic volitional impulses (sankhara), and consciousness (jnana).

Aggregate The reality of these phenomena is the impermanent and illusory world (flow) of the individual, whose existence is relative and conditional. All living and non-living phenomena, moreover, are non-substantial. Born from causes and conditions, they have no existence of their own, resulting in emptiness. However, moderately, they exist. Buddhism postulates the law of causality, which follows the process of birth and death.

Rebirth is given the following explanation: a human being is a continuous stream, a successive emergence, and the disappearance of special states of five psychophysical phenomena. This allows us to speak of a continuum. Since there is no permanent entity remaining for any length of time, nothing permanent can pass from one existence to another. A dying and then resurrecting being is neither the same nor a different being - it is a continuous stream drawn by the moral force of actions. Thus, beings attached to their actions potentially carry their being in themselves. Therefore, the law of Karma (or actions) and the law of new birth are closely related: Karma (volitional impulses) is a kind of energy that feeds the flow of psychophysical phenomena or the continuum.

Buddhist ethics is based on altruism and compassion and rests on refraining from bad deeds:

- do not take anyone's life, be it a person or an animal;
- do not steal;
- do not get drunk;
- do not utter erroneous, empty, or false speeches;
- do not commit adultery.

2) The position of Buddhism concerning some of the problems associated with biomedicine.

Judgments regarding the risk associated with the application of the latest achievements of biomedicine follow the basic principle of the highest sanctity of human life and any form of existence in general.

— The highest sanctity of human life takes precedence over all other considerations, because, according to Buddhist teaching, only human life, which is extremely difficult to acquire, makes it possible to realize deliverance from the bonds of samsara.

- Biologically, the embryo arises as a result of the fusion of the sperm with the egg, but Buddhism claims that a third element is also necessary for life - the continuum of consciousness.

- At the moment of death, the dissolution of physical elements occurs: the solid element dissolves in the liquid, the liquid is absorbed by heat, and heat is dissipated in the air. At each of these stages, the dying person has a feeling of heaviness, loss of support, and immersion in liquid. It is assumed that the continuum of consciousness is present in the physical shell for three days from the moment of clinical death.

- According to Buddhist teachings, a person is more than a biological being and the result of the union of two individuals. It exists in its psychophysical wholeness and inherits previous actions. Man, although determined by his past actions, can choose and change his formation. Buddhism always emphasizes the power of previous deeds as the main explanation for the diversity of beings and their situations.

“From these basic principles regarding the new birth, the law of causality and compassion, Buddhist medical ethics flow.

Euthanasia. The destruction of life (one's own or another) is in the first place among the negative actions. Euthanasia is a complex and delicate issue, and attitudes depend on whether it is "passive" or "active" euthanasia. Active intervention that hastens the approach of death is unacceptable, as is an intensive treatment to maintain life, which is considered a form of violence since the approach of death is essential and should be as quiet and serene as possible.

Embryo. The fetus is sacred and carries the full potential of the human being.

Abortion. Corresponds to the destruction of life, regardless of stage.

Contraception. The preferred method is the use of condoms.

Sterilization. Should be avoided due to the reversibility problem.

Fertilization in vitro. According to Buddhism, the process of birth can be carried out in various ways. An in vitro embryo is the germ of life and should enjoy the same protection as a human being. Persons born as a result of the use of methods of artificial reproduction, and children born naturally, should enjoy the status of equality at all levels. However, there are complications. The fact is that such a method becomes unacceptable in itself because in this case, several eggs are fertilized, then they are selected and, finally, destroyed or stored in a cryogen, and according to Buddhist teaching, a continuum of consciousness arises from the first moment of fertilization. ¬completion.

Carrying someone else's child. If such a practice involves artificial insemination, then it becomes unacceptable for the above reason, but the institution of the pregnant mother itself is allowed. If, nevertheless, such an operation is performed, precautionary measures should be taken: it is necessary to proceed from altruistic intentions and obtain the consent of all concerned.

Organ transplantation. The problem of organ transplantation requires ethical reflection. It is an act of compassion, a gift to help others. The concept of death is perceived differently by Buddhism and the Western scientific tradition. According to Buddhism, with signs of clinical death, there can be no absolute certainty that consciousness has left the physical shell. Although science does not detect this continuum, traditional Buddhist thought believes that it can be determined by some signs. Sensory and mental consciousness disappear at the moment of physical death, but consciousness can remain in the body shell for up to three days.

With instantaneous, unexpected death, the continuum of consciousness immediately leaves the body, but, apart from this case, there is a danger of interfering with the natural process of psychophysical death if any manipulations with the body are performed within three days after the onset of clinical death. But, on the other hand, the donation of an organ can help one's neighbor, for example, in the case of a cornea transplant.

Abrahamic ethical traditions in medicine

As you know, the three monotheistic religions - Judaism, Christianity, and Islam - believe in one God, in the integrity of the universe. Hence their common name - the Abrahamic religions. Abrahamic religions are monotheistic religions originating from an ancient tradition dating back to the legendary patriarch of the Semitic tribes, Abraham.

Jewish ethical tradition.

(1) Source of authority. While the standards of Hippocratic ethics are the business of the doctor himself or the profession as a whole, Jewish medical ethics relies on the tradition of Jewish law, which is interpreted and formulated by the rabbi. The law was given its full expression in the Torah, while the current rabbinic tradition, the Halakhah, is based on the ancient text, the Talmud.

Main content. Differences in ethical issues divide leading rabbis. While everyone agrees in actively condemning the murder, views differ as to whether treatment can ever be withdrawn or resuscitation efforts suspended. Orthodox Jews see it as a duty to keep alive at almost any cost, in striking contrast to other traditions.

(and with the opinions of many unorthodox Jews) who allow occasions when it is possible to allow dying.

(2) Essential principles generally shared by all include the moral duty to maintain health, the rejection of superstition and unintelligent healing (i.e. prayer medicine), and severe restrictions on the treatment of the newly deceased.

One of the basic principles of Hebrew medicine is the principle of the unity of a human being, whose spirit and body form a single whole. According to Judaism, the soul and body are one, and the Ten Commandments of God apply equally to them. Hygiene and morality complement each other. Such interdependence of the soul and the body leads to the fact that the causes of bodily ailments must be sought in the spiritual area, and vice versa. Judaism's concept of life and death follows directly from this principle. Respect for human life is complemented in Judaism by a respectful attitude towards the body of the deceased, since, being the physical shell of the soul, the human body requires respect even after death. This circumstance explains to us the severe restrictions that Jewish medical ethics imposes on autopsies and organ transplants.

According to Judaism, human life is absolute, sacred, and inviolable. Its value is infinite, for it is a gift from God. Therefore, according to the rules of Hebrew medicine, the doctor must fight for life until his last breath. This behavior is based on the idea that a person does not know everything and his verdict is not yet God's judgment. And when an inexorable and incurable disease suppresses the human word, the doctor must do everything possible to alleviate the acute, inhuman pain.

The concept of death and discussion among the Jews about the definition of the moment of its occurrence. The point of view of Jewish Law is strict and very specific. The definition of the moment of death, accepted by all Orthodox Jews, corresponds to that given by Rabbi Moshe Schreiber. He believes that death is characterized by immobility, cardiac arrest, and lack of breathing (ie, corresponds to the traditional concept of "biological death"). Death can be ascertained only in the presence of these three signs. The above definition of death was, for example, adopted by the General Assembly of French Rabbis, which adopted the following document on May 18, 1978:

“In the context of the existence of various laws and bills regarding the collection and transplantation of organs and tissues, the General Assembly of French Rabbis considers it their duty to recall the following principles of Judaism:

- the deeply sacred nature of life obliges that both society and individuals do everything for the salvation of human existence;
- according to Judaism, the signs of death are the complete cessation of the functions of breathing, circulation, and the nervous system;

in the absence of these three signs, it is not permitted to perform any of the many procedures usually performed immediately after death. Any action on a dying person is considered to have caused his death.

Unorthodox Jews tend to accept cerebral death.

Recently, because of the advances in technology, the Israeli Supreme Council of Rabbis agreed to accept brain death, including brain stem death, as the criterion for death. However, most Jewish leaders do not accept the criterion of cerebral death.

Organ transplantation and autopsy.[1] Judaism has a positive attitude to everything that allows you to save the life of any person, without any advantages of one over the other. Therefore, the life of the recipient cannot be considered more valuable than the life of the donor, even if it is doomed. Respect for a dying person requires that nothing be done to hasten his death, for such actions, regardless of the state of the dying person, are considered murder. Therefore, it is strictly forbidden to take a heart from a dying person before death, even if there is no chance of saving his life. Conversely, respect for the dying is manifested in not artificially prolonging his life for the sole purpose of gaining time to prepare the future recipient for surgery. On the other hand, in the case of a kidney transplant, for example, the question is no longer about permission, but in terms of the obligation. A person is obliged to help the one in danger and to put one of his organs at the disposal of the patient. Thus, it is allowed to come to the aid of a terminally ill person

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[1] Autopsy (autopsy, necropsy, section) (Latin Sectio - cutting) is a pathological-anatomical or forensic medical procedure, post-mortem autopsy and examination of the body, including internal organs. Usually performed to determine the cause of death.

by transplanting an organ taken from a living person, provided that the life of the donor is not endangered.

Taking organs from the deceased for subsequent transplantation comes up against three prohibitions:

- the body of the deceased cannot be an object of profit;
- it should not be mutilated in one way or another;
- the body of the deceased must be interred.

An autopsy is allowed to be performed:

- when it comes to saving human life;
- if there is the consent given by the deceased during his lifetime;
- if it is impossible to determine the cause of death in another way (with the participation of three medical specialists);
- in the interests of justice;
- to save the lives of others;
- to determine hereditary diseases to protect the health of close relatives or children.

However, an autopsy can only be performed if the following conditions are met: the doctors performing the autopsy must show

respect for the deceased (no smoking, no irrelevant conversations); at the request of the family, the operation can be performed in the presence of a rabbi; upon completion of the autopsy, the body and its parts are transferred to the funeral service for burial.

Abortion. Judaism regards the artificial termination of pregnancy as unnatural and argues that abortion and the unwillingness to have children are contrary to history itself and the messianic destiny of the Jewish people.

Sterilization. Judaism allows sterilization (for example, tubal ligation) because a woman is not obliged to participate in childbearing on an equal basis with a man. However, he has a negative attitude toward male sterilization. Since the duty of procreation lies mainly with the man, he is forbidden to take any steps to deprive himself of this opportunity.

Attitude to new reproductive technology. In the Talmud, in the treatise Hagigah 15a, it is said that if a virgin woman bathes in water containing sperm, then she can become pregnant. These words, written 1700 years ago, were taken as the basis for considering the possibility of artificial insemination. They form the basis for the legalization of the problem of artificial insemination. The vast majority of rabbis categorically condemn any insemination with donor sperm. However, if it is definitively proved that no other therapy is possible, then, as a last resort, fertilization with the husband's sperm is allowed. Today, any form of "borrowing your womb" from a barren wife is completely prohibited. The prohibition is motivated by the importance of the relationship between mother and fetus.

Euthanasia. According to Judaism, the lack of reliable diagnostic tools does not give the doctor the right to decide whether the disease is curable or incurable. Equally, he has no right to listen to the wishes of the patient, since a person does not have the right to dispose of his life and death. An injection made with the intent to end the patient's life, according to Judaism, is among the acts prohibited by law: "In everything that concerns him, the dying must be considered as a living person ..." (Joma 85 b).

Orthodox ethical tradition.

source of authority. For centuries, Orthodox medical ethics have been transmitted and interpreted, as a rule, by the Church, and not by the medical profession. ABOUT The basis of Orthodox medical ethics is the teaching of the Orthodox Church, which is attributed to a divinely revealed character. The moral authority extends only to religious authorities, among which more conservative Orthodox scholars tend to see the evidence of Holy Scripture and the Church Fathers, and more liberal-minded authors - and modern Orthodox authorities.

Main content. The approach of Eastern Orthodoxy to the problems of biomedical ethics unfolds in two major directions: 1) the protection of life and 2) the continuation of life.

1) Protection of life.

Orthodox ethics universally assert that life is a gift from God and, as such, is a necessary precondition for all other physical, spiritual, and moral values. As a gift from God, it is a moral good. Society and the individual are morally responsible for preserving, prolonging, and increasing the value of human life. The responsibility of the individual to preserve life means that people are not given the right to end a person's life. "Even exceptions to this rule arise from a situation where conflicting claims to live are mutually incompatible and a choice must be made."[1] Consequently, in Orthodox medical ethics, it is the protection and continuation of life that is the key argument in making a morally correct decision.

Abortion. Eastern Christianity's opposition to abortion has a long history. Her ethical views, contained in canon law, church books, and many ethical guidelines, condemn abortion as a form of murder. Since Orthodox Christians consider human nature as a psychosomatic unity, and life as a continuous and endless development of a person as an image and likeness to divinity, the achievement by the fetus of certain stages of development is ethically irrelevant to the issue of abortion. Thus, any abortion is considered by Orthodox Christians a sin, since it is evil. Orthodox ethicists reject those counterarguments that appeal to economic and social considerations since life is then seen as something less valuable than money or comfort. They disagree with justifying abortion because women have the right to control their bodies; Without denying the very principle of self-determination, the ethics of Eastern Orthodoxy reject its use as an argument that the fetus is only a part of the mother's body. The opinions of Orthodox ethicists on the question of the morality of considering the possibility of abortion were divided. The conservatively minded ethicists of Eastern Orthodoxy reject such a possibility (this concerns, first of all, representatives of the Russian Orthodox Church). [2] Liberal Orthodox ethics allow for the moral acceptability of considering abortion, but only if the development of the fetus endangers the life of the mother. In this case, in their opinion, the highest value is the preservation of the life of the mother. However, such a decision is assessed by them as falling into the category of "involuntary sins", when "the harm of the deed is recognized, but the guilt of the individual is mitigated."[3]

Organ transplant. The ethicists of Eastern Orthodoxy believe that in the case of organ transplantation, two decisive ethical points should be taken into account: firstly, the harm that can be caused to the donor and, secondly, the needs of the recipient. Historically, the Orthodox Church has not objected to such procedures, such as blood transfusions

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[1] Kharakas S. Orthodoxy and bioethics // Man. - No. 2 - 1994. - P. 91.

[2] Meletius Metropolitan of Nikopol. Abortion. - 3rd ed. - M., 1993. This position is taken by the representative of the Russian Orthodox Church, Archpriest Dmitry Smirnov. See: Save and preserve. - 3rd ed. - Moscow: Orthodox Medical and Educational Center "Life", 1995. - pp. 30-39, especially ss. 34-35.

[3] Kharakas S. Orthodoxy and bioethics // Man. - M., 1994. - No. 2. - P. 94.

and skin tissue grafts, since in both cases the life of the donor is not in significant danger, and the recipient is greatly benefited. Similar considerations are taken into account by Orthodox Christianity in the case of organ transplants. “Providing some organ, the loss of which could harm or threaten the life of a potential donor, is not an obligation or moral duty of the individual.” Those types of organ transplants should not be objected to if physical well-being and health are not at risk (for example, in the case of a kidney transplant). On the other hand, the recipient must be in good condition for the donor's risk to be justified. A special case is a heart transplant since there is a possibility of death of the donor. Even though many hierarchs of Orthodoxy reject heart transplantation since in church literature it is regarded as the receptacle of the soul, for the most part, they do not deny the fundamental possibility of such operations. However, until the success rate of such operations is very high and the phenomenon of tissue rejection is not well understood, the moral question regarding heart transplant operations remains unanswered.

Death and euthanasia. According to the traditional definition, death is "the separation of the soul from the body." In this understanding, death cannot be the subject of objective research, which means that the definition of medical criteria for death and the beginning of the process of dying is not the competence of theology. And yet some can distinguish between the attitude towards a terminally ill person. Physical life is traditionally understood as the ability of a person to maintain his vital activity. It follows from this that physical death begins from the moment of failure of the interdependent systems of the human body. Consequently, death occurs when the process of destruction of these systems becomes irreversible. For all the difficulty of determining when exactly the process of dying begins, the desire of the Church and doctors has always been to do everything possible to maintain life and in every possible way to prevent the onset of death. Therefore, surgical intervention, the medical use of drugs, and even artificial organs are considered appropriate, provided that the likelihood of timely assistance and the possibility of returning to normal life activity is sufficiently high. The situation is different when modern medicine can maintain the "life" of the human body with assistance in the complex use of artificial organs, drug treatment, transfusion, and other means. In such cases (especially when the absence of manifestations of brain activity is associated with somatic disorders), one can hardly expect the restoration of the vital functions of the body and we can confidently assert that the patient no longer lives in any religiously significant sense. In these situations, there is no moral obligation to continue using artificial medical devices.

The Eastern Orthodox Church practices an entire service dedicated to the dying. When death is delayed and attempts to die are futile, the key moment of the service calls to God to separate the soul from the body and give rest to the dying. However, this does not mean at all that the above considerations can be used to justify the practice of euthanasia. The fact is that “it is one thing to allow a dying person to die when there is no undoubted hope that life can be saved, and even to pray to the Creator of Life to take the life of a“ suffering to die ”, and quite another thing is euthanasia, which is an active intervention, with to end the life of another." [1] The most serious objections to the ethics of Orthodox Christianity are based, firstly, on the exceptional difficulty of drawing a line between “bearable” and “unbearable suffering”, given the great importance that Eastern Orthodoxy attaches to the possibility of spiritual growth through suffering;[2] secondly, elevating euthanasia to the rank of a right or obligation would lead to a direct contradiction to the basic ethical position that human beings are only the guardians of life, which flows from a source other than us.

2) Continued

In the ethical thought of Orthodox Christianity, the continuation of life is no less a fundamental duty of mankind than its protection. Not being the sole purpose of marriage, the continuation of life turns out to be the realization of the fulfillment of duty and moral responsibility.

Human sexuality. The Church teaches that human sexuality is a divinely given dimension of human life, which finds its embodiment in marriage. The purposes of marriage are not limited to the reproductive function. It should be emphasized that the goals of marriage and their classification by importance are for Orthodox authorities (both for the fathers of the church and for modern ones) a matter on which their opinions are divided, but the evidence of Holy Scripture and the fathers of the church speaks of four of these goals without classifying them

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[1] Kharakas S. Orthodoxy and bioethics // Man. - M., 1994. - No. 2. - P. 96.

[2] Rom. 8: 17-39. // Bible. Books of the Holy Scriptures of the Old and New Testaments. - M..: Ed. Moscow Patriarchy, 1976. - pp. 1234-1235.

according to their importance: (1) giving birth and caring for children; (2) mutual assistance of the couple; (3) satisfaction of sexual desire; (4) spiritual growth in unity and reciprocity, that is, in love. The full purpose of human sexuality is thus embodied in the interplay of these purposes ethically and humanely.[1]

Contraception. Birth control or contraception is the use of mechanical, chemical and other means, both before and after sexual intercourse, in order to prevent the fertilization of an egg by a spermatozoon, thus avoiding the consequences of sexual intercourse - conception and subsequent birth of a child. There is general agreement among Orthodox ethics on two points: 1) since one of the goals of marriage is the birth of a child, the couple acts immorally if they constantly resort to contraception as a means of avoiding the birth of a child and there are no extenuating circumstances; 2) contraception is immoral even when it promotes fornication and adultery. There is no unanimity on the issue of contraception in marriage to delay the birth of children or limit their number. Some writers of Eastern Orthodoxy take a negative view of this and consider any use of contraception, in or out of marriage, to be immoral. These authors tend to give the dominant value to the purpose of marriage for the birth and upbringing of children, and to consider any other manifestations of sexual activity as voluptuousness. For them, abortion and contraception are closely related and no distinction is made between them. Other Orthodox ethics question the exclusive focus of marriage on procreation.[2] They point to the incompatibility of the propaganda of abstinence in marriage with the biblical teaching about the purpose of marriage, including the possibility of the ethical realization of sexual desire, in order to avoid fornication and adultery. "This point of view certainly supports the use of contraceptives to delay the birth of children and limit their number in order to give more freedom to the couple to show their mutual love."[3]

Artificial insemination. Artificial insemination of an unmarried or married woman, but without the freedom and protection of her husband, is rejected by the Orthodox Church, firstly, as a form of fornication, and

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[1] Constantelos D. J. Marriage, Sexuality and Celibacy: A Greek Orthodox Perspective. - Minneapolis, 1975.

[2] Harakas S. Quote. Op.; Zaphiris Ch. The Morality of Contraception. An Eastern Orthodox Opinion. In: J. of Ecumenical Studies. - 1974, N 11. - R. 677-690

[3] Harakas S. Quote. cit., p. 98

secondly, as a form of adultery. Depending on when donor sperm is used and the husband gives permission, Orthodox ethicists are of the opinion that this means a third person's intrusion into the sacred marriage bond and reject it as a form of adultery. If a married couple is unable to have children, the other purposes of marriage are still on the move, and such a couple may decide to adopt a child. In cases of artificial insemination with the husband's sperm, opinions differ.

Some Orthodox ethicists are of the opinion that insemination with the husband's sperm (IHS) is unnatural, since the child is not conceived as a result of normal sexual intercourse. Stanley Harakas (professor of Orthodox theology at the Hellenistic College of the Greek Orthodox School of Theology of the Holy Cross) in the materials presented in the 5-volume Encyclopedia of Bioethics puts forward an argument refuting such a position, namely, IHS does not infringe on the integrity of marital relations and allows you to fulfill one of the goals of these relations. Orthodox ethics did not address the issue of artificially fertilized egg implantation and in vitro conception. Another topic little studied by Orthodox authors is sterilization: vasectomy in men and tubal ligation in women.

Muslim ethical tradition.

The rapid growth of problems associated with the progress of biomedical technologies in the West has led to the emergence of bioethics. The origins of the bioethical teachings of Western philosophy are undoubtedly of great importance in the formation and development of Islamic bioethics, associated with many of its concepts. However, the last 35 years, during which Muslim bioethics has been developing, have shown its features and priorities. They concern not only religious consciousness, but also social, cultural, philosophical, legal and other aspects. It should be noted the enormous role of Muslim bioethics in the development of global bioethics: we are talking about the importance in this process of great scientific, medical and philosophical heritage left by Arabic-speaking scientists of East and Central Asia. Undoubted recognition of this historical fact is the establishment by the Executive Board of UNESCO in 2004. Avicenna Prize for research in the ethics of science, as well as proclamation in 2007 by International Islamic Educational, Scientific and Cultural Organization (ISESCO) of Tashkent as one of the three capitals of Islamic culture. The program of honoring the capitals of Islamic culture was approved by ISESCO in 2001 and involves the annual election of three capitals representing three Islamic regions - Arab world, Africa and Asia.

The Eastern tradition of philosophizing, based on Islam, is syncretic (inseparability), and therefore, a doctrine of proper behavior of an educated person, “adabnoma”, was formed here. The ancient sources of Islamic bioethics include: Avicenna's "Canon of Medicine", "Adab Al-Tabib" - practical ethics of doctor Al-Ruhawi (Ishaq ibn Ali Al-Ruhawi), "Spiritual Medicine" - "At-Teb al-Ravani » Ar-Razi and many others who have become classics in annals of medical ethics. This knowledge continues to form spiritual basis in Islamic medical code, bioethics, environmental and biomedical ethics.

Syncretism of Eastern tradition of philosophizing gave rise to a term that has no analogues in European culture - "adab", the doctrine of proper behavior of an educated person - "adabnoma". It combines general education, the theory of morality and rules of conduct, which can be simplistically reduced to good breeding, with a formation of an ideal and perfect person in the East - “komil inson”. The fundamental methodological sources of Uzbek model of bioethics include: Central Asian codes of conduct "Kobusnoma" by Kaikovus, treatise "On ethics" by Ibn Sina, "Four conversations" by Samarkandi, "Code of decorum in the East" by Sadyk Kashgari and many others.

A distinctive feature of Muslim medicine was its ethics. Muslim hospitals served people regardless of creed, color or origin. The hospital staff treated all believers equally, whether they were Christians, Jews, or other believers. A Muslim doctor was called "hakim", which is translated from Arabic as "wise". Muslim doctors were deeply religious, they practiced with the name of God.

Considering classical sources, examples of medical ethics, spiritual basis of Muslim medical code.

Inspired by the ancient legacy of Hippocrates in the field of medical ethics, Ishaq ibn Al-Rukhavi, Ar-Razi, Ibn-Sina, Maimonides created an open system of moral values Adab al-Tabib. Unlike European neo-hippocratism, the value system of Adab al-Tabib is flexible and multifunctional. It can adapt ancient knowledge to the bioethics of the 21st century.

Back in the 9th century, a physician Ishaq bin Al-Ruhawi wrote the first treatise on medical ethics, Adab al-Tabib. In this treatise, Ruhawi refers to doctors as "guardians of soul and body", here he observes and analyzes the deeds and actions of a Muslim doctor. Al-Rukhavi, in his work did a lot for the "humanization" of medicine, taking into account the problems of relationships with patients.

He believes that the goal of a doctor is to bring good and good to human race, relatives, friends and even our enemies. God has taken an oath on doctors not to invent poisons.[1] Al-Ruhawi quotes Aristotle, Socrates, Galen, Hippocrates and supports their ideals, but Adab al-Tabib, first of all, is a text built on Muslim traditions and beliefs. Adab al-Tabib is not only a guide to professional ethics, but contains important information about personal hygiene, the patient doctor, clarifies the relationship between the profession and society.[1] Adab al-Tabib consists of 20 chapters, which are divided into 3 categories: 1) behavior of a doctor, 2) behavior of a patient, 3) attitude of general public towards a medical profession and towards patients. The content of Adab al-Tabib covers the doctor's personal beliefs and practice, emphasizing his faith in God, personal health and hygiene, and his manner of dealing with colleagues and patients. Al-Ruhawi emphasizes the importance and role of the authority and respect of patients, even though the doctor has to cancel the patient's wishes when it is necessary for his health[2]. He says that doctors should be high in the social hierarchy, they should be well paid so that the doctor does not look for some other job, but doctors should not flaunt their wealth. Al-Ruhawi says the costs charged to wealthy patients should be sufficient to cover the costs of poor patients who cannot pay for themselves, and medical care should be equally good for the rich and the poor.[3]

In Adab al-Tabib, al-Ruhawi talks about legislative practice and punishments for lies and incompetence of doctors. Inspired by the work of Galen, he advocates the practice of medical examinations and

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[1] B.A.Zikria. Medical Ethics of Medieval Islam with Special Reference to Al-Ruhawi's Practical Ethicsof the Physician", Vol. 57, Part 3,1967 translated by Martin Levey

[2] Hassan Chamsi-Pasha, FRCP (Glasg), FACC, Mohammed A. Albar, MD, FRCP. Islamic medical ethics a thousand years ago www. smj.org.sa Saudi Med J 2013; Vol. 34 (7) P 673-675; Aksoy S.The religious tradition of Ishaq ibn Ali al-Ruhawi: the author of the first medical ethics book in Islamic medicine. JISHIM 2004;3:9-11

[3] Hassan Chamsi-Pasha, FRCP (Glasg), FACC, Mohammed A. Albar, MD, FRCP. Islamic medical ethics a thousand years ago www. smj.org.sa Saudi Med J 2013; Vol. 34 (7) P 673-675; Aksoy S.The religious tradition of Ishaq ibn Ali al-Ruhawi: the author of the first medical ethics book in Islamic medicine. JISHIM 2004;3:9-11

licenses. He encourages physicians to keep a record of a patient's symptoms, treatment, and recovery. Al-Rukhavi admits that survival of patients is not always manageable, and if the situation develops in such a way that the patient is doomed, then in this case he should die under a care of a doctor. Al-Ruhawi suggests extreme punishments for doctors that allow patients to die due to their negligence, incompetence, up to and including the death penalty.

Another great physician, philosopher, scholar of Islamic civilization, Abu Bakra Muhammad ibn Zakariya al Razi (865-925), wrote more than 200 books on various sciences[1]. In the history of Islam, Razi is considered the only physician who can be compared with Abu Ali ibn Sina. Al-Razi is indeed a unique phenomenon in Islamic civilization, rarely seen in history. He was a doctor, scientist, teacher and humanist. [1] Al-Razi lived his life serving Islam, science and humanity, died at the age of 60 in Shaaban. Al-Razi was not only a therapist, but also a surgeon with great experience. The most famous book in the history of Islam on medicine Al-Hawi is Al-Hawi fi elm al-tadawi or “The encompassing Book on Medicine”, which includes various studies and clinical observations of Al-Razi in Baghdad and Ray. The works of Al-Razi "Al Khawi" and 10-volume "Medical book dedicated to Mansur" - "Al-Tibb al-Mansouri" (named after Mansur Ibn-Ishaq, the ruler of Khorasan), consider various medical issues in internal medicine, surgery and ophthalmology. "Al Khawi" and "Al-Mansuri" are original medical encyclopedias in Arabic. Many authorities in the field of medicine consider the latter to be the largest and oldest textbook. Translated into Latin, they served as a guide for physicians for several centuries. Razi wrote a book for general public, "Medicine for those who have no doctor" ("Man Layuzaruh ut-tabib") is a general course of medicine. The book deals with various medical issues in internal medicine, surgery and ophthalmology. Al-Razi intended to keep it concise, although it ended up being ten chapters. Many European scholars were motivated to translate the book into different languages such as Latin, English, German and Hebrew.
It was first circulated in Milan in 1481 AD and remained a key reference text for European physicians well into the 17th century. Muhammad ibn

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[1] Karaman H. Abu Bakr Al Razi (Rhazes) and Medical Ethics. Ondokuz Mayis University Review of the Faculty of Divinity 2011; 30: 77-87.

Zakariya al-Razi was the first physician in history to describe in detail the symptoms and signs of smallpox and measles on the basis of a clinical examination, explain necessary prophylaxis of these diseases, and he was the first to distinguish between these two diseases, making so-called differential diagnosis. In the Book of Smallpox and Measles (Kitab al-Jadari wa 'l-Hasba - The Book on Smallpox and Measles), he first spoke about infectious diseases and described night blindness. This book was reprinted in Europe four times between 903-1283. AD (1498-1869 A.D.) He also wrote a book called "Al-Asrar fi al-Kimyaa" or "Secrets of Chemistry", which for many years remained a fundamental reference book on chemistry in Eastern and Western schools. He also wrote another book called "At-Teb ar-Rawani" or "Spiritual Medicine", which aims to encourage people to respect reason, suppress whims and reject immorality in order to discipline the soul. Al-Razi's philosophical concept is based on the doctrine of five eternal principles: "creator", "soul", "matter", "time", "space". The atomism of Ar-Razi is close to the atomism of Democritus. It is said that Razi was a friendly and generous physician. He did not let the sick go until he diagnosed the disease, he was very friendly towards the poor and provided them with free medicines and food. He could accumulate a huge fortune, but did not strive for this, he was absorbed in the study of sciences. Al-Razi was devoted to his friends and acquaintances, sympathized with the poor and the sick, providing for them, and in some cases providing them with work. He advised his students to be guided primarily by caring for patients, and not by financial reward. He also urged them to give equal attention and care to the poor and the rich. His interest in the treatment of the poor led him to write a book called "Teb al Fuqaraa" or Medicine of the Poor. In it, he described various diseases and symptoms that afflict the poor and suggested various herbal and nutritional treatments in place of expensive drugs. This interest in ethics prompted him to write a book called "Ahlak al-Tabib" or "Doctor's Ethics" in which he detailed the relationship between doctor and patient. Al-Razi's book Akhlaq al-Tabib presents a model of Muslim medical ethics. It is important for a doctor not only to be a professional in his field, but also to be an example in all respects. His ideas in medical ethics were divided into the following concepts: the doctor's responsibility to the patient, the patient's responsibility to himself, and the patient's responsibility to the doctor. According to Al-Razi, a doctor, while practicing, should continue to engage in his education, strive to acquire new knowledge. He recommends that physicians be virtuous, humble, and strive to earn the respect of their patients. The doctor has obligations to patients. First of all, showing compassion, one should be attentive, kind. Following the Hippocratic Oath, Ar-Razi believed that the doctor's second duty was to keep secret what he learned in the process of treating his patients. Another duty of a doctor is to provide moral and psychological support to a patient in every possible way, to inspire him with hope for recovery, even if there is none. The doctor is obliged, according to Ar-Razi, to treat all patients equally, regardless of their social status. The goal of healing should not be money, but treatment itself and health of a patient. Physicians should be attentive to the treatment of the poor and the homeless. On the other hand, the patient also has obligations to the doctor.

Abu Ali Al Hussein Ibn Abdullah Ibn Sina (980–1037 AD), was born in the village of Afshona near Bukhara. Referred to in Western sources as Avicenna, this outstanding physician (who was also a poet, politician, philosopher and mathematician) is inscribed in annals of the history of Islamic medicine. Humanistic orientation of philosophical teachings of Ibn Sina, his ideas concerning problems of man and interpersonal relations, are closely intertwined with the philosophical system of Aristotle. Having adapted in the cultural space of Eastern thought everything valuable that was in the philosophical teachings of Greek philosopher, Ibn Sina was able to create a teaching on this basis that inscribed a new page in the history of the peripatetic school. A complex of views on the problems of man and interpersonal relations of Ibn Sina includes not only such sciences as ethics, politics and economics, designated by scientists as areas of practical philosophy that study various states of the relationship between man and society. These ideas are also reflected in other parts of his multifaceted teachings: physics (the doctrine of the soul), metaphysics (about the origin and essence of man), medicine (the biological and psychological aspects of human nature) and in other areas. In his writings, such as "Healing", "Philosophy of the Easterners", "Danish-name", as well as in a specially written treatise "On the classification of rationalistic sciences" ("Gift of axomi ulumi aklia"). Ibn Sina divides philosophy into two parts: practical and theoretical. Theoretical philosophy was mainly called upon to sanctify the universal principles of being, the substantive foundations of natural bodies and processes. Practical philosophy was focused on solving the pressing problems of man, on determining his place, vocation and purpose in this world. Consideration of human issues, i.e. the identification of the socio-political and moral essence of a person is carried out mainly within the framework of practical philosophy, which includes: politics, economics (or housekeeping) and morality. Ibn Sina divides practical philosophy into three components, each of which deals with the "arrangement of man" in accordance with his destiny. On this issue, he basically repeats his previous statements, changing only the sequence of sciences in the general qualification system. Thus, Ibn Sina devotes the first part to ethics, or, as he calls it, “Education of morality” (Tahzibi akhlok). Thanks to her, “a person should know what morality he will acquire, what features he should be endowed with, and what actions he should perform in order to achieve happiness in earthly and heavenly lives.” The best guide in this, the scientist believes, can be Aristotle's book "Nicomachean Ethics". The author of many works on medicine, philosophy, as well as poetic works, most of which are written in the form of a rubaiyat. The poem about medicine (Urjuza), written by Ibn Sina, is still alive today. Her place of residence is the Institute of Oriental Studies of the Academy of Sciences of Uzbekistan (Tashkent). This is the second largest and most important medical work of Ibn Sina after the famous "Canon of Medicine". In the 12th century, the poem was translated into Latin, and later into many other European languages. It immediately catches the eye that the poem was written by a philosopher doctor, an encyclopedist, a man of the most extensive knowledge, a philanthropist, primarily concerned about not harming the patient. The advice of the great doctor has not lost its significance even today. Ibn Sina also developed his own teaching on the temperament and character of a person - the theory of mizaj. The main work of Ibn Sina is "Canon of Medicine" in 5 books, which is a synthesis of ancient, Indian and Central Asian medicine based on canons of Islam. Ibn Sina, a creator of "Canon of Medical Science", considering various aspects of medical activity, emphasized the uniqueness and individuality of those seeking medical help: "... Each individual person has a special nature inherent in him personally." In his famous “Canon of Medical Science”, he presents the art of medicine as an integral theoretical and practical knowledge, focusing on an integral vision of a person as a spiritual and bodily being. The theoretical basis of this work is a system of Galen, which made it equally in demand both in Islamic countries and later in European universities.

Ibn Sina's treatise is characterized by an accentuated attention to the humanitarian, psychological and moral aspects of healing. Ibn Sina is also credited with saying: "The doctor must have the eye of a falcon, the hands of a girl, the wisdom of a snake and the heart of a lion." One of the main ideas of the "Canon of Medicine" is the need to prevent the disease, to which the efforts of the doctor, the patient, and the healthy should be directed. According to his teachings, human nature is divided into four simple types: hot, cold, wet and dry (which in modern psychology corresponds to four temperaments). These natures are not stable, but change under the influence of internal and external factors, such as meteorological conditions and the change of seasons. Changes in body fluids can also correct nature in the appropriate direction. In addition to simple natures, Avicenna distinguished four more complex natures, depending on the prevalence of one of four body fluids (blood, mucus, yellow or black bile). The first book of "Canon" covers the theory of medicine (anatomy and physiology), as well as the principles of hygiene: proper nutrition, physical activity, water procedures. Ibn Sina emphasizes hygiene of children, pregnant women, and the elderly. Ibn Sina's physiological ideas are based on the humoral theory and the doctrine of temperaments. The 2nd and 5th books are devoted to pharmacology: the 2nd - simple drugs, and the 5th - "complex" drugs, poisons and antidotes.

"Canon" describes more than 800 medicines with an indication of their action, methods of application, rules for collection and storage. Ibn Sina played an important role in the development of the science of drugs: he formulated the basic principles for testing drugs, including animal experiments and observation at the patient's bedside; described the possibility of interactions between several drugs and possible side effects, as well as chemical methods for their preparation. The 3rd book describes individual diseases, their diagnosis and treatment. "Canon", in particular, contains a classic description of rabies, leprosy and a number of other diseases. The 4th book is devoted to surgery (dislocations, fractures, abscesses, tumors) and general diseases of the body (fever, contagious diseases, skin diseases, cosmetics, the doctrine of poisons). The Treatise on Ethics (Risala fi-la-akhlak) enumerates the good and bad moral qualities of a person. It was medical activity that helped the scientist to get closer to the life of ordinary people, to find out their needs and sufferings.

So, both the work of Al-Rukhavi Adab al Tabib and the work of Al Razi Akhlaq al Tabib, Canon of Medicine of Abdullah Ibn Sina, are excellent illustrations of problems of professional responsibility and ethical dilemmas that are still relevant in medicine today, these are undoubtedly one of the most outstanding achievements of medicine in the Eastern Renaissance era. With an in-depth reading, these works can provide guidance not only for enriching the theory of bioethics, but also serve as a guide to action, work as a mechanism for humanization of modern medicine and healthcare. Bioethical basis laid down in them, in which medicine and a decent lifestyle constitute a single philosophy of health today, not only has not lost its relevance, but in many respects is ahead of our ideas about the ethics of a doctor. Arming the doctor with knowledge about laws and principles of transformation of spiritual principle in a person, Al-Rukhavi, Al-Razi and Ibn Sina create a philosophical basis for the behavioral standards of both the doctor and the dying patient. Unlike Christianity, Islam regulates all spheres of life, determines not only cultural, social, legal issues, but also penetrates into the interpersonal relations of members of Muslim community. Currently, public, legal, economic aspects of ethical issues, key problems of bioethics in the field of healthcare, medicine and biomedical technologies in the context of Muslim faith are being studied.

Bioethical research is actively ongoing in Iran, where Sharia law is the law of the state. At the end of the 20th century, a package of documents was adopted in Iran concerning the issues of transplantation, criteria for brain death (in 2000), and therapeutic abortion (in 2005).

Modern Muslim medicine and bioethics are developing within the framework of enlightened Islam and medical ethics. However, despite the current practice of Muslim bioethics, there are problems and contradictions, starting with the recognition or non-recognition of its status.

The world religion of Islam has common sources: Koran, Shariah and Hadith. Muslim medical ethics, both in the past and today, rely on the tradition of Islamic law. At the same time, some existing internal differences in the philosophy and theory of Islam, its legal schools should be taken into account. Consequently, there are differences not only external, with the main Western philosophical theories, perspectives on medical ethics, but also internal, due to different trends in Islam itself. Therefore, before considering the main principles of Muslim morality used in the field of biomedical ethics, it is necessary to point out the various sources of Islamic law.

1) The sources of Islamic law.

Sharia is a set of canonical Islamic laws covering all aspects of creation. Sharia is based on:

- Koran is the holy book of Muslims;
- Hadith - stories about the deeds, deeds and words of the Prophet Muhammad. In addition, lawyers use the following sources of Islamic law:

"Istislah" - common interests;

"Paradise" - own opinion;

"Kiyas" - judgment by analogy;

"Ijtihad" - the ability and right of interpretation

2) The principles of Muslim morality in relation to biomedicine.

The biological revolution of the last decades has posed new serious problems for man. What is the attitude of Muslims to these problems? The absence of the institution of clergy in Islam makes it difficult to find an answer to this question: the believer himself is responsible for the decision. "Ijtihad" allows a believing Muslim to comprehend the problem and change his attitude towards it, taking into account the new circumstances that arise in connection with the tremendous achievements of medicine, biology and biotechnology.

Key elements of biomedical ethics in Islam are the concepts of human personality and death. The concept of human personality determines the believer's attitude to such an act as a voluntary termination of pregnancy or childbirth with the participation of medicine. Related to the definition of death is organ transplantation, especially when it comes to the vital organs of a deceased donor. The same definition is associated with the choice in relation to intensive care and euthanasia.

Study of Key Problems of Bioethics in Islam: Modernity

The study of the key issues of bioethics in the context of the teachings of Koran, Shariah, Hadith, (with the involvement of a large historical experience in the field of medicine, achieved in the era of Muslim Renaissance by Arab and Central Asian scientists), began to transform at the end of the twentieth century in relation to delicate and complex medical and biological problems in code of Islamic medical ethics and bioethics. In the history of development of Islamic bioethics, as a new form of scientific knowledge in the twentieth century, a creation of Islamic organization of medical science IOMS and holding of the first (1981, Kuwait) and the second conference of Islamic organization of medical sciences in Kuwait (1982), where the code was adopted, are of great importance. Islamic medical ethics. The adoption in 1982 at the second international conference of the Islamic organization of medical science of the code became the starting point in the development of Islamic bioethics.

The code consists of thirteen parts, which combine the ancient and modern ethical teachings, the traditions of Eastern medicine, Islam, and philosophy. The code defines the medical profession, the doctor's oath, regulates doctor-doctor relations, doctor-patient relations, doctor-society relations, doctor and biotechnological progress, medical secrecy, doctor's duties and responsibilities in wartime. Particular attention is paid to the sanctity of human life, medical education, topical issues of Islamic medicine. Here are some provisions of doctor's oath:

- a doctor has certain obligations to society, patients and colleagues;
- a physician must uphold the honor of a medical profession;
- such qualities as sincerity, compassion and sympathy, patience and modesty are inherent in a doctor;
- a physician must obtain the patient's informed consent and the woman's consent;
- all the time of practical activity should be accompanied by continuous medical education.

Compared to Western bioethics, which has a strong emphasis on human rights, Islamic bioethics is based on the obligation to preserve life, seek all kinds of cures, and the rights (of God, society, the individual) are reflected in bioethics as human dignity (Ihsan).

Islam is open to scientific knowledge, as evidenced by Qur'anic verses and the traditions of the Prophet:

“... you need to go to study, seek knowledge, no matter how far it may be, even if you have to go to China”;

- “The ink of a scholar is more sacred than the blood of a martyr. The acquisition of knowledge is obligatory for every Muslim, whether it be a man or a woman.”

- Say: "My Lord, increase my knowledge." (Taaha 20:114)

Islam requires a patient to behave rationally and seek appropriate treatment, requires medical personnel to strictly fulfill their mission of protecting and saving lives:

- “And the one who saves this soul will, as it were, save all people from death. (QUR'AN. 5:32. Translation of meanings by Valeria Porokhova)

Islamic medical ethics has become an important component in international ethical discussions and at the III World Congress in 1996 in San Francisco there was a section "Islamic Bioethics", where Muslim scientists spoke.

One of the famous researchers in the field of Islamic bioethics, whose works have received worldwide recognition, is the 2005 Avicenna Prize winner Professor Abdallah Daar. He made a significant contribution to the study of the complex issues of bioethics in Islam. Among the most important events that have been significant in the development of Islamic bioethics is a publication of Guide to International Ethical Principles Including Human Biomedical Research (in the Perspective of Islam), Geneva, 2004. The guide was prepared and published by the Council of International Organizations for Medical Sciences (CIOMS) in cooperation with WHO and Islamic Organization for Medical Sciences (IOMS) in Geneva in 2004.

The general principles of professional ethics for a Muslim physician stipulate that all research with human beings must be conducted in accordance with three basic ethical principles, namely, respect for individual autonomy, generosity, and legality. Each ethical principle is accompanied by commentaries from Koran or principles, laws of Islamic jurisprudence, which confirm this principle. When involving representatives of vulnerable contingents (minors, persons with impaired mental capabilities, disabled people, terminally ill patients, patients in a coma, etc.) to participate in the study, they should also be given the opportunity to choose whether to participate or not to participate (to the extent as far as they can do it). Their objections must not be ignored, their rights must be carefully defended. Each group of such persons must be considered separately.

Respect for individuals includes obtaining informed consent from third parties (such as a witness) to participate in a study in order to enhance the protection of subjects' rights. Consent to participate must be voluntary. Violence or undue pressure to obtain consent to participate in the study is unacceptable, especially among representatives of vulnerable contingents. Here are some comments from Qur'an given in the Guide.

In the rules of Islamic jurisprudence:

- "Any act that is harmful or interferes with benefit must be prohibited."
- "Obligatory prevention of greater evil when lesser of two evils is chosen."
- The law of Islam calls for the recognition, prevention and reduction of harm.

Ethical requirements are a prerequisite for research, they are part of research management and a criterion of research quality, which should not become an obstacle. This condition requires new and additional qualities on the part of the researcher, requires special education (bioethics, biomedicine) and training of researchers. Therefore, not everything that can be done in terms of scientific and technical possibilities can be ethically allowed.

Currently, social, legal, economic aspects of ethical issues of key problems of bioethics in the field of health care, medicine and biomedical technologies are being studied in the context of Islamic dogma.

Muslim bioethics is developing dynamically, mobile. It is not limited solely by the aspect of dogma, but integrates and transforms the most important international documents (Nuremberg Code, Declaration of Helsinki, Universal Declaration on Bioethics and Human Rights, etc.).

Over the past 35 years, such issues of bioethics in Islam as organ and/or tissue transplants, criteria for brain death, principles of care and technologies in the intensive care unit, problems of reproductive technologies, cloning, genetically engineered biotechnologies, AIDS have been put on the agenda and considered providing psychiatric care, etc. International conferences were held by Islamic Organization of Medicine (IOMS) in Kuwait, Istanbul, Karachi, Cairo, etc. Various key issues of bioethics, the rights of the child are considered, attention is paid to spiritual development, the moral component of medical educational programs in order to prepare a Muslim doctor with their help.

Muslim jurists regularly meet to discuss ethical issues related to the progress of biomedical technologies: the problems of organ and / or tissue transplantation were considered at the third symposium on medical law (1987), at the fifth international conference of Islamic medicine in Cairo (1988), etc.

Modern Muslim medicine and bioethics are developing within the framework of enlightened Islam and medical ethics. However, despite the current practice of Muslim bioethics, there are problems and contradictions, starting with the recognition or non-recognition of its status.

The position of conservatively minded part of Muslim scientists (for example, Omar Hasan Kasule) is that they justify the emergence of bioethics in the West, its concepts, theories, principles not by the rapid development of biomedical technologies, but exclusively by secularization. Therefore, they believe, bioethics is neither a law that would represent a force for the government nor a moral force - conscience, it does not have the status of a science. As Omar Hasan Kasule believes, Islam looks at the problems of the experiment with a person as purely legal issues, since Sharia law provides for adequate principles and guarantees, because Islamic law (Sharia), unlike Western law, includes both law and morality in its fabric [1].

In Islam, all actions are divided into obligatory, recommended, permitted, condemned and forbidden. Therefore, under special circumstances, especially when the question is about life and death, even the forbidden can be allowed.

Islamic medicine is eclectic, choosing the best, modern, affordable medical technologies that are compatible with the spirit of Shariah and Islamic society. Lawyers seek and find answers to solve the problems posed by modern life. Auxiliary concepts are aimed at combining with the guidelines of Sharia so that Muslim patients can use modern medical methods and technologies for the benefit of their health, without violating the principles of Islam. The syncretism of Eastern tradition is also expressed in the fact that many Muslims, including those in the secular states of our region of Central Asia, strive to adhere to their religion in almost all spheres of life. They mention the name of Allah every day, live according to the instructions of Koran, the instructions of

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[1] Omar Hasan Kasule. Medical ethics from maqasid al shari'at.//Jimasa volume12, #3 2005. P 2-4

the Prophet and believe that their deeds are counted, that they will be judged at the Last Judgment. Despite the fact that concessions are made to individuals in the status of a patient, nevertheless, many try to adhere to the Muslim lifestyle. Hence the relevance of a deep understanding of Islamic bioethics by doctors, which can improve the quality of treatment for this large population.

The states of Central Asia are secular states, but believers of various faiths live here. Therefore, it is very important to take into account the socio-cultural realities of one's own historical and national traditions, to study the experience in making decisions on key issues of bioethics in world practice in the context of not only Muslim, but also other faiths.

Bioethics today is a socially significant field of knowledge that develops standards for the ethical and legal provision of human well-being in the field of healthcare, medical science, education,

The concept of cerebral death. In Muslim countries, the definition of cerebral death is strictly approached. Cerebral death means the final and irreversible stop of the activity of the brain (hemispheres and brain stem) with the complete destruction of its cells. With cerebral death, with the help of artificial ventilation, it is possible to maintain the vital activity of other organs.

Some ethical problems of reproductive technologies.

The main ethical problem associated with reproductive technologies is the question of the status of the embryo, about from what point in its development it is a person who has the right to protect his life and human dignity. Is the use of selection of “extra embryos” in IVF — and in general the production of excess embryos that cannot be transferred into the uterine cavity — the very concept of “life” and is a moral bar of our society lowered? In Islam, it is considered necessary that the problem of the prolonged absence of children in the family be solved within it, that is, without the use of donor sperm or eggs.

Otherwise, there is a violation of both the pedigree and the genetic code of a particular family. Islamic theologians and jurists compare this problem with the issue of adoption. Holy Qur'an forbids adoption when adopted children take the surname of their stepfather. “Speak to them according to their fathers. This is more just before God. And if their fathers are not known to you, call them your brothers in faith” (Holy Quran, 33:5). Donation in the matter of pregnancy (the use of donor sperm and eggs) is seen as an unusual form of adultery, since in both cases it is not clear who is the true father or mother of the unborn child, pedigrees are mixed. What is the ontological and moral status of the embryo?

At what stage in the development of the fetus should he be considered a human being? To what extent does he have human rights? In the literature on bioethics, the question of at what stage of development of the embryo should it be considered a human being, various answers are given: from the moment of conception, when the uniqueness of the future human in genetic terms arose; from the 14th day, when, under conditions of natural development, the implantation of the embryo into the uterus occurs and when the actual germ cells are released (“primary streak”); after the 30th day, when the differentiation of central nervous system begins; from 7-8 weeks, when the embryo begins to respond to stimuli; after 7 months, when the sucking reflex is formed and the fetus acquires the ability to live outside the mother's body. **The general view of the Muslim tradition on the status of the embryo is expressed in the fact that full human life with its rights begins only after the accomplishment of "ensoulment"[1],** although there is some other form of life that exists before the angel breathed the soul into the embryo. Based on the interpretation of approaches in Qur'an and hadiths of the Prophet, Muslim scholars agree that this concept of ensoulment occurs approximately 120 days (4 lunar months plus 10 days) after conception. In verse 228 of the second sura of Qur'an, it is said that a divorced woman cannot remarry before 90 days, thus avoiding doubts about paternity. A widowed woman should, for the same reason, wait 130 days, or 4 months and 10 days, before remarrying. By setting a period of 90 to 130 days (from 3 months to 4 months and 10 days), the Qur'an indirectly determines the period during which the fetus takes the form of a person. Based on these provisions of the Koran and based on the tradition of the Prophet Muhammad, according to which God breathed a soul into the fetus at 3 months and one week, Muslims conclude that “the embryo as a human person can really be spoken of starting from the first week of the fourth month , i.e. on the hundredth day of pregnancy.

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[1] When an angel breathed a soul into an embryo.

Other scientists, perhaps a minority, believe that this happens after about 40 days. Muslim legal scholars have somewhat different views regarding abortion. Abortion is allowed after implantation and before the ensoulment of the embryo occurs, in cases that relate to legal or medical reasons. Acceptable causes include rape.

However, many Shiites and some Sunnis generally forbid abortion at any stage after implantation, even before ensoulment, if the mother's life is not in danger. Abortion after ensoulment is strictly forbidden by all authorities, but the vast majority make an exception in order to preserve the mother's life. If in a dilemma the choice must be made between saving the life of the mother or the embryo, then the mother's life is given preference. It is considered as a root, and the embryo as a twig.

A Muslim tradition, says Natal Abul Fadl Mohsin Ebrahim, professor of theology at Islamic University of KwaZulu, in his study Abortion, Birth Control and Surrogacy: An Islamic Perspective, presents some diversity of views on the issue of abortion and the status of the embryo in different schools of Islam. He points out that the most flexible position regarding abortion among the various legal schools of Islam (madhhabs) is noted in Hanafi school. Here, before the fourth month of pregnancy, an abortion can be performed if the pregnancy threatens the life of the mother. Maliki position forbids abortion after implantation has taken place. Shafiites support the ban, calling abortion a crime if the fertilized zygote is violated. The Hanbali school, while specifying the cause of miscarriage, considers abortion to be a sin. After ensoulment, in which the embryo is considered to have equal rights with the mother, the dilemma is resolved by the general principle of Shari'ah: choosing the lesser of two evils. Without losing both lives, it is the life that should be given preference - that is, the mother's life. Referring to the Qur'anic tradition (5:32) of protecting the sanctity of life, A.F. Mohsin Ebrahim concludes that every person has the right to be born, the right to live as long as Allah allows. The right to life in Islam is absolute.

Childbirth with the participation of medicine. There are various ways of artificial childbearing.

- Artificial insemination. This method consists in introducing sperm directly into the uterine cavity. It is resorted to with the sterility of one of the spouses. According to Muslim laws, the use of this method is allowed only if the sperm donor is a legal spouse.

- In vitro fertilization and embryo transfer (for women suffering from obstruction of fallopian tubes). Fertilization is carried out outside the body, and 48 hours after fertilization, an egg is formed and this embryonic germ is implanted in the mother's uterus. Then the pregnancy proceeds in the usual way. According to Islam, in vitro fertilization is considered legal only if the sperm of woman's husband is used for it.

What is said about artificial insemination, which method is allowed, and which is considered forbidden? Is it possible for believing Muslims to use these methods? To answer these questions, the ulema of Uzbekistan conducted studies on this issue. In particular, the head of the fatwa department of the Muslim Board of Uzbekistan, Khomijon Ishmatbekov, took part in the second meeting of the Council on Fatwas of Eurasian Islamic Union, held in Istanbul on December 16-17, 2017. The agenda of the meeting included issues related to artificial insemination, artificial insemination. Having studied all aspects of this issue, the scientists of the Muslim Board of Uzbekistan published a fatwa "On artificial insemination." “In recent years, in our country, couples who cannot have children, in order to save their families and have a child, have expressed a desire to turn to the practice of artificial insemination. It became known that some even had a child in this way. It should be noted that the practice of artificial insemination, not knowing the requirements of Sharia and not observing them, leads to some moral, social and religious problems. As stated in the text of the fatwa, in particular, “opportunities are opening up for women who want to have a child without getting married; secondly, the number of children born out of wedlock will increase; thirdly, there may be situations of mixing the pedigree (origin), ignorance of who is the mother of the child; Fourthly, trade in fertilized eggs or non-fertilized eggs and seed cells can become a source of income.”

“Considering the above, Muslim Board of Uzbekistan announces this fatwa.

1. The use of artificial insemination is allowed only in extremely necessary cases for married couples who were married in accordance with Muslim traditions - nikoh.

2. In the course of artificial insemination, when storing the semen of men and women who were in a Sharia marriage, all precautions must be taken to prevent mixing of the semen of strangers. Also, this operation must be carried out by a qualified doctor.

3. It is forbidden to use artificial insemination for couples who are not in a Sharia marriage.

4. Muslims who are not indifferent to the preservation of the purity of their ancestry should not use prohibited methods of artificial insemination,” the document concludes.

“**Carrying someone else's child**. There can be two cases here:

1) If a woman's ovaries are functioning normally, but she is unable to bear a child, one or more eggs can be taken from her to be fertilized in vitro with her husband's sperm. The fetus obtained in this way is placed in the uterus of another woman after 48 hours, who gives birth to a child after 9 months. Since Islam recognizes polygamy, the gestating mother can be the second wife of her husband, who will give her sperm to fertilize the first wife's egg.

2) Islam forbids this method of childbearing if the egg does not belong to the wife of her husband or if the child is carried by an outside woman.

So, Muslim religion allows resorting to artificial childbearing with the intervention of medicine only to legal spouses and subject to the following conditions:

- it is necessary to know the donor of germ cells in order to exclude incest and ensure legal family ties in accordance with Islamic law;
- the mutual voluntary and conscious consent of the legal spouses is required.

Prenatal diagnosis. Great success has been achieved in this area, giving rise to a number of issues of a legal, economic, ethical nature. Another problem arises: should such a diagnosis be carried out before in vitro fertilization in order to ensure the good quality of the embryo. In this case, it is easy to slip into eugenics, which is condemned by the morality of all religions. The traditional method of prenatal diagnosis is a **cytogenetic analysis** with the establishment of the karyotype of the embryo, carried out on cells taken during amniocentosis (can be performed at 14 or 15 weeks).

A new method (1980) - **trophoblast biopsy and molecular hybridization** - consists in selecting a particle of the chorionic villus through the vagina, which has the same genetic material as the embryo. It allows prenatal diagnosis at 5 or 6 weeks. If a genetic anomaly is found in the fetus, then the question of voluntary termination of pregnancy at 9 or 10 weeks can be considered, that is, under more favorable conditions.

Some problems in the field of organ and/or tissue transplantation in Muslim bioethics.

From the point of view of Muslim public, it is pointless to interfere with the actions of nature in relation to imminent death. If active medical intervention in the case of a severely brain-damaged patient results in further suffering for the patient and those associated with him in society (relatives or the Republic of Uzbekistan), the ensuing harm cannot be ignored. However, there is no reason in Islam to put an end to human life just because of the suffering of the family and the patient.

In Muslim culture, until recently, when modern medical technology did not recognize the difference between the cessation of brain and cardiorespiratory functions, the announcement of death was based on criteria provided by the viability of the interconnected systems of the human body. The concepts of cerebral death and brain death are neologisms in Muslim society, which perceives death as the cessation of vital functions in a certain organ system, and not a part of the body.

Complete cessation of the heartbeat is considered by Muslim jurists to be a sufficient criterion to declare a person legally dead. The problem arose when modern medical technology gained the ability to maintain the functions of life through respiratory support in the patient's brainstem. The patients were alive according to the traditional definition of death. Accordingly, another equally important issue of organ transplantation was raised.

Long discussions in Muslim society continue to this day. In Iran, in 1995, the adoption of the current criteria for brain death on the basis of the principle of no harm was rejected, but enlightened Islamic theologians believe that brain death is a sufficient criterion for declaring a person dead. This is also stated in the fatwa of Muslim Law Council of Great Britain, which moves from the problem of brain death to the issues of transplantology:

“In the past, medical professionals considered the heart to be the center of life in the body, and thus death was defined after the heart stopped functioning completely… The last five decades have witnessed a great leap forward in medical science, bringing great benefits and skills that were unthinkable before. As a consequence, the central role of the heart in relation to life and death has now been replaced by the brain and especially the brainstem. The Council concluded that if reliable doctors certify that the brainstem is dead, this means that the person is dead according to Islam and, thus, the organs necessary to save the lives of others can be removed, and the life support system can be disabled."[1]

Islamic Organization for Medical Sciences (IOMS) discussed the issue at two symposia held in 1985 and 1996 respectively and concluded that brain death is an acceptable criterion for death. The same view was adopted by International Islamic Fiqh Academy (IIFA) at its third session held in 1986. However, Islamic Fiqh Academy (IFA), at its tenth session held in 1987, did not recognize brain death as an adequate criterion for death in Islam.

Over the past 30 years, issues such as organ and/or tissue transplantation, brain death, the principle of care, technologies in the intensive care unit have been raised and considered on the agenda of Islamic bioethics. The problems of organ and/or tissue transplantation were considered by Islamic jurists at the Third Symposium on Medical Law (April 1987). In Iran, at the International Congress of Bioethics (March, 2005) it was said that decisions on key issues of bioethics should be made taking into account the existing religious norms of morality, cultural traditions. Organ transplantation, for example, transplantation of the cornea of a deceased person, is permitted under the following conditions: - death must be established by three doctors, including one neurologist (the surgeon who will perform the transplantation should not be part of this group); - the deceased did not object to such an operation during his lifetime, or the consent of relatives should be obtained; - transplantation is carried out in centers officially recognized by the Ministry of Health of the respective country. Bioethics was seen as a bridge to the future, through which humanity can and must learn to protect human rights and dignity.

1) Living donors. Organs capable of regeneration (kidney, bone marrow, liver) can be transplanted from a living donor. In these cases, Islam does not impose any restrictions**.**

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[1] Mohammed Ghaly. Religio-ethical discussions on organ donation among Muslims in Europe: an example of transnational Islamic bioethics. 2012

2) Dead donors. In dead fetuses, the only case recognized as legitimate is when the organs are used for therapeutic purposes. In dead adults, the main condition for stopping the artificial maintenance of respiration and blood circulation and subsequent organ sampling for transplantation is a statement of cerebral death. The Council of Ministers of Health of Arab-Islamic countries adopted a draft law on transplantation of human organs consisting of 11 articles. Content (abbreviated):

- Transplantation of organs of a deceased person is allowed with the consent of the relatives of the deceased and provided that:

a) death was established by three specialist doctors, including a neuropathologist, and the surgeon who will perform the operation should not be part of this group;

c) the deceased during his lifetime did not object to the removal of any organ of his body.

- It is forbidden to sell and buy any organ or make it the subject of a gift for any consideration.

- Organ transplantation is carried out in medical centers officially recognized by the Ministry of Health.[1]

Questions for self-examination:

1. Eastern ethical traditions in medicine:
A) In Avesta
B) In Ayurveda,
C) In Buddhism, Confucianism and Taoism
2. Abrahamic ethical traditions in medicine
A) Jewish ethical tradition.
B) Orthodox ethical tradition.
C) Muslim ethical tradition.

Bibliography.

1. Rtveladze E.V., Saidov A.Kh., Abdullaev K.V. Avesta “The Law Against Devas” (Videvdat). St. Petersburg: Publishing House of Polytech, University, 2008. p.301.

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[1] Ben HamidaF. Muslim morality, medicine and biotechnology // Medicine and human rights. - M.: JSC IG "Progress", "Progress-Inter", 1992. - P. 53.

2. Shepotiev N. Scientific notes of Kazan University. B. III, book 4. - Kazan, 1890. - p. 57.

3. Harakas S. Orthodoxy and Bioethics // Man. - № 2 - 1994. - p. 91.

4. Metropolitan Meletios of Nikopol. Abortion. - 3rd ed. - M., 1993. This position is taken by the representative of Russian Orthodox Church, Archpriest Dmitry Smirnov. See: Rescue and Save. - 3rd ed. - Moscow: Orthodox medical and educational center "Life", 1995. - S. 30-39, especially pp. 34-35.

5. Moscow: Orthodox medical and educational center "Life", 1995. - pp. 30-39, especially pp. 34-35

6. Roman. 8:17-39. // Bible. Books of the Holy Scriptures of Old and New Testaments. - M.: Ed. Moscow Patriarchy, 1976. - p. 1234-1235.

7. Constantelos D. J. Marriage, Sexuality and Celibacy: A Greek Orthodox Perspective. - Minneapolis, 1975.

8. Harakas S. Cited. Com; Zaphiris Ch. The Morality of Contraception. An Eastern Orthodox Opinion. In: J. of Ecumenical Studies. - 1974, N 11. - pp. 677-690

9. B.A.Zikria. Medical Ethics of Medieval Islam with Special Reference to Al-Ruhawi's Practical Ethicsof the Physician", Vol. 57, Part 3,1967 translated by Martin Levey

10. Hassan Chamsi-Pasha, FRCP (Glasg), FACC, Mohammed A. Albar, MD, FRCP. Islamic medical ethics a thousand years ago www. smj.org.sa Saudi Med J 2013; Vol. 34 (7) P 673-675;

11. Aksoy S.The religious tradition of Ishaq ibn Ali al-Ruhawi: the author of the first medical ethics book in Islamic medicine. JISHIM 2004;3:9-11

12. Karaman H. Abu Bakr Al Razi (Rhazes) and Medical Ethics. Ondokuz Mayis University Review of the Faculty of Divinity 2011; 30: 77-87.

13. Dr. Ragheb Elsergany. Al Razi (Rhazes), a Miracle in Medicine over Generations. https://islamstory.com/en/artical/23560/Al%20Razi-miracle-medicine-across-generations

14. Abdul Nasser Kaadan. Al-Razi on Smallpox and Measles. https://muslimheritage.com/al-razi-smallpox-measles

15. Com.: Biography of Abu Ali Ibn Sina, written down by Abu-Ubayd Al-Dshuzjani // Literary Tajikistan. 1953. №. 5. p. 131;

16. Danish-name (Book of knowledge). Stalinabad, 1957;

17. Canon of medical science / Per. from Arabic. T. 1-6, Tashkent, 1954-1960
18. Rakhimov M.H. Anthropology of Abu Ali Ibn Sina. Abstract dis. ... Dr. Phil. Sciences: Dushanbe, 2004
19. Written monuments and problems of the history of the culture of people of the East XV. Annual scientific session of Leningrad Region of IV Academy of Sciences of the Soviet Union of Soviet Socialist Republics Part III (reports and reports on the work of Ibn Sina). "Science", Moscow .1981
20. Materials of the scientific session of the Academy of Sciences of Uzbek SSR, dedicated to the 1000th anniversary of Ibn Sina, Tashkent, 1953;
21. Petrov B. D. Ibn Sina, Tashkent, 1976
22. Mukhamedova Z. M. Bioethics. Tashkent, 2009
23. Omar Hasan Kasule. Medical ethics from maqasid al shari'at.//Jimasa volume12, #3 2005. P 2-4
24. Ben Hamida; Muslim morality, medicine and biotechnology / / Medicine and human rights. - M .: A / O IG "Progress", "Progress-Inter", 1992. - p.50
25. Islam Encyclopedic Dictionary. M. Science. 1991. p. 152.
26. Mohammed Ghaly. Religio-ethical discussions on organ donation among Muslims in Europe: an example of transnational Islamic bioethics. 2012

Conclusion. The transition to a post-industrial society has dramatically expanded ideas about the living and increased the possibilities of manipulating it. In the seventies of the last century, a new science was created - bioethics, genetically related to medical deontology. Bioethics is not part of medical ethics, but a new, perhaps the deepest layer of philosophical anthropology and ethics. New trends in bioethics are associated with a change in paradigms from legal to ethical-anthropological. Bioethics is not only a new field of knowledge and cognition - bioethics should also be understood as "an emerging social institution of modern society." [1]

In the second half of the 20th century, there is a sharp clash not only between the ethical principles of classical science and the practice of

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[1] Yudin B.G. Social institutionalization of bioethics / Sat-Bioethics: problems and prospects. - M., 1992.

unusual scientific application, but also between scientific empiricism and the presence of various value systems in society. There is a need for universal regulators of human activity. Dialogic in its essence, the "culture of humanism" provides the basis and the possibility of finding solutions to this problem. Biomedical ethics is an ethically justified response to the most acute moral problems posed by the progress of medical science and biomedical technologies, adequate to modern social conditions. [1] The fundamental provisions of bioethics (such as, for example, the rule of voluntary informed consent) formed the theoretical basis for the new internationally recognized ethical standard of medical practice that has been formed in recent decades, which has found expression in numerous documents of international law, national legislation, ethical codes and declarations of international and national medical associations.

Bioethics clearly and definitely raises the question “Is a dialogue possible between carriers of different types of culture and rationalities” and acts as a criterion for the moral maturity of culture and society as a “science of the intrinsic value of life” and “a new ideology of healthcare” (Yu M Khrustalev, 2004). Bioethics arose and is developing in a situation of “decentralization of the value world”. Although in many publications the subject of bioethics is narrowed in the definition, the very structure of the presentation of the material encourages the interpretation of bioethics broadly as a philosophy and practice of non-violence. There is also a view of bioethics as a "philosophy of transdisciplinarity". Bioethics poses the problem of "making a decision" in the face of scientific, rational, moral uncertainty, the lack of "sufficient grounds" for making a responsible decision. In this understanding, bioethics includes in its subject area the problem of attitude to all living things. The production of scientific knowledge at the present stage is “a hybrid of fundamental research focused on the knowledge of truth and research pragmatically focused on obtaining a useful effect” (L P Kiyashchenko, 2005). In this new way of producing knowledge, a reflection on value attitudes arises, which is realized through transdisciplinary mechanisms of normative formalization of scientific practices. Bioethics dialogizes and concretizes traditional

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[1] Mukhamedova Z.M. Current problems in the development of bioethical culture of the population. Sat.-mat-in Inter. reg scientific practical training seminar "Bioethical expertise in biology, medicine and education." Dushanbe: Asia Print, 2010.317p. P.196-202

problems, unusually actualizing them precisely in anthropological terms. Bioethics is a vivid type of modern “post-non-classical” science, where “doing” is further defined by communicative practices of achieving a solution that is generally significant by agreement. In modern conditions, it is essential to look at science as a certain type of sociocultural communication. Traditionally, the scientific community proceeded from the notion that science is distinguished in the whole culture. It was in the 1960s and 70s that the piety of science began to be challenged. An anti-scientist movement emerges and develops. What is important is that this movement put knowledge, understood as communication, at the forefront, highlighting an essential feature of post-non-classical science. Bioethics is a scientific and practical form of implementing the dialogue between culture and science in the interests of man. It is a product of the need to develop a special type of dialogic culture - tolerance for uncertainty and the ability to choose behavior in a situation of uncertainty. The question of the "humanity" of the act is brought to the forefront. Bioethics is at the center of the circle of these problems, and acts as a scientific basis for humanitarian expertise. Bioethics, relying on existing legal laws and pushing for the creation of new ones, adheres to the observance of human rights. The fundamental ideas of humanism about the value of human life, respect for the human person, human free will, non-violence and the preservation of human individuality are fundamental to bioethics and are embodied in a kind of theoretical basis of bioethics . The basic principles of bioethics - "do no harm", "do good", respect for the autonomy of the patient, the principle of justice - a manifestation of this fact. However, none of these principles - the criteria for evaluating specific situations - is absolute - each of them has its own area in which it looks the most reasonable. Modern humanism affirms the most important philosophical and theoretical principle of diversity and, following from it, the moral requirement of respect for “other” and “the other”. Bioethics substantiates generally valid approaches to resolving situations related to the application of science in the context of cultural diversity. Bioethics is based on humanistic values, a humanistic worldview, personalistic philosophy, in the light of which the modern anthropological crisis is being illuminated. It is thanks to humanistic ideas, the development of the theory of humanism in the modern world that such an unusual science as bioethics could appear, connecting the moral sphere of culture with science.

Bioethics seeks to subject all aspects of scientific application to humanitarian expertise. Induced abortion is the most "everyday" and tragic problem of life manipulation and is the quintessence of cultures of philosophical and anthropological issues of bioethics. Bioethics is a scientific and practical form of implementing the dialogue of culture and science in the interests of man. A correct approach is needed to such problems as "nature and society", "nature and man", "nature and culture" This requires the development of a special type of dialogic culture - tolerance for uncertainty and the ability to choose behavior in a situation of uncertainty.

1) Questions about “human dimension” of the act are brought to the fore Bioethics, like ecology, is at the center of these issues, problems and tasks

2) Bioethics develops regulators of human activity and acts as a scientific basis for humanitarian expertise, revealing the vital importance of human activity in all its manifestations

3) Bioethics is a "concentrated" expression of the problems of modern science, philosophy, culture in general. Bioethical knowledge and practice contribute to the development of values, goals and ideals in assessing the state of life and the prospects for its development. It is an expression of the tendencies of the humanization of social consciousness and culture.

4) Bioethics in modern culture occupies a special place, determined by its transdisciplinary nature, its deep connection with the ideas and traditions of humanism and its praxeological orientation

5) The ultimate value-anthropological foundation of bioethics is humanism and anthropocentrism. In a certain respect, bioethics is the product and expression of the imperative of humanism in culture.

PRACTICAL WORK

I. Test questions

Medicine and ethics

001. Medicine refers to one of the following types of knowledge:

1) natural science
2) humanitarian
3) interdisciplinary

002. The fundamental basis that forms the medical profession is:

1) economic
2) cognitive (epistemological)
3) moral

003. The main goal of the professional activity of a doctor is:

1) saving and preserving human life
2) social trust in the medical profession
3) respect for colleagues
4) material gain

004. The main distinguishing feature of the professional ethics of a doctor is:

1) the right to deviant behavior
2) conscious choice of moral principles and rules of conduct
3) criminal liability for non-compliance with professional ethical standards
4) the unconditional need to subordinate personal interests to corporate
5) the priority of the interests of medical science over the interests of a particular patient

005. Medicine and ethics are united by:

1) a person as a subject of study
2) research methods
3) mastering the techniques of overcoming conflicts in human relationships
4) the desire to know the mechanisms of human behavior and to manage it
5) focus on achieving the financial well-being of a person

006. The correct definition of ethics as a science is:

1) ethics - the science of the relationship of living beings among themselves

2) ethics - the science of the nature and meaning of moral relationships and moral principles

3) ethics - the science of minimizing evil in human relationships

4) ethics - the science of the ability to behave correctly in society

007. The ratio of general ethical teachings and professional biomedical ethics has the character:

1) regulatory

2) defining

3) informative

4) there is no connection between them

Forms of regulation of medical activity

008. The form of social regulation of medical activity does not include:

1) ethics

2) morality

3) etiquette

4) right

5) art

009. Morality is a concept that defines:

1) a set of subjective reactions and forms of human behavior

2) a propensity for goodness and the ability to endure the hardships and hardships of everyday life

3) part of philosophy

4) culture-classified mores

5) a cultural and historical phenomenon, which consists in the ability of a person to help another person

010. Etiquette is a form of behavior that means

1) recognition of the importance of special rules of conduct in social and professional relations

2) custom

3) special conditional politeness

4) the science of the nature and meaning of moral relationships and moral principles

5) a person's ability to social adaptation

6) recognition of the importance of social subordination

011. Morality is:

1) relations and mores of people classified by culture according to the criterion of “good-evil”

2) the totality of scientific facts
3) philosophical doctrine
4) strict observance of laws and the constitution
5) a form of "collective unconscious", which indicates due
6) mind game
7) the field of scientific knowledge relating to the general laws of the development of society

012. The concept of “right” includes all of the above meanings, except that it is:

1) an element of the system of state power
2) a form of coercion and punishment of a person by a person
3) the phenomenon of social solidarity and connection between man and man
4) “spiritually educated will”
5) a set of state laws related to any form of activity (for example, medical law)
6) the science of jurisprudence
7) individual will to punish and punish people

013. Moral regulation of medical activity differs from legal regulation:

1) freedom of choice of action
2) the arbitrariness of the motive of activity
3) criminal impunity
4) social approval
5) the presence of monetary interest

014. Biomedical ethics and medical law should be able to:

1) independence
2) medical law - priority
3) the priority of biomedical ethics must be maintained
4) biomedical ethics - a criterion for the correctness of medical law
5) medical law determines the correctness of biomedical ethics

015. According to Kant, morality and law are in the ratio:

1) morality is subject to law
2) morality and law do not oppose each other, for these are related spheres of the spirit
3) morality is opposed to law
4) law is subject to ethics

016. A German psychiatrist and philosopher K. Jaspers understands the phenomenon of “criminal statehood” as:

1) the rights of the people expressed in law

2) legalized freedom of human action

3) the adoption by the state of a law that is contrary to moral standards

4) apparatus forcing a person to comply with the rule of law

Basic concepts of general and professional biomedical ethics

017. The value of human life in biomedical ethics is determined by:

1) age (number of years lived)

2) mental and physical usefulness

3) racial and national identity

4) financial viability

5) the uniqueness and uniqueness of the individual

018. The concept of “honor” of a person includes all of the following, except:

1) physiological and mental characteristics of a person

2) following the given word

3) reasonableness

4) a sense of responsibility for the perfect act

5) social origin (aristocratic, noble)

6) inner nobility

7) non-participation in sin

8) fidelity to the chosen principles

019. The concept of “dignity” of a person includes all of the listed meanings, except for:

a) purity of thoughts and intentions, motives of an act; b) the image and likeness of God; c) health; d) physiological characteristics of the human body; e) freedom; f) economic and financial success; g) public recognition, popularity; h) critical self-assessment, self-confidence; and i) the availability of human abilities and talents; j) awareness of the special purpose of a person in life.

1) b,e, g,i

2) c, d,f

3) b, f, i

4) a, b

020. The correct definition of justice includes:

1) justice is mainly the principle of distribution of material wealth and money
2) justice is equality
3) justice is righteousness, the observance of the law and the return of good for evil
4) justice is a principle that regulates relations between people
5) justice is a reward for the “best” - “the best”
6) justice is a situational benefit, action, result

021. Good is all of the following except:

1) the ability and willingness to help others
2) a good that is valuable and significant in itself
3) individual health
4) that which is the opposite of evil
5) absolute will
6) unattainable ideal
7) property and wealth
8) what benefits
9) knowledge about the essence and existence of good

022. Evil is what is listed, except:

1) that which moves away from the ideal of moral perfection, biblical commandments, God
2) death
3) crime and lawlessness
4) what is harmful to human life
5) violation of the divine order
6) associated with vice and moral corruption
7) that which leads to misfortune and disasters
8) what can bring profit and benefit
9) intellectual fiction

023. The ratio of good and evil is that:

1) good is self-sufficient and self-significant
2) good exists independently and separately from evil
3) evil is self-sufficient
4) evil is the absence of good
5) good and evil are the same
6) good and evil are mutually dependent

024. Duty is that which is performed by virtue of:

1) professional duties

2) the dictates of the time
3) the demands of conscience and the consequences of the moral ideal
4) ideological justification of social progress
5) the order of the chief
6) Mutual benefit
7) the requirements of loved ones

025. The following properties belong to the conscience of a person, except for:
1) the ability to survive the default of duty
2) inner knowledge of good and evil
3) requirement of the categorical imperative
4) a moral feeling that encourages good and averts from evil
5) the ability to recognize the quality of an act
6) the vector of moral life, aimed at due
7) a symptom of a mental disorder

026. Freedom differs from arbitrariness:
1) awareness of responsibility for the perfect act
2) justifying the sinfulness of man
2) recognition of the ability of a person to do whatever he wants
3) the inability of a person to subordinate the will to the requirement of the moral law
4) indifference to a person's ability to moral improvement

027. Freedom is:
1) the ability of a person to do whatever you want
2) the possibility of creativity
3) the law of nature
4) the law of social life
5) a conscious opportunity and ability for moral improvement
6) property of human nature
7) the complete emancipation of the baser instincts of man
8) denial of all moral and ethical restrictions
9) the basis of human rights

028. The definition of the concept of "pleasure" is associated with all of the following, except:

1) satisfaction of needs
2) deliverance from suffering
3) biological adaptation function
4) the triumph of reason
5) expression of interest of a social group
6) illness

ANSWER KEYS

001 – 3,002 – 3,003 – 1,004 – 2,005 – 1,006 – 2,007 – 1,008 – 5,009 – 1,010 – 1,011 – 1,012 – 7,013 – 1,014 – 4,015 – 4,016 – 3,017 – 5,018 – 1,019 – 2,020 – 4,021 – 6,022 – 9, 023 – 1,024 – 3,025 – 7,026 – 1,027 – 5, 028 - 6

Basic ethical theories and history of professional biomedical ethics

034. The professional ethics of a doctor refers to one of the following types of ethical theories:

1) anthropocentric (naturalistic-pragmatic)
2) ontocentric (idealistic-deontological)
3) occupies an intermediate position

035. According to ethical anthropocentrism, human behavior and actions are determined by:

1) the interests of a social group
2) innate biological and material needs of a person
3) moral duty
4) professional obligations
5) national interests
6) the will of God

036. According to ethical ontocentrism, human behavior and actions are determined by:

a) the interests of a social group; b) the material needs of a person; c) innate biological needs; d) moral duty; e) professional obligations; f) national interests; g) by the will of God

1) d, e, g

2) a, e
3) b, c
4) f

037. The conservative ethical tradition in biomedical ethics is formed by two main teachings: a) hedonism, b) traditional Christian worldview, c) pragmatism, d) Kant's ethics, e) Freudianism.

1) a
2) b, d
3) c
4) a, e
5) e

038. The liberal position in biomedical ethics is based on: a) Old Testament morality, b) the teachings of F. Nietzsche, c) pragmatism, d) stoicism, e) Platonism.

1) a
2) d
3) b,c
4) a, e
5) e

039. One of the listed forms of professional ethical consciousness cannot be attributed to the historical and logical models of biomedical ethics:

1) Hippocratic model
2) Paracelsus model
3) deontological model
4) bioethics
5) fascist medicine

040. In Hippocratic model of biomedical ethics, the main principle is:

1) do no harm
2) don't kill
3) the priority of the interests of science
4) the principle of individual autonomy

041. For the medical ethics of Paracelsus, the basic principle is:

1) do good
2) do not bear false witness
3) don't steal
4) “knowledge is power”

5) the principle of individual autonomy

042. For the deontological model of the doctor-patient relationship, the main principle is:

1) do your duty
2) do not commit adultery
3) keep medical confidentiality
4) help a colleague
5) the principle of non-intervention

043. For the modern model of professional morality - bioethics, the main principle is:

1) the principle of “observance of duty”
2) the principle of “do no harm”
3) the principle of the priority of science
4) the principle of priority of rights and respect for the dignity of the patient
5) the principle of non-intervention

044. The peculiarities of the attitude to bioethics in Orthodox moral anthropology include all of the following features, except:

1) commercial interests of the scientific and intellectual elite
2) understanding of God as the source of human striving for perfection
3) the principle of synergy (the possibility of cooperation between man and God in the transformation of life9)
4) the principle of “sanctity of life”
5) understanding of the calling of man as a “participant of the divine nature”

045. Islamic moral and religious tradition is characterized by:

1) orientation to Koran and the code of canonical laws of Islam
2) the priority of human free will
3) the dominant socio-political interests of the state

046. The basis of Muslim legislation governing activities in the field of health is:

1) common national interests
2) a set of canonical laws of Islam
3) judgment by analogy
4) the ability and right to interpret a specialist
5) interests of science

047. The concept of a human person in Islam is defined by:

1) based on the provisions of the Koran about the entry of the soul into the fetus at three months and one week, i.e. on the hundredth day of pregnancy

2) righteousness of parents

3) human life activity

4) own opinion of a professional

048. For Buddhist ethical consciousness, all of the above principles, except:

1) enlightenment and personal responsibility

2) the will of God

3) inner freedom

4) the desire for liberation from suffering

5) overcoming ignorance and knowledge of the nature of the spirit

049. Buddhist ethics is based on the understanding of a person as:

1) natural being

2) beings created by God

3) a person is the result of the fusion of parental germ cells and the "continuum of consciousness" ("creatures of a new birth")

KEY ANSWERS

034 – 2**,**035 – 2**,**036 – 1**,**037 – 1**,**038 – 3**,**039 – 5**,**040 – 1**,**041 – 1**,**042 – 1**,**043 - 4

044 – 1**,**045 -1**,**046 – 2**,**047 – 1**,**048 – 2**,**049 - 3

SITUATIONAL TASKS (CASES)

Each of 10 small groups is given their own version of a situational task, consisting of 3 parts

I. Examples of situational problems of the first type are aimed at determining the type of classical ethical theories that determine or determined the moral choice of your decision and action: 1) naturalistic-pragmatic type or 2) idealistic-deontological type. **The first part includes naturalistic-pragmatic ethical theories.** The benchmarks of an act for this type are benefit, economic benefit, material interest of the acting person. **The second type is idealistic-deontological theories.** Within this type, we do the right thing if we correlate our action with moral values, for example, with professional duty, moral laws and rules.

II In the second part, it is required to determine whether each situation belongs to one of the 4 types of moral action: an incident; dilemma; moral deed, or feat; crime. As a key to making the right choice, we offer the following definitions for each of these types of action. **1. Incident** (lat. - complex, confusing case), (medical error) is an action that has outward signs of an offense, but committed from positive moral and ethical motives. **2. Dilemma** (Greek - two assumptions) - a situation from which it is necessary to make a choice between two possibilities (equally imperfect). **3. A moral deed**, a feat is an action performed in accordance with the moral law (or principle) out of recognition and respect for the law (or principle) itself. **4. Crime** (moral) - an action that is contrary to the moral law, principle, commandments. **Examples of situational tasks of the second type** are aimed at determining whether each situation belongs to one of the 4 types of moral action: incident; dilemma; moral deed, feat; crime.

III. In the third part, it is required to correlate each situation with the implementation or violation of such principles and rules of professional biomedical ethics as: the principle of truthfulness, the principle of confidentiality, the principle of informed consent, the principle of justice, the principle of mercy.

The key to the right choice, we offer the following characteristics of these principles. The principle of truthfulness lies in the fact that the doctor must give the patient, in a form accessible to him, the available information about his state of health, including information about the results of the examination, the presence of the disease, its diagnosis and prognosis, methods of treatment, the risk associated with it, possible options for medical intervention, their consequences and the results of the treatment. The principle of truthfulness also applies to the patient, who must not hide the truth about his disease. **The principle of confidentiality** states that medical information should not be transferred to third parties without the consent of the patient. Article 61 of the "Fundamentals of the Legislation of the Russian Federation on the protection of the health of citizens" states: "Information about the fact of applying for medical care, the state of health of a citizen, the diagnosis of his disease and other information obtained during his examination and treatment constitute a medical secret." **According to the principle of informed consent,** any medical intervention, including and above all when conducting experiments on humans, must include the voluntary consent of the patient. The doctor is obliged to inform the patient about the goals, methods, side effects, possible risks, duration and expected results of the study. The doctor is called upon to respect the rights and dignity of the patient's personality and to accept the patient's subjective decision for execution. **The principle of justice** means the doctor's action solely in the interests of the patient, regardless of gender, race, nationality, language, origin, property and official status, place of residence, attitude to religion, beliefs, membership in various public associations and political parties. **The principle of mercy** includes an active, responsive participation in trouble in different circumstances, a compassionate, caring attitude towards the patient, the ability to be selfless in order to help the patient. **Examples of situational tasks of the third type require** each situation to be correlated with the fulfillment or violation of such principles and rules of professional biomedical ethics as: the principle of truthfulness, the principle of confidentiality, the principle of informed consent, the principle of justice, the principle of mercy.

Situational tasks of the first type

The first type includes **naturalistic-pragmatic** ethical theories. The benchmarks of an act for this type are benefit, economic benefit, material interest of the acting person. The second type is **idealistic-deontological theories**. Within this type, we do the right thing if we correlate our action with moral values, for example, with professional duty, moral laws and rules. Here are some examples

1. A patient came to see a doctor with a diagnosis of hypertension. Dietary supplements were recommended, which were distributed by the doctor, although he knew about their low effectiveness in this case.

2 There is a patient in the room with a clear diagnosis and a treatment plan. Everything is done according to the canons of medicine, but due to technical reasons, his examination was delayed. Relatives, having learned about this situation, contacted the leaders of the hospital and offered them money. The patient received expensive modern medicines, the necessary examinations were quickly performed and expensive (optional) examinations were prescribed; improved living conditions in the department. What are the moral motives of the hospital administration?

3 The doctor of the department of functional diagnostics conducts a study for a patient for a certain material reward, exaggerating its diagnostic information content and keeping silent about the presence of other, no less informative research methods. What interests determine the doctor's actions?

4. A five-year-old girl with a complex injury to her lower limb was in the trauma department of the hospital. The doctors tried every treatment available to them to save the child's leg, but were unsuccessful. Then the hospital staff turned to a research center specializing in such a pathology, because. an operation of such complexity could only be carried out there. Otherwise, it was about amputation of the leg. After assessing the situation, the doctors of the scientific center refused to carry out the treatment, since there were very few chances for success, and this could ruin the reputation of the clinic. What type of moral consciousness dominated among the doctors of the institute?

5 A single patient, 89 years old, is admitted to the department in a planned manner for surgical treatment for cataracts in her only eye, suffering from glaucoma, which will not allow full restoration of vision. During the initial examination, the patient was offered a free lens for compulsory medical insurance (which often causes inflammation in the eye). However, the patient insists on the implantation of an improved model of the lens according to VMI (for a fee). In addition, the patient must independently purchase some antibacterial agents. Taking into account the financial and family situation of the patient, the doctor calls a chemotherapist who prescribes these drugs from the hospital pharmacy especially for the patient. What moral standards guided the doctor in this situation?

6. In the hospital with a stroke, there is a lonely old woman who no one visits. A doctor from a neighboring department after duty visits her regularly and takes care of her. What is more expedient - to take care of an old woman or spend this time in the library, improving your professional skills in order to provide more qualified assistance to patients? What moral and ethical tradition determined your answer?

7. Children born in a state of clinical death, after resuscitation, in most cases are transferred to artificial lung ventilation and require observation and treatment in the intensive care unit of the maternity hospital. In a large percentage of cases, these children are in a state of

deep coma and have an extremely unfavorable prognosis of the disease. Despite the presence of an intensive care unit, long-term treatment of these children in a maternity hospital is not possible due to a lack of medicines, specialized equipment, and highly qualified resuscitators. These patients should be observed in specialized neonatal intensive care units. However, resuscitation doctors often refuse to transfer these patients to their department, explaining this by their “futility” and the inexpediency of using special equipment to maintain the life support of this child, while this equipment can be used to save the life of another child who has a high chance of surviving and not to remain at the same time a deep invalid. What type of ethical theory arguments do doctors use when refusing?

8. An extremely serious patient with myocardial infarction was in the intensive care unit after resuscitation for ventricular fibrillation. Resuscitation measures took a long time, as a result, the cerebral cortex died according to external signs. The patient was constantly on a ventilator. At the same time, this patient had no further prospects; nevertheless, normal cardiac activity remained on the background of lung ventilation. There is only one ventilator in the department, so when another patient requiring emergency ventilation was admitted, the doctor disconnected this hopeless patient from the ventilator. What ethical theories can be used to explain the doctor's actions?

9. Before performing surgery for calculous cholecystitis, the doctor tells that most patients are operated on using laparotomy access, but it is possible to perform surgery using the laparoscopic method, which speeds up recovery time after surgery and achieves better cosmetic results. “The choice of the method of surgical intervention remains with the surgeon,” the doctor says, thereby hinting at the desirability of reward. In what moral paradigm is the doctor?

10. A sick citizen of Moldova was admitted to the ENT department in a serious condition with a diagnosis of “Secondary purulent meningitis. Exacerbation of left-sided purulent hemisinusitis. According to emergency indications, a sanitizing operation on the sinuses was performed. Given the patient's lack of an insurance policy, the head of the department insists on his discharge within 5 days after admission and stabilization of his condition, explaining this by the high cost of treatment for the hospital budget. The attending physician, in turn, insists on continuing inpatient treatment, although he understands that

the patient's stay in the hospital negatively affects the wages of him and his colleagues. What moral ideas determine the position of the head of the department and the attending physician?

Answers to the tasks

1 NPT, 2. NPT, 3. NPT, 4. NPT , 5. IDT,6. IDT, 7. NPT , 8. NPT. 9. NPT , 10.NPT/IDT

Abbreviations: NPT - Naturalistic-pragmatic type of ethical theories,

IDT - Idealistic-deontological type of ethical theories

Situational tasks of the second type

In the second option, it is required to determine whether each situation belongs to one of the 4 types of moral action: an incident; dilemma; moral deed, or feat; crime.

As a key to making the right choice, we offer the following definitions for each of these types of action.

1**. Incident** (lat. - *complex, confusing case*), (*medical error*) is an action that has outward signs of an offense, but committed from positive moral and ethical motives.

2. **Dilemma** (Greek - *two assumptions*) - a situation from which it is necessary to make a choice between two possibilities (equally imperfect).

3**. A moral deed, a feat** is an action performed in accordance with the moral law (or principle) out of recognition and respect for the law (or principle) itself.

4. **Crime** (*moral)* - an action that is contrary to the moral law, principle, commandments.

1. There are many cases in history when doctors devoted their lives to helping people from underdeveloped countries. Albert Schweitzer abandoned his career as a musician and theologian and devoted his life to medical practice, serving people. Together with his wife, nurse Helene Breslau, he founded a hospital in Lambarene (Gabon) at his own expense in 1913, worked in the rainforest for half a century, providing medical care to patients with leprosy, malaria, dysentery and other diseases. How is the activity and life of A. Schweitzer assessed in European culture?

2. High myopia often serves as an indication for laser coagulation of the retina in order to prevent further retinal detachment. However, this operation has its indications and not always, even with high myopia, it is necessary. Nevertheless, at present, this operation is often prescribed to almost everyone indiscriminately, especially in clinics where this operation is paid. Even if this is not particularly necessary, it is more profitable for the doctor to frighten the patient a little with a possible retinal detachment, perform laser coagulation and receive a fee, without thinking about the long-term consequences of such an intervention. And as a result, the patient gets in the future peripheral retinal dystrophy and loss of visual fields. What type of moral action is this practice?

3. By ambulance, a patient with a head injury and an organ of vision is admitted to the emergency department. He was examined by the doctor on duty, who assessed his condition as moderately severe, and performed a primary eye treatment on the patient. During the procedure, the patient began to have convulsions, and nasal liquorrhea appeared. These symptoms indicate a craniocerebral injury and, accordingly, an extremely serious condition of the patient. In this situation, the doctor underestimated the severity of the patient, and this could lead to his death. How to evaluate the actions of a doctor from a moral standpoint?

4. In the process of diagnosing and treating diseases, the question often arises of using research methods that are not provided for in this medical institution, usually these are expensive procedures (CT, MRI, etc.). Not all patients can afford it. Can a doctor ask a patient (or his relatives) to pay for such services? After all, the diagnosis will be more accurate, which will make it possible to more effectively treat the patient. How to define this moral situation?

5. A patient died in the department. The doctor, according to the rules, called the dispatcher, then filled out a medical history, and called his relatives in the morning. However, the relatives of the deceased said that they had already been informed about the death by employees of the ritual agency. The fact is that there is competition among ritual agencies, so the agencies pay a certain amount to the person who reported the death. The guard transporting the bodies to the mortuary recognizes the phone number of relatives and the patient's passport data, which are recorded on the first page of the medical history, and reports them to the staff of the ritual agency. What is the moral assessment of the actions of the staff on the part of the administration and relatives?

6. A 57-year-old patient was in the cardiology department due to suspected unstable angina pectoris, she received standard therapy, despite a not quite typical clinic. On the second day of hospital stay, the patient died; at autopsy, the diagnosis of coronary heart disease was not confirmed. The patient turned out to have aortic dissection, a disease requiring urgent surgical treatment, in which the prescribed drugs worsened the patient's condition. This case is a typical medical error. The prescription of drugs that may have accelerated the lethal outcome was due to the fact that the clinical picture of the diseases is similar, and special research methods are required for accurate diagnosis. Can a moral assessment of what happened mitigate the legal responsibility of a doctor in a possible trial?

7. A child of 3 days of age was in the neonatal pathology department in a serious condition. Due to the need for a blood transfusion, the blood type was determined. According to the results of the analysis, it turned out that the father of the child is another person, but in order not to aggravate the difficult morale in the family, the doctor kept silent about this fact. In what moral situation did the doctor find himself?

8. Often in dermatological practice, a situation arises when a doctor must decide on the authority to perform certain manipulations. If melanoma is suspected, the doctor has a choice: take a piece of skin for examination or excise the entire affected area. In the case of taking a biopsy, the doctor can provoke a more rapid development of the tumor, harming the patient, if the entire lesion is excised and the diagnosis is not confirmed, the patient is harmed, since he remains a cosmetic defect. If a doctor has to make a choice, in what moral situation does he find himself?

9. A young woman who was troubled by recurrent lower back pain came to the clinic for an examination. After a superficial study, which included only a survey radiography of the abdominal cavity, the doctor categorically made a diagnosis: cancer of the right kidney. For six months, the woman constantly thought and prepared herself for death. In a serious condition, she ended up in another clinic. On the round, the head of the department allowed himself to doubt the diagnosis. After conducting painstaking, complex studies, attracting additional specialists, spending many hours in conversations with the patient, the doctor convinced her that the initial diagnosis was fundamentally wrong

and was due to the insufficient amount of research and the incorrect interpretation of the meager data received, which returned the patient to a full existence. Does the professional failure of the first doctor and the act of the second have a moral meaning (and what?)?

10. At night, on duty, a doctor-laboratory assistant received an application. Due to the fact that the child is unwell, he was asked to do an analysis, which he is not obliged to do, since the laboratory does not serve the department from which the analysis came. The laboratory that serves this department does not work at night. The analysis was made. What moral act did the doctor perform?

Answers for tsasks

1 F, 2 C, 3I, 4. I, 5. C, 6. I, 7. I, 8 D. 9. C / MA, 10. MA

Abbreviations: D - dilemma, I - Incident, C - Crime, MA. — Moral act, F– Feat, C / MA – Crime + moral act.

Situational tasks of the third type

In the third option, it is required to correlate each situation with the fulfillment or violation of such principles and rules of professional biomedical ethics as: the principle of truthfulness, the principle of confidentiality, the principle of informed consent, the principle of justice, the principle of mercy. The key to the right choice, we offer the following characteristics of these principles.

The principle of truthfulness lies in the fact that the doctor must give the patient, in a form accessible to him, available information about his state of health, including information about the results of the examination, the presence of the disease, its diagnosis and prognosis, methods of treatment, the risk associated with it, possible options for medical intervention, their consequences and the results of the treatment. The principle of truthfulness also applies to the patient, who must not hide the truth about his disease.

The principle of confidentiality states that medical information should not be transferred to third parties without the consent of the patient. Article 61 of the "Fundamentals of the Legislation of the Russian Federation on the protection of the health of citizens" states: "Information about the fact of applying for medical care, the state of health of a citizen, the diagnosis of his disease and other information obtained during his examination and treatment constitute a medical secret."

According to **the principle of informed consent**, any medical intervention, including and above all when conducting experiments on humans, must include the voluntary consent of the patient. The doctor is obliged to inform the patient about the goals, methods, side effects, possible risks, duration and expected results of the study. The doctor is called upon to respect the rights and dignity of the patient's personality and to accept the patient's subjective decision for execution.

The principle of justice means the doctor's action solely in the interests of the patient, regardless of gender, race, nationality, language, origin, property and official status, place of residence, attitude to religion, beliefs, membership in various public associations and political parties.

The principle of mercy includes an active, responsive participation in trouble in different circumstances, a compassionate, caring attitude towards the patient, the ability to be selfless in order to help the patient.

1 Assistant of the Department of Skin Diseases, consulting a patient with psoriasis, to the patient's question: "How long will he suffer from this disease?" replied: "All my life!" The patient, who did not expect such an answer, was very upset, because he thought that his disease could be easily cured. What moral principle did the assistant violate by giving a categorical conclusion about the timing of the course of the disease? Was he obliged to explain in detail to the patient that his disease is chronic, difficult to treat, but with the selection of adequate therapy, stable remission can be achieved?

2. Patient F., 56 years old, was admitted to the clinic with a worsening course of II degree hypertension. Against the background of the therapy during the week, the patient's condition improved, blood pressure returned to normal, and after the completion of the examination plan, the patient was scheduled to be discharged. However, after 8 days of stay, the patient abused alcohol, after which an episode of inappropriate behavior was noted. What principle were the doctors guided by when the next day, taking into account the achievement of the clinical effect, and despite the unfinished plan of additional examination, the patient was discharged for violation of the regimen with recommendations for outpatient additional examination

3. The woman had a premature birth at 28 weeks. The actual pregnancy came after years of unsuccessful fertility treatments. The chances of the child surviving are minimal. The mother asked the doctor to invite a priest to baptize the child. The doctor granted the woman's request. Subsequently, he provided moral support to the woman and, as far as possible, accelerated the discharge from the hospital, since the woman experienced suffering while being close to women with healthy newborns. What principle of biomedical ethics did the doctor follow?

4 The child is sick with acute leukemia. For massive transfusion therapy, chemotherapy, the placement of a central catheter under anesthesia is indicated. Parents are informed about possible complications. What principle must be followed by physicians to carry out this treatment?

5 A homeless patient was admitted to the emergency department in winter, in severe frost. When examined by an ophthalmologist, an inflammatory disease of the left eye (catarrhal uveitis) was revealed, which does not require hospitalization in the department, but requires mandatory outpatient treatment. Taking into account the social status of the patient, the doctor of the emergency department rewrote the diagnosis to a more dangerous one and hospitalized the patient in a hospital. What principle of biomedical ethics did the doctor follow?

6. As part of the research work, the doctor conducts a comparative analysis of two methods of physiotherapy exercises for limb injuries in children. One of them is traditional, old, in the light of new ideas, something is wrong. The other is newly developed and extremely effective. What ethical rules are violated in relation to patients in the control group

7. A young woman had epileptic seizures for the first time in her 30s. She was examined permanently in the neurological department of the Republican Hospital and diagnosed with epilepsy. But at discharge, a different diagnosis was indicated in the disability certificate: “Vegetovascular dystonia”. What principles did the doctors follow?

8. Patient A. was admitted to the Department of Maxillofacial Surgery with a diagnosis of fracture of the zygomatic-orbital complex on the left. The results of the HIV test were positive. The doctor had to inform the patients in the ward that their neighbor was HIV-positive, so that they use personal hygiene products individually, do not use this patient's ointments and drops, as there is a tendency among patients to

use each other's medicines. What principle of biomedical ethics was violated by the doctor, and what guided his actions?

9. An obstetrician-gynecologist, working in a pharmaceutical company and receiving 20% of the cost of the drug if it is sold, prescribes an expensive multivitamin complex to all pregnant women in his area. At the same time, he "forgets" to talk about possible side effects, such as frequent allergic reactions of varying severity and early closure of a large fontanel in a child, and possible cheaper, but no less effective analogues. What moral and ethical principles does the doctor violate?

10. The patient is operated on for appendicitis. The operation revealed signs of cancer of the caecum. A radical operation is being performed. Metastases were not detected. According to what principle was the patient informed about the reason for the expansion of the operation after the operation?

Answers to the tasks

1 M, 2. F, 3. M, 4. Inf., 5. M, 6 F+M, 7. C, 8. C+T, 9. Inf.+T, 10. T,

Abbreviations. Principles: Inf. - Informed consent, C - Confidentiality, M - Mercy, T - Truthfulness, F - Fairness, C + T - Confidentiality + Truthfulness, F+ M - Fairness + Mercy, M + F - Mercy + Fairness, Inf. + T - Informed consent + truthfulness.

Autonomy (from Greek *autonomia: autos* - itself and *nomos* - law) is a principle of medical ethics based on the unity of the rights of a doctor and a patient, involving their mutual dialogue, in which the right of choice and responsibility are not concentrated entirely in the hands of the doctor, but are distributed between him and the patient. According to the A principle, the patient independently makes a decision regarding treatment *after being informed* by the doctor about his state of health. Complex medical interventions are carried out with the written consent of the patient, familiarized with their purpose and possible results. The ethical basis of the principle of A. is the concept *of personal autonomy* - its independence and the right to self-determination.

Adaptation (from Latin *adaptatio* - adaptation) - 1) the process of adapting self-organizing systems to changing environmental conditions (for example, changes in temperature, oxygen content); 2) the result of the adaptation process, i.e. the system has adaptability to some environmental factors; 3) in psychology, the concept of adaptation (disadaptation) is used in the analysis of the relationship of an individual (personality) with the environment. In bioethics, it is applied to biological systems (an individual organism, its organs, a population of organisms), reflecting the expedient response of a complex hierarchical self-organizing system to changing environmental conditions.

Axiology (from Greek *axios* - value and *logos* - word, concept) - the doctrine of values, the purpose of which is to explore the highest sense-forming principles as a condition for the necessary and generally valid distinction between true and false, good and evil, just and unjust. The most important questions of A. are: what is good, the place of value in the structure of being - objective reality, its significance for the subject and society.

Altruism (from Latin *alter* - another) is selfless, conscious and voluntary service to people, the desire to help others, to contribute to their happiness based on the motive of love, devotion, loyalty, mutual assistance, sympathy, compassion.

Amoralism (from Greek *a* - not, without and lat. moralis - moral) - 1) a socio-historical phenomenon, expressed in the denial of generally accepted norms of morality in people's behavior; 2) the principle of practical or ideological orientation, which justifies the legitimacy of a nihilistic attitude to universal norms of morality in human behavior; 3) a characteristic of the totality of the negative qualities of a person, his actions and lifestyle (meanness, dishonor, lack of principle, betrayal, dishonesty, lies, etc.)

Anthropomorphism is the endowment with human properties of natural phenomena, animals, objects - their "humanization", as well as the representation of the gods in a human form.

Anthropocentrism is a worldview according to which man is the center of the universe and the ultimate goal of the entire universe.

Apathy (from Greek *apatheia* - insensibility) is a term of ancient ethics, meaning dispassion, serenity, the ability to dominate oneself. It was considered an essential property of wisdom, providing the ability to overcome affects, passions, the main of which are sadness, fear, lust, the desire for pleasure. In biomedical ethics, the concept of apathy is updated in the study of the problem of the human right to life and the human right to “dying with dignity”, moral problems of euthanasia, etc.

Ataraxia (from Greek *ataraxia* - equanimity) is a term of ancient ethics, meaning a state of peace of mind, serenity, immunity of the soul to affects of feelings. The state of A. is a concentration on “the most general and main thing”, which helps to get rid of the anxiety in the soul, which arises, first of all, from false opinions about the gods and death.

Affect (from lat. *affectus* - emotional excitement, passion) - a relatively short-term, strong and violently flowing emotional experience (fear, horror, despair, rage, etc.), accompanied by screaming, crying, sharp expressive movements; can disrupt the normal course of perception, thinking, cause clouding of consciousness up to a pathological form. Some biotechnical achievements in changing states of consciousness are also accompanied by affectation, which must be taken into account in bioethical studies on humans.

The autonomous model of the relationship between the doctor and the patient is based on the principle of patient autonomy, respect for the autonomy of the individual and the desire to ensure the good of the patient. It involves the adoption of an ethically reliable medical decision based on mutual respect between the doctor and the patient and their active joint participation in this process, which requires competence, patient awareness and voluntary decision-making.

Communication barriers are obstacles that prevent contact between the communicator and the recipient, adequate reception, understanding and assimilation of messages in the communication process. Within the framework of bioethics, psychophysical, mental, somatic, and other bioethics are distinguished, in particular, in the relationship between a doctor and a patient.

Jeremiah Bentham (1748-1832) was an English philosopher and jurist, the founder of utilitarianism. In his essay "Deontology, or the Science of Morals" (1834), he affirms the principle of utility as the guiding ethical principle of behavior. The moral ideal, according to Bentham, is “the greatest happiness of the greatest number of people”; the criterion of morality is “achievement of benefit, benefit, pleasure, goodness and happiness”. In his opinion, each person seeks to increase the pleasure he receives from life and, accordingly, to reduce suffering. For the first time he introduces the concept of "deontology" into ethics.

Immortality is a term meaning belief in the perpetuity of human existence, especially the human soul. In human culture, the following concepts of B. are distinguished: 1) B. as an introduction to the world of eternal ideas - an eidetic concept (from Greek eidos - an idea, an image that exists separately from individual things); 2) B. as resurrection and communion with the grace of Holy Spirit - a Christian concept (comes from human mortality,

embodying the unity of body and spirit); 3) B. the beginnings of human nature (atoms, genetic code, etc.) and the frailty (mortality) of human existence - a naturalistic concept; 4) B. as the preservation of the achievements of the human personality in the memory of mankind - a socio-cultural concept.

Biogenetic law, or "the law of embryonic recapitulation" - was put forward in 1868 by the German scientist Ernst Haeckel, who applied Darwinian theory of evolution to the embryonic development of a child during mother's pregnancy. The law states that ontogeny is a recapitulation of phylogeny, i.e., each organism during the period of its embryonic development repeats all the stages that its species went through in the course of evolutionary development.

Biomedical ethics (BME) is an ethical and applied discipline, the subject of which is the moral attitude of society as a whole and professionals - doctors and biologists in particular - to a person, his life, health, death, and which sets itself the task of making their protection a priority right of every person . If bioethics focuses its attention on the problems of life of any living being, then BME specifies the principles of bioethics in relation to a person. In contrast to the "traditional" medical ethics, BME is integrative in nature, uniting, linking, concentrating common bioethical problems and requirements; at the same time, it relies on the so-called medical incidents - specific situations, turning them into precedents that become the basis for ethical generalizations, conclusions and subsequent recommendations. This is the situational nature of BME. The range of the main problems of the BME: establishing the status and role of moral values in the professional activities of physicians and biologists; resolution of moral conflicts in specific situations that arise in the process of biomedical research and treatment of patients; ethical regulation of interpersonal relations in the system of vertical and horizontal connections in the field of medicine. BME solves its problems not on a professional-corporate basis, but on a broader basis, with the involvement of representatives of other professions and the general public.

Bionics is an applied science about the application in technical devices and systems (in particular, in artificial intelligence systems) of the principles, properties, functions and structures of wildlife.

Biopolitics is the doctrine of an integral system of theoretical developments and practical measures to ensure the preservation of life and its diversity on Earth; also denotes the use of biological approaches, methods and data in policy and political science research.

Biodiversity is a combination of all types and forms of living things, interconnected, interdependent and necessary to each other, which determines the requirement of careful attitude towards it and human concern for its conservation. The concept of B. implies the variability of organisms within the same species, between species, and the diversity of ecosystems. In 1992, an international Convention on the Conservation of Biological Diversity was signed in Rio de Janeiro, on the basis of which drafts of the National Strategy for the Conservation and Sustainable Use of Biological Diversity in the Republic of Uzbekistan were developed.

Biosphere (from Greek *bios* - life, *sphaire* - ball) is a shell of the Earth, containing the totality of living organisms and that part of the planet's substance that is in continuous exchange with them.

Biota (bios) (from Greek biotē - life) - 1) a historically established set of plants and animals united by a common area of distribution; 2) an integral set of life on Earth.

Biophilosophy is an interdisciplinary direction focused on the study of ontological, epistemological, methodological, ideological, axiological problems of being through the prism of studying the phenomenon of life.

Bioethics (bioethiks - English) is an interdisciplinary direction that focuses on the study and resolution of moral problems generated by the latest achievements of biomedical science and practice. The highest moral value in bioethics is a morally understanding attitude towards Life and any Living Being, in particular concern for the rights of the bios. The main principle of bioethics is reverence for life. The founder of bioethics is V.R. Potter, who in 1969 first introduced the concept of "bioethics" and gave it a definition. He considers bioethics as a "bridge to the future", which should be based on the synthesis of natural science and humanitarian knowledge. Bioethics is developing in two main directions: 1) understanding and ethical assessment of medical medical practice; 2) substantiation and establishment of ethical expertise and control over the conduct of biomedical research.

Bioethical situation is a non-standard situation in medicine that arises in connection with the latest achievements in biomedical science, practice and biotechnology (in the field of genetic engineering, cloning, transplantation, psychiatry, etc.) and requires ethical intervention, expertise or control.

Blessing- in a broad sense, everything that is useful to people, their health, satisfaction of their needs - vital, social, spiritual; accordingly, that which is useless, unnecessary, or harmful is not good. B. is not the benefit itself, but that which benefits, just as evil is not the harm itself, but that which causes harm. In modern bioethics, the category of good, which traditionally appears in the formula "Do no harm", i.e. use in medicine those means that will not harm the patient, expanded to “not only do no harm, but also do good deeds”, although the very interpretation of the concept of good deeds is not unambiguous, since B. is relative: there is nothing that would be only harmful or just useful. Therefore, B. in one respect may be evil in another; What is good for one person may be harmful to another. The relativity of blessing in bioethics is especially evident when discussing issues of maintaining life in a vegetative state, cloning living beings and humans, etc.

Reverence for life is a principle of humanistic ethics that requires an individual to make an individual choice based on the formula of A. Schweitzer: “I am a life that wants to live ... among a life that wants to live”, according to which one should “treat every living being with reverence and respect it as one's own life... Preserving life, moving it forward, bringing developing life to the highest level means... doing good; to destroy life, to interfere with life, to suppress the developing life means ... to do evil. This is a necessary, absolute, basic principle of morality ... Therefore, the ethics of reverence for life includes everything that can be denoted as love, self-sacrifice, compassion, participation in joy and striving ... Truly, a person is moral only when he obeys the inner impulse to help anyone life, which he can help and refrain from doing any harm to the living. In this approach, the truly moral person is motivated to show equal reverence for his own will and life as for any other.

Gratitude is a feeling of obligation, respect and love for another person for a good deed rendered to them. In contrast to antiquity, where

B. was interpreted as a virtue, in Christianity it is understood as a duty and correlates with mercy. From the point of view of I. Kant, beneficence, as a “sacred duty” of a person, reinforces the motive of beneficence. The interpretation of the concept of B. as a duty, duty is the subject of discussion in bioethics in the study of the moral content of the relationship between a doctor and a patient, a researcher and a subject, etc.

Prudence is a principle of action that orients a person to achieve maximum good. Separating B. from morality, I. Kant showed that B. is aimed at a natural goal - happiness, and a prudent act is only a means for it. The concept of B. attracts special attention in the search for answers to the moral dilemmas of modern biomedicine, the definition of its status and principles.

Disease is a violation of the vital activity of an organism, expressed by physiological and structural changes that occur under the influence of extreme (for a given organism) stimuli of the internal and external environment. B. is characterized by a general or partial decrease in adaptability to the environment and restriction of freedom of life. The task of medicine is the treatment of B., which consists in the impact of the disorder.

Vegetative existence (from lat. *vegetativus* - vegetable) - the biological existence of an organism that is in an unconscious state due to the cessation of brain functioning. Medical care is the artificial maintenance of the basic vital functions of the body with the help of equipment that contributes to the reproduction of only biological - plant - life, which will never become autonomous-sovereign, but is doomed to progressive degradation. With appropriate medical support, the patient's body can maintain this plant-animal existence for an arbitrarily long time. But since brain damage is irreversible, a person whose brain does not function ceases to be a person (Casus Quinlen).

Veresaev V.V. (1867-1945) - Russian doctor and writer, who left medical practice for the sake of literary creativity, author of the book "Doctor's Notes" (1901), devoted to issues of medical ethics, ambiguously assessed by contemporaries. The book contains many productive thoughts on the role of medicine in society; on the training of future medical specialists; about the problem of medical secrecy; on conducting medical research on humans and animals, etc.

Vitalism (from lat. *vitalis* - vital) - the doctrine of the fundamental difference between living systems and non-living ones; the irreducibility of life processes to the laws of inorganic nature; the presence in living systems of special forces and principles that are absent in inanimate ones - such as expediency, indivisibility, etc. According to V., a purposefully acting life force, integral causality, is inherent in living organisms, while inanimate bodies - “causality of elements”. In modern science, many characteristics that V. considered inherent only in biological systems are considered as manifestations of all complex self-organizing systems, and the features of living systems are identified in the context of their origin and genesis of life (see: synergetics).

Vitalogy (from Latin *vita* - life and Greek *logos* - word, concept) - "science of the XXI century" - the doctrine of life and its highest form - man as an integral spiritual and material entity. He sees his destiny in preventing the emergence in the world of a situation incompatible with life, for which humanity must move to a qualitatively different way of existence. The transformation of the world through the training, education and improvement of man is not considered an effective means for improving the human race, because the point of application of efforts here is the man himself. He sees his task in directing all his efforts to the knowledge and improvement of the human soul, to help a person solve these problems and find happiness. The basic concepts of V. are set out in the book Seven Steps to the Golden Age.

Will - the ability of the individual to carry out the regulation and self-regulation of activity and behavior, manifested in the active overcoming of difficulties, contradictions and conflicts in achieving consciously set goals; expresses the individuality of a person, serves to self-affirmation and self-expression of his "I".

The World Health Organization (WHO) is a specialized agency of the United Nations, the largest international medical organization that has proclaimed the goal of its activity to be “the achievement by all peoples of the highest possible level of health” (Article 1 of the WHO Charter). In 1994, WHO formulated the three main components that underlie the modern model of doctor-patient relations (the right of all people to health, the patient's right to information, the doctor's duty to explain to the patient everything that interests him), and officially approved the principle of providing the patient with reliable and information that is understandable to him, and providing access to objective and verifiable information to the doctor.

Moral choice is a form of manifestation of moral freedom. The choice is provided by reason and will. Any decision is made by the mind, preparing the ground for healing factors or for the causes, or for the mechanism of its development, as well as in mobilizing the body's defenses.

Pain is a kind of psycho-physiological state of a person, a painful, depressing sensation that occurs under the influence of strong or destructive external influences that cause organic or functional disorders in the body. B. is a protective reaction of the body and plays a positive role in the life of living beings, as long as it warns or protects the body from danger threatening it, or helps the doctor to recognize the disease. Prolonged pain sensations, which are not amenable to healing, prescribe decision-making to him, and the mind provides the will with appropriate goals and means of choice of a doctor is determined by the hierarchy of values that prevail in medical ethics, in which human life is a priority value, and human health is the highest good.

Gaaz Friedrich Iosifovich (Fyodor Petrovich) (1780–1853) – doctor and public figure. Born in Germany, educated at the universities of Jena and Vienna, moved to Russia in 1803. From 1828 until the end of his life he was a member of the Moscow Provincial Prison Committee and chief doctor of Moscow prisons. All his life F.P. Haaz dedicated to caring for prisoners sentenced to hard labor, their children, the sick and the homeless poor. On the collected F.P. A hospital was built in Moscow with donations from Gaaz, where the homeless, victims of fires, cold, and hunger were admitted for treatment. “Gaaz has no refusal” – such a saying was put together by the people about him. On his gravestone is inscribed the motto of his life: "Hurry to do good."

Genetics (from Greek *genesis* - origin) – a science of laws of heredity and variability of organisms; about methods of controlling heredity and hereditary variability in order to obtain the forms of organisms necessary for a person or in order to control their individual development.

Human genetics is a branch of genetics closely related to anthropology and medicine. It is divided into anthropogenetics, which studies the heredity and variability of the normal signs of human body, and medical genetics, which studies its hereditary pathology (diseases, defects, deformities, etc.).

Genetic engineering is an applied area in genetics, within which various types of biotechnologies are developed, genetically modified organisms and modified products are created, the possibilities of gene therapy for certain human diseases, its germ and somatic cells are realized, obtaining identical genetic copies of a given organism, etc. Noting the scientific and economic prospects of genetic engineering, it is necessary to keep in mind its potential threat to man and mankind. New biological knowledge, which contains many possibilities of genetic control over an individual, can lead to social and professional discrimination of people, to serious consequences. If everything that genetic engineering creates as a result of working with microorganisms and individual cells is fundamentally possible to do with a person, then the following become real: a directed change in hereditary material; identical reproduction of a genetically programmed individual (cloning); creation of chimeras (man-animal) from the hereditary material of different species.

Genetically modified products (GMP) are new, genetically engineered products (food, drugs, cosmetics, etc.), the long-term effects of which on humans are not yet known. The possible danger lies in the fact that, once in our environment, they will be fundamentally different from those harmful substances that threaten man and nature, the effect of which has been studied and can be limited. New products will be much more dangerous. Therefore, bioethics requires a particularly responsible attitude to the possibilities of genetics to synthesize previously unknown genes and integrate them into already existing organisms.

Hippocrates (c. 460–c. 370 BC) is a great ancient Greek physician, a reformer of ancient medicine, the founder of the principle of an individual approach to the patient. Developed a treatment system based on the following principles: 1) benefit and do no harm; 2) the opposite is treated with the opposite; 3) to help nature, to conform one's actions to her efforts in order to get rid of the disease; 4) be careful, spare the strength of the patient; do not suddenly change drugs, use more active drugs when less active ones do not work. Identified the main types of temperaments (sanguine, choleric, phlegmatic, melancholic) and their predisposition to certain diseases. The name of Hippocrates is associated with the concept of the high moral character of a doctor and the ethics of his behavior - the Hippocratic Oath.

Humanism (from Latin *humanus* - human) is a worldview based on the principles of equality, justice, humane relations between people, imbued with love for people, respect for human dignity, concern for the welfare of people.

Humanistic paradigm in bioethics is characterized by a radical turn from an empirical description of medical morality to a heightened ethical and philosophical reflection on the moral foundations of biomedical research, which led to the expansion of the problematic field of bioethics by including moral, philosophical, and legal components in it; unification of various value systems: biological (physical existence, health, freedom from pain, etc.), social (equal opportunities, receiving all types of medical services, etc.), environmental (recognition of the inherent value of nature, its uniqueness, co-evolution), personal (security, self-respect, etc.). It can be implemented while respecting moral principles and legal norms.

Humanology is a new direction in the sciences of man (G.L. Tulchinsky), which is based on the modern humanistic paradigm, which ensures the resolution of the contradiction between the anthropocentrism of the "old" worldview, which made man the exclusive center of the universe, and the new, "non-anthropocentric" approach, which takes care of Life and Alive in all their manifestations. Biomedical ethics, removing this contradiction, makes both paradigms complementary - "coexisting" and complementary to each other. Not a person by himself within the framework of traditional humanism and anthropoegoism, but the freedom of his will, aimed at choosing his true values, opens up a new post-humanity - humanity of a higher level, revealing the ability of a person not only to egocentrism, but also to care for life and rights of Living to-, non- and not to human levels. Thus there is a spread expansion of human and humanity beyond the limits of its biological species.

Demographic regulation of ethical problems D.R. (demography is the science of population and patterns of its *development,* in particular its reproduction due to the natural processes of fertility and mortality) - the problem of **D. R.** Arises in the 2nd half of the twentieth century. in connection with the "population explosion" - the rapid growth of population in underdeveloped countries. There are several models of **D.R.** , which contain a different ethical assessment from the point of view of human rights: 1) birth control by state-legal means; 2) implementation of medical and biological birth control (up to sterilization); 3) religious and humanistic propaganda of the rights of man and the embryo; 4) free choice by each person of his own method of reproduction. One of the most common individual means of birth control is still abortion and contraception, which carry their own bioethical problems.

Deontology herbal (medical) (from Greek. *deon* - due, proper and *logos* - teaching) - the doctrine of duties and norms of behavior of medical personnel, ensuring the optimal quality and effectiveness of its work to restore and preserve people's health. It assumes the *doctor's duty* to society and patients, *the right* of doctors to professional dignity and honor, includes *normative principles* of behavior that determine the nature of the relationship between the doctor and the patient. Fits into the structure of *medical ethics,* is embodied in *deontological codes.*

Good and Evil are the most general concepts of moral consciousness, delimiting the moral and the immoral; universal ethical characteristic of any human activity and relations. G. is everything that aimed at creating, preserving and strengthening the good; E. is the annihilation, the destruction of the good. All professional medical codes and oaths, which formulate the basic moral principles that define ideals, motives and actions of a doctor, are focused on E.: they proclaim "Sanctity of life", "Reverence for life", "Gratitude to teachers", "Mutual assistance of colleagues" , requirements "Do no harm", "Do not kill". These norms of goodness should, first of all, guide the doctor in determining a strategy and tactics of treatment. In medical ethics, the problem of G. and E. in specific situations aims at ambiguous solutions, which are complicated by the fact that in real life there is no absolute G. and absolute E. Each action can, to one degree or another, carry both.

Physician's task is to be able to identify this degree and minimize E., creating G. to the maximum.

Voluntariness principle - the principle of biomedical ethics, which implies the autonomy of the patient, his voluntary (independent) decision or consent to medical manipulations or research, provided he is informed.

Virtue (literally - active good, doing good) - 1) an ethical concept that characterizes the readiness and ability of a person to follow good; 2) a set of spiritual and intellectual qualities that express a perfect moral ideal; 3) the ability to do the best in everything that concerns pleasure and pain and that is associated with the achievement of happiness, identical to the highest good; the path to happiness and an essential part of happiness itself (Aristotle); 4) the moral firmness of the will of a person in observance of his duty, which is a moral coercion on the part of reason, duties towards oneself and others (I. Kant). In the area of interests of bioethics, bioethics is associated with the moral dilemmas that arise in modern biomedicine, the rationale for moral choice in specific situations of relationships between a doctor and a patient, a researcher and a subject in the context of biomedical research.

Trust principle is a principle of autonomous biomedical ethics, based on the symmetry, reciprocity of the relationship between the doctor and the patient, in which the patient puts himself in the hands of the doctor with faith in his professionalism and good intentions. Medical (professional) duty is a key concept of medical deontology and medical ethics. The doctor's duty is to fulfill all the requirements associated with his work and achieve the main goal - success in medical activities and recovery of a patient, regardless of conditions and time of medical care, on a condition of a doctor and his attitude to personality of a patient.

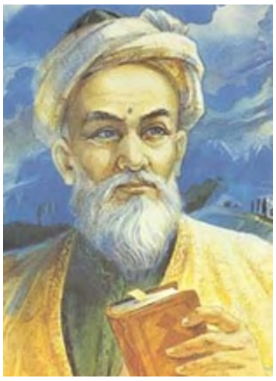
Eugenics (from the Greek *eugenes* - thoroughbred) is an influential scientific trend in the first half of the 20th century, within which the task was to improve the hereditary characteristics of the human population (physical and intellectual). E. methods were aimed at stopping the genetic degeneration of mankind associated with the development of medicine and social support for individuals, as a result of which the effect of natural selection was weakened. Within the framework of negative E., the idea of depriving inferior citizens (alcoholics, drug addicts, criminals, etc.) of the possibility of procreation and the transmission of "unworthy" genes is advocated. Within the framework of positive E., the task is to provide advantages for the reproduction of the most gifted (physically and intellectually) people. In recent decades, E. has begun to develop again in connection with the rapid progress of molecular genetics, cloning, and other biomedical research, requiring that ethical and sociocultural factors of intervention in hereditary programs be taken into account, and that they be regulated and controlled, based on the benefit of the human population. “Living Ethics” is a doctrine created by N.K. and E.I. Roerichs in 1924-1938 and developed by a number of Russian representatives of Buddhist thought (E.P. Blavatsky and others). This is an ethic of mutual solidarity, mercy and justice based on the religious and philosophical values of Buddhism. According to it, our planet has entered the Age of Fire, where the role of psychic energies is growing, the mastery of which presupposes a moral transformation of nature. “Living Ethics” develops a kind of "ethical occultism" - the strengthening of spirituality through selfless moral asceticism and improvement. It is represented by a series of books: "Illumination", "Community", "Agni Yoga", "Heart", "Brotherhood", etc.

Life is a form of existence of integral high-molecular systems, characterized by metabolism and energy, the ability to reproduce, grow, actively regulate its composition and functions, irritability, adaptability to the environment, etc. However, this definition cannot be considered exhaustive. In biology and medicine, a specific distinction between living and non-living, especially in borderline cases, is difficult. Currently, the criterion of human life is the functioning his brain. Life of a person is considered in ethics as natural, i.e. an inalienable right inherent in a person from birth, as the highest value; in bioethics - as the main goal of healing. Identification of the criterion and essence of life is a central bioethical and professional medical problem, in particular for determining the fate of the embryo, in resuscitation, transplantology, therapeutic cloning, and other manipulations with human life.

Health is the natural state of the body, characterized by its balance with the environment and the absence of any painful changes, “a state of complete physical, mental and social well-being, and not only the absence of disease and infirmity” (WHO).

Healthcare is a social system that includes a set of actions, the main goal of which is to protect the health of the population - its strengthening, restoration and maintenance; prevention and treatment of diseases; creation of healthy working and living conditions; promoting the comprehensive physical and spiritual development of the population; provision of publicly available qualified medical care.

Quackery is an amateur practice of healing by persons who do not have a medical education, by means and methods not based on the data of medical science. Biomedical ethics is evaluated from the point of view of the ratio of *goals* and *means of cure*, therefore, it requires not only condemnation and neglect, but also careful study, since it may contain elements of traditional or alternative medicine unknown to science.



Ibn Sina Abu Ali al-Hussein ibn Abdallah-Avicenna (980-1037) - was born in the village of Afshona, near Bukhara, philosopher, doctor. The goal of ethics as one of the practical sciences was considered to be good, striving for perfection. I saw self-improvement in the cultivation of such moral qualities as temperance, courage, wisdom, justice, and in the suppression of the mental forces of lust and anger. He connected the highest happiness with the achievement of harmony of moral virtues. He saw the highest degree of morality of a doctor in his readiness to do good without any calculation, even calculation for gratitude or a good impression.

Identification (from Latin *identificare* - to identify) is a psychological category that reflects the process and result of an individual's emotional and other self-identification with another person, group, model or ideal.

Identity is a concept used to describe individuals and groups as relatively stable, self-identical subjects. The personal "I" is formed by achieving a balance between the individual (personal) and social I., the presence of which must be taken into account in bioethics.

Internet addiction *(Internet addiction disorder, IAD)* is a real-life phenomenon of psychological dependence on the Internet. There are two approaches to the interpretation of network addiction: 1) addiction to the Web is seen as a social phenomenon, as a phenomenon of mass culture, when a person working on the Web gets *"communication pleasure"*; 2) Internet addiction is interpreted as a disease, the result of the influence of information technology on human consciousness, manifested in a special passion for the Web, when a person suffers from such an addiction, but cannot stop this communication or regulate it without outside help.

Intimacy of relationships (from lat. *intimus* - deep, inner) - closeness, close relationship; in medicine - bilateral "human relations" in the system “doctor-patient”, assuming their mutual willingness to comply with moral standards, bear responsibility, show respect, honesty, frankness towards each other. One of the most delicate issues in medical ethics is the possibility of developing deep and complex feelings, sexual desires or simply intimate relationships with patients on the basis of attention, trust, care for another person, which are essential for the treatment process. Traditionally - from Hippocrates - acting person between doctor and patient is frowned upon as it is considered to jeopardize the treatment process.

Informed consent is a principle of biomedical ethics, which implies respect for the patient's right to know the whole truth about his state of health, about the existing methods of treating his disease and the risk associated with each of them. In an autonomous model of relationships, the principle of I.C. is a communicative dialogue between a doctor and a patient; here I.C. is not made dependent on the good will or desire of the doctor, but acts as his duty. I.C. involves the observance of a number of ethical and procedural norms: taking into account the mental state, the level of culture, the national and religious characteristics of the patient, the tact of the doctor or researcher, his moral qualities, the ability to ensure that the patient understands the information. Correct information about the state of health and its prognosis gives the patient the opportunity to independently and adequately dispose of his right to life, providing him with freedom of choice.

Artificial (extracorporeal) fertilization - a modern biotechnological method of overcoming infertility - conception in vitro (in vitro): ectopic fertilization of an infertile egg.

Incident is a complex, unusual case in medical practice or biomedical research, requiring the adoption of a specific extraordinary decision.

Cloning ethical issues (from the Greek *klōn* - branch, offspring). Cloning is the production of genetically homogeneous offspring through asexual reproduction. The developed methods of C. animals are still imperfect; there is a high mortality of fetuses and newborns; many theoretical questions are not clear C. from a separate somatic cell. At the same time, there is a theoretical possibility of creating genetic copies of a person from a single cell of any of his organs. However, the idea of human C. is estimated by experts ambiguously and therefore is subjected to a comprehensive bioethical examination. The medical and biological motivation for the ban on human C. is associated primarily with a high percentage of failures - damage to embryos and stillbirths in C. animals, which is why it is unacceptable to transfer the experiment to people; in addition, in the process of culturing cells in test tubes and obtaining somaclones, various kinds of mutations can occur, which can lead to an increase in the human population of genetically defective people, including mentally ill people. Ethical considerations are connected with the fact that the result of C. is not the child of his parents, but the identical twin of the father or mother, which gives rise to new moral and legal problems; there is also the danger of abuse and speculation on the misfortune of childless people. Proponents of human genetics see in it, first of all, a method of reproduction that can be used by people who do not have the opportunity to reproduce their genes in a different way and get their own child as a result. As for the danger of using a person's C. for immoral, immoral purposes, it is necessary to tighten the constant ethical control over such studies. To prohibit the cloning of people and animals means to stop the whole scientific direction and the work of human thought.

Therapeutic cloning is a direction of modern genetics, the purpose of which is to clone not a whole organism, but its individual organs in the interests of treating patients, in particular for transplantation. One of the proposed methods is cloning and use of embryonic stem cells, which brings researchers back to the ethical issues of the status of the embryo.

Hippocratic Oath is a set of moral and ethical norms for the behavior of a doctor in relation to patients and colleagues, providing for a respectful attitude towards teachers who have taught the art of healing; observance of the principle "Do no harm"; recognition of the sanctity of life; readiness to refrain from atrocities and corruption, to keep medical secrecy; give all the strength and knowledge to improve the health of patients; share knowledge with colleagues.

Code (from lat. codex - book) - a set of moral standards prescribed for execution: Code of Medical Ethics; Hippocratic Oath;

Ethical (bioethical) committees are special structural subdivisions for conducting independent ethical control, which is mandatory for all biomedical research. First appeared in the 50s. 20th century in the United States for the purpose of conducting an official ethical review of federally funded research. In the United States, not only biomedical, but also psychological, anthropological, and other studies are subject to mandatory ethical review if they are conducted on humans or animals. Since 1967 EC are created at hospitals and research institutions in Great Britain, then Germany and France. One of the goals and functions of EC – monitoring compliance with the basic principles of biomedical ethics in treatment and biomedical research: respect for the autonomy and rights of the patient, informed consent, fairness, striving for the best results while minimizing risk. With the expansion of the practice of biomedical research, their ethical support, carried out by EC, is becoming the norm throughout the world. Today, every research project must be approved by an independent EC.

Confidentiality principle (from Latin *confidentia* - trust) is a principle of biomedical ethics that ensures mutual trust between a doctor and a patient. It is based on two ethical arguments: 1) utilitarian, based on considerations of utility, because the violation of confidentiality worsens the relationship between the patient and the doctor and makes it difficult for the latter to fulfill his duties; 2) deontological, based on moral considerations: each individual has the right to decide for himself to what extent his thoughts, experiences, feelings can be communicated to another. CP. implies strict observance of medical secrecy, anonymity of ongoing research, minimization of interference in the patient's personal life, careful storage of confidential data and restriction of access to them not only during life, but also after the death of the patient.

Corporatism professional (medical) (from Latin *corporatio* - association, community) - devotion to narrow group interests within professional associations (corporations), manifested: 1) in the preservation and cultivation of *professional (medical) secrets*; 2) in *"shop solidarity"* - assistance and protection of representatives of their (medical) "shop" in any conditions; 3) in special symbols: traditions, customs, clothes; 4) in an appeal to a special language of professional communication (Latin among physicians).

Manassein V.A. (1841-1901) - "knight of medical ethics", professor, editor of the Russian newspaper "Vrach". Irreconcilable opponent of private practice in medicine, demanding its worthy state support; stood for the absolute preservation of medical secrecy under any circumstances. The author of one of the first "Ethical Rules" in Russia, published in "Doctor" (1884).

Medical (medical) ethics is a branch of applied professional ethics, which is an integral part of biomedical ethics and regulates "human relations" in medicine "vertically" (doctor-patient) and "horizontally" (doctor-doctor) based on the traditional principles of medical deontology. Has a corporate character. The prevailing attention is paid to the rights and obligations of the doctor in relation to patients, as well as the normative regulation of relationships "within" the medical profession.

Mercy is a universal value, a manifestation of the human in a person, the most effective, “practical” form of compassion for the sick, “love of heart, willingness to do good to everyone, love in deed” (Vl. Dal). The role of M. is especially great in medical practice, which often deals with the disabled, the seriously ill, the infirm, and the elderly. M. formed the basis for the name of one of the medical professions - sister of mercy.

Moll Albert - German physician, author of the book "Medical Ethics" (1902), which deals with the basic rights and duties of a doctor; one of the first to apply the term "ethics" to medical practice.

Moratorium (from lat. *moratorius* - delaying) - a temporary ban on conducting any research in the field of the latest biotechnologies, postponing the introduction of certain scientific discoveries, the long-term consequences of which can be harmful or dangerous.

Neuro-linguistic programming (NLP) is a new interdisciplinary direction, the purpose of which is to form a model of successful psychotherapy based on the use of text change methods (transformational grammar) and its impact on a person. It took shape thanks to the efforts of J. Grinder, who, as a linguist, analyzed the verbal techniques used in issuing instructions to another person, and R. Bandler, who, as a mathematician, presented all this in the form of technologies, i.e. algorithms, procedures. The unique possibilities of NLP are used in various fields of human activity (therapy, education, sports, commercial activities, personnel management, business, for the training of special services). NLP techniques allow you to quickly achieve mutual understanding with others, activate mental abilities (neuro); use language (linguistic) in a special way to achieve their goals;

learn to manage the state of your mind, psyche, bring your beliefs and values in line with the desired results (programming).

Noosphere (from Greek *noos* - mind and *sphaire* - ball) is the evolutionary state of the biosphere, in which the rational activity of a person becomes a decisive factor in its development. V.I. Vernadsky developed the idea of N. as a qualitatively new form of organization that arises from the interaction of nature and society as a result of human creative activity that transforms the world, based on scientific thought.

Norma (from lat. *norma* - guiding principle, rule, pattern) is an established standard for evaluating existing and creating new objects. The most well-known area of application in medicine is a diagnosis that allows you to determine whether a given subject is within the boundaries of N. Within the framework of modern science, it is noted that when studying the behavior of complex and super-complex self-developing systems, it is necessary to move away from a rigid linear principle and take into account all interacting factors, the nature of external parameters affecting the system and more clearly approach the interpretation of N. "Rigidity" in the formulation of a clinical diagnosis, as evidenced by modern biomedical and bioethical approaches, is not justified in any way, because it is impossible not to take into account the unique physical and spiritual properties of individuals, the individuality of the manifestation and course of the disease in individual patients. The rejection of one-linearity and rigidity, the appeal to synergistic models, theories of random and probable processes that take into account "free will" in its dynamic expression, are designed to help update judgments about N. and pathology, blur the boundary between them with a wide range of adaptive reactions, and the idea of N. will change along with society and the transformation of the model of modern medicine.

Morality is a set of moral norms and rules that regulate the relations and behavior of people in society. Often used as a synonym for the concept of "morality", but has its own specifics. The main difference between these concepts is based on the opposition of what should be, what a person should strive for (the world of due), and those practical mores that a person encounters in everyday life (the world of existence). With this approach, morality is understood as a specific sphere of culture in which high principles, ideals and values that regulate human behavior and consciousness are concentrated and generalized. A more “mundane”, “living” meaning is put into the concept of morality, including the norms of real practical behavior of people, in which the severity of high moral principles is significantly softened. In modern bioethics, ethical principles are formulated that ensure the regulation of the behavior of specialists in various areas of their professional activity and the formation of a moral assessment of rapidly developing biomedical research.

Morals are forms of behavior accepted in society, actually existing “everyday”, “living” norms of morality (as opposed to higher, declared strict ideals and moral norms), existing in a certain community (sphere of life) in a certain era. Stereotypes of human behavior, objectified in duties and becoming a way of thinking and acting, are born in real life and are not specifically sanctioned.

"Special" people ("unusual" people) - persons with disabilities or serious obstacles to physical or mental development. The term was introduced by Russian prof. D.N. Isaev as a humanistic alternative to the traditional term "inferior people (children)", which carries a direct violation of bioethical principles that prohibit the segregation (separation) of people on any grounds. The main ethical problem is connected with the unpreparedness of society and specialists - doctors and teachers - to include these people (children) in the system of public relations, to consistently adapt them, to create conditions for their "normalization".

Moral assessment is a judgment that expresses a moral attitude to the phenomena of the value world (approval - disapproval, good - evil, right - wrong, etc.). In bioethics, O. m. plays the role of a moral sanction for ongoing biomedical research involving humans, the application of new biomedical knowledge and technologies, and the latest achievements in biomedical science and healthcare practice.

Medical error - in medical ethics is closely related to the concept of responsibility. The problem of ME ratio and moral responsibility of the doctor is based on a number of provisions: 1)ME reasons of century. lie in the extraordinary complexity of the object with which doctors deal, in the sharply increased activity of modern methods of treatment and diagnosis, in the progressive specialization in medicine and often do not depend on the personality of a doctor; 2) registration, systematization, analysis and study of ME should be the basis for the development of scientific and medical thought; 3) it is necessary to clearly differentiate between ignorance and ignorance, which is not always easy: the doctor's ignorance should lead to his disqualification, ignorance can be the result of "honest delusion"; 4) a causal relationship between the actions (or inaction) of the doctor and the deterioration of health or even the death of the patient does not yet mean the guilt of the doctor: it can be an accident, although in moral and ethical terms it is still a defeat for the doctor in the struggle for the life and health of the person entrusted to him patient. If morally ME can be excusable due to objective or subjective circumstances - cramped, non-optimal conditions for the doctor's activity, the exceptional complexity of the medical profession itself, then in legal and legal terms, the emphasis is on the guilt of the doctor and, therefore, his responsibility, therefore, differentiation of the concepts of "accident" or "ME" has no independent significance for legal authorities. From the point of view of medical ethics, a doctor must always be honest with himself and admit his professional mistakes, which is considered not as heroism and exclusivity, but as a professional ethical standard of a doctor. The presence in medical practice of ME and accidents as unavoidable phenomena accompanying treatment, should not mean "the doctor's right to make a mistake", which could give rise to elementary professional dishonesty. From the standpoint of medical ethics, the attitude to professional mistakes should be irreconcilable, therefore, medical ethics requires a direct and impartial moral assessment of each ME.

Panpsychism (from Greek *pan* - everything and *psychē* - soul) is the point of view according to which all nature has a psyche. It comes from the idea of the universe being animated, the assumption of the immortality of spiritual atoms wandering in the world and moving into different organisms (K.E. Tsiolkovsky).

Paracelsus (Paracelsus: real name Philip Aureat Theophrastus Bombast von Hohenheim (Philippus Quredus Theophrastus Bombastus van Hohenheim) (1493-1541) - physician and chemist, one of the most prominent representatives of the culture of the early Renaissance. Born in Switzerland in the family of a doctor, educated at the university in Italy. He fought against the abuses and acquisitiveness of pharmacists and doctors associated with them. Known for his statements about the public image and duty of the doctor: "A doctor does not dare to be either a tormentor, or an executioner, or an executioner's servant."

Paternalism (from Latin *paternus* - paternal) is a principle of biomedical ethics that defines the form of caring for the needs of another (patient), just as a father takes care of a child. The essence of P. is that the doctor not only assumes the obligation to act on the basis of the patient's good, but also independently decides what exactly this good consists of. The question of the extent and in what aspects a patient can receive reliable information about his condition, about the strategy, tactics and prospects for treatment is within an exclusive competence of a doctor. Extreme forms of P. generally deprive the patient of the right to choose both in relation to the attending physician and in relation to the strategy and tactics of treatment. Thus, P. carries in itself a violent restriction of the freedom of the individual, due to "concern" for her well-being.

“Weakened” (limited) paternalism is a boundary model of the relationship between a doctor and a patient, which allows partial restriction of the freedom of the individual in the event of a decrease in the level of its autonomy, for example, when it is necessary to keep an individual with a markedly reduced level of personality from causing significant harm to himself or others (suicide attempt, drug addiction). hallucinations) and gain time to find out the seriousness of his intentions.

Pathology (from Greek *pathos* - suffering and *logos* - teaching) - 1) a branch of medicine that studies disease processes and conditions in a living organism; 2) painful deviation from the norm.

Pathosophy (from Greek *pathos* - suffering and *sophia* - wisdom) - "wisdom about suffering", which consists in the ability to understand suffering, the willingness to accept suffering and the ability to overcome suffering. A person's reaction to suffering, the model of his behavior depend on the understanding of suffering and attitude towards it. As a result, we either run from it or accept it. P. acts as the highest wisdom for employees and patients of hospices.

Pirogov N.I. (1810-1881) - an outstanding Russian scientist, teacher, public figure, doctor, one of the founders of general surgery as a scientific discipline, the founder of military field surgery. For the first time, he attracted women (sisters of mercy) to care for the wounded at the front. In the famous autobiographical work "Annals" he sets out his views on the problems of medical deontology, in particular on the problem of medical error.

Behavior is a system of internally interconnected and coordinated with the environment actions of an object (subject) aimed at the implementation of the corresponding functions. In a broad sense, we can talk about the behavior of any objects (starting from an electron and ending with systems of a biological and social type); in a narrower sense, the concept of "behavior" describes the moral actions of a person (in philosophy, ethics), as well as the systemic characteristics of the mental activity of biological individuals of various levels of organization to maintain their existence (in physiology, psyche, ethology, etc.). Relying on the theories of reflex (N.A. Bernstein, P.K. Anokhin), Gestalt psychology (L. Levin), psychological school (L.S. Vygotsky), genetic psychology (J. Piaget) and other approaches, in modern bioethics, specific mechanisms of human behavior are studied in the context of biomedical research; legal, moral and value parameters of the behavior of medical professionals in the context of decision-making in extreme situations; mechanisms for regulating the behavior and relationships of individuals and society regarding the application of new biomedical knowledge and technologies.

Benefit - a concept that reflects the value parameters and the significance of individual objects in relation to the interests of a person and society; everything that contributes to their good. In the framework of the activity-target approach, what is considered useful is that which contributes to the achievement of goals; from the point of view of the value-target approach, it is recognized as useful that, along with the achievement of the goal, ensures success, i.e. obtaining results close to the set goal, and efficiency, i.e. achieving the goal at the lowest cost. The principle of usefulness (“take advantage of everything for your own interest”) is thus complemented by the principle of success (“use the best means and strive for success in achieving goals”). In bioethics, the moral-ideological and civic sounding of the principle of benefit is important, which allows you to set the boundaries of the socially significant individual behavior of scientists, physicians, specialists in biomedical research and experiments with human participation and limit selfish-pragmatic self-will and absolutization of the principle of benefit and commercialism, contributing to the development of the values of mercy and justice.

Potter Van Ransler is a well-known American researcher-oncologist, who in 1969 first introduced the concept of "bioethics" and gave it a definition; is considered the founder of bioethics as a new direction in science. Author of the book “Bioethics: bridge to the future” (1971) – “Bioethics: bridge to the future” (Kyiv, 2002), which is dedicated to finding ways to solve the global problem of human survival, which includes demographic, environmental and technological components. Potter assesses the problematic existence of mankind as a biologist, but he sees the ways to solve the problem in the moral improvement of consciousness, therefore he considers a new branch of knowledge - bioethics, as a "bridge to the future", which should be based on the synthesis of natural science and humanitarian knowledge, in which "ethical values are not must be considered outside of biological facts."

Rights of Living (bios) are based on the principle of reverence for life, recognizing the inherent value of any Living as an independent subject, regardless of its benefit or harm to a person. The moral and legal recognition of RL. orients the human community towards the preservation and care of the Other Living. Currently, in some countries RL are issued as legal ones.

Right to a decent life implies the implementation by the individual and society of the attitude to life as a natural, inalienable right of every person, which belongs to him from the moment of his inception. Therefore, any attempts to control his life and health should be suppressed, including the claims of medicine to fully decide the fate of patients, or the claims of the state to solve its problems at the expense of the lives of citizens (for example, in wars), or the desire of society to ensure its security by retaining the death penalty. .

Right to a dignified death (RDD) is a natural right of every person, the same as the right to a dignified life, since death is the other side of human life. In RDD, the generic essence of a person is manifested - a natural desire to receive pleasure and avoid suffering - physical and spiritual. RDD fixes in itself the moral aspects of dignity, harmonizing the life of an individual and society as a whole. Not only death for personal reasons, when a person himself prefers a dignified death to an unworthy life, but also non-standard situations generated by scientific and technological progress in the practice of medicine (organ transplantation, maintaining a person in an unconscious - "vegetative" state, new approaches to determining the criterion death, etc.) force the society to revise and deepen its attitude towards the RDD. This right implies a moral concern for the autonomy and dignity of the dying person, first of all, on the part of medical professionals who must give the patient truthful information about his diagnosis, medical procedures and the arguments for and against them, so that the patient himself can make a choice. PDS includes the concept of "dying with dignity".

Praxeology (from Greek *praktikos* - active, active) is a concept that describes the mechanisms for the effective organization of human practical activity. Drawn up by the beginning of the 20th century, in the context of the search for universal principles of universal organizational science - technology, forms of rational activity - the most general norms for the maximum expediency of actions; systems of general technical recommendations and warnings in relation to professional activities. Currently, an instrumental understanding of practice is being formed and developed, which is expressed, on the one hand, in philosophical reflection on its foundations, and on the other hand, in its technologization. In biomedical practice, this is a search for operational mechanisms for organizing professional activities, technological and analytical development principles, levels, components and mechanisms of professional activity. In bioethics, the ideas and generalizations of praxeology are very important in the analysis of decision-making mechanisms in biomedical research, the moral choice of medical scientists, their actions in extreme situations, the regulation of relationships between the individual and society in the process of applying the latest biomedical technologies, the normative-value aspects of cooperation and the interaction of a doctor and a patient, etc.

Predestination is the point of view of a religious world outlook, proceeding from a determinism of ethical behavior of a person, his “salvation” (“judgment”) by the will of God. Having developed within the framework of religious systems and being their specific product, the concept of fatal predestination in modern bioethics serves as a kind of philosophical and logical model for actualizing such important problems as free will, moral responsibility, moral choice, the moral duty to “treat to the end”, the problem of euthanasia and etc.

Prenatal diagnosis - determining the sex of the child, identifying hereditary diseases and other manipulations during the period of intrauterine development of the fetus. The moral legitimacy of the procedure is determined, firstly, by the goals of diagnosis: determining the sex of the fetus or identifying hereditary pathology in it; secondly, the consequences of the diagnosis: whether it will entail a selective termination of pregnancy, depending on the result. Ethical examination of this technique involves taking into account the following circumstances: the degree of voluntariness of PD. of the population in order to identify carriers of hereditary diseases (especially when one of the parents of the unborn child is a carrier of a defective gene); the justification of the moral desire of parents - carriers of hereditary diseases to have offspring; deciding which hereditary diseases of the fetus allow (or directly oblige) parents to have an abortion; whether abortions are allowed when the only reason for them is the desire of the family to have a child with a pre-planned gender. Opponents of PD accuse her primarily of being the basis for abortions. However, the possibilities of genetic counseling, which makes it possible to identify various chromosomal diseases, diseases associated with the sex of the child, birth defects, etc., require the doctor to adhere to an ethically neutral position in the case of genetic counseling: the patients themselves must make decisions on issues of interest to them. The moral justification for PD is that it saves more lives than it takes, allowing "doubting" parents to make sure that their child is healthy. At the same time, many ethical issues of PD remain unresolved, in particular, the issue of selective abortion if a disease is detected in the fetus that can be treated with drug therapy or will not necessarily adversely affect the health of a child.

Principalism is a concept that favors a theoretical development of the fundamental principles of bioethics. It was proposed by American bioethicists T. Beechamp and J. Childres in the book “Principles of Biomedical Ethics” (1979). Now P. is more characteristic of Western Europe.

Principles of bioethics are the most fundamental concepts of biomedical ethics, on the basis of which specific moral norms for the behavior of a doctor and medical researcher are developed. The main PB first of all, *respect for the autonomy of the individual* (its right to self-determination) and *the desire to ensure the welfare of a patient* are recognized, based on fundamental democratic values, which are, in particular, solidarity, complicity, compassion (B. Jennings). "Classic" principles of bioethics (T. Beechamp, J. Childres) include: *respect for the autonomy of the individual, justice, non-malificence, charity (do good).* The Declaration of Helsinki includes among the main PB principles of personal *autonomy, informed consent and confidentiality*. The Western European approach - "Kemp's principles" (2000) - puts forward the autonomy of the individual, human dignity, integrity and vulnerability of a person as fundamental.

Prognosis (from Greek *prognosis* - foresight) - originally - prediction of the course of the disease, based on its recognition, diagnosis; then, in general, any specific prediction, a judgment about the state of a phenomenon in the future (the forecast of the weather, the outcome of elections, etc.). In the modern sense, it is a scientifically based judgment about the possible states of a phenomenon in the future and / or about alternative ways and terms for the implementation of these states.

Professionalism of a doctor is a concept that includes knowledge at the level of the latest achievements of medical science; knowledge in the field of practical and social psychology; the ability to think logically, the presence of developed intuition and the ability to analyze and synthesize facts; possession of a high technique for performing the necessary actions; high moral qualities, such as humanity and fidelity to duty.

Medical psychology is one of the components of the professionalism of a doctor who daily deals with specific and different in their mental reactions people, each of whom needs an individual approach, taking into account their psychological characteristics, socially and individually determined behavioral and ideological stereotypes, which requires a doctor deep assimilation *of practical and social psychology.*

Resuscitation ethical problems (from lat. *re-animatio* - revival again) - a set of measures to revive a person in a state of clinical death. Resuscitation measures are aimed at delaying the transition from life to death and restoring the body's vital functions as soon as possible. The main regulator for R. is the time factor - an interval of 5-6 minutes (sometimes less) - a quantitatively expressed measure of life that remains in conditions of clinical death. Ethical problems of R.: when deciding on the issue of saving the life of incurable patients - how ethical are the ideals of traditional medical ethics, which prescribes to fight for life “to the end”, if the patient prefers “easy death”; in transplantation, the contradiction between the need to remove a still “living” donor organ for transplantation, for which the donor himself must already be irreversibly dead; when extending the patient's life with the help of equipment - what arguments will be ethically weighty when the equipment is turned off, i.e. in fact, "killing" the patient, etc. Medical risk - the need to make a decision and make a conscious responsible choice in extreme medical situations. R. can be: 1) operational - reflects the incompleteness of knowledge of medicine or lack of experience of the doctor; 2) ethical - reflects the area of interpersonal relations between the doctor and patients, with their relatives, the doctor's self-assessment of his capabilities and abilities; 3) calculated - in the case when the methods of diagnostic or therapeutic exposure are carefully analyzed and the doctor chooses the method that is associated with a lower R. and greater effectiveness of medical intervention. It is possible to reduce ethical R. to a minimum provided that the patient is objectively informed about the actual and possible R. for his life as a result of intervention and the maximum reduction of operational R. The concept of R. is close, but not identical to the concept of "danger", which characterizes the objective life situation itself according to yourself; R. concept reflects the doctor's subjective attitude to a dangerous life situation.

Self-awareness is an individual's awareness of his physical, intellectual,moral, personal specifics, national and professional affiliation, place in the system of social relations.

Freedom of will is a philosophical concept that expresses a person's ability to moral self-determination, his moral autonomy, a kind of intellectual and moral will. In modern bioethics, the concept of free will is concretized through such concepts as “freedom to make a decision”, “freedom of action”, “freedom of choice” and acts in close connection with the moral and legal responsibility of the subject making the decision in a particular biomedical situation.

Freedom of choice is the basic and necessary quality of moral choice. The choice is free when all intellectual and volitional abilities are connected to it and when moral requirements merge with the internal needs of the individual. It is limited and not free when the place of reason is occupied by feelings of fear or duty caused by external coercion or arbitrariness, and the will of the individual is hampered by contradictions between *I want, I can and I must.*

Synergetics (from tGreek synergos - acting together) is an interdisciplinary direction in modern science, within which the theory of complex self-organizing systems is substantiated, the joint action of many subsystems of a very different nature is studied, which results in a structure and corresponding functioning (G. Haken, 1978) . Acts as the methodological basis of modern bioethics as a science.

Death is the cessation of the vital activity of the organism and, as a result, the death of the individual as a separate living system; the process of transition from the living to the dead. Defining the philosophical and ontological status of death involves solving the problem of the existence and essence of death: if death (in the strict sense of the word) exists, then it is a process of dying, the transition of one quality into another, one form of being into another.

Clinical death - a special kind of existence - a terminal state, the border of being and non-being of the living; the process of dying as a transition from one quality to another. A specific feature of CD is its fundamental reversibility, since from a biological point of view with CD, a sufficient number of “elements of life” are still preserved, many of whose functions have only stopped. The time interval characterizing CD - 5-6 minutes (sometimes less) - a quantitatively expressed measure of still remaining life. The ethical imperative requires physicians to treat clinical death as a condition in need of urgent care.

Compassion - pity, sympathy caused by misfortune, grief, suffering of another person, combined with a desire to help him. C - the ability to suffer together with another, to sympathize, empathize, sympathize with him - an integral quality of a doctor, which is based on a highly developed emotional and sensual side of the personality. For doctor C - an element of his professionalism. The moral value of SC is determined by the degree of its effectiveness. Forms of manifestation of C: support for another in word and deed; charity; the ability to forgive; mercy (for example, sister of mercy).

Medical subordination (from Latin *sub* - under and *ordinatio* - putting in order) - a system of official subordination of junior medical personnel to middle and senior, based on the rules of service discipline.

Surrogate mother (from Latin *surrogatus* - replacing another) is a woman who carries someone else's embryo, a fetus implanted in her body (the fertilized egg of another woman who cannot or does not want to bear a child). Ethical problems arise because of the mutual claims of the genetic parents and the surrogate mother regarding the “belonging” of the born child.

Medical secrecy is a fundamental value and principle of medical ethics, which includes the confidentiality of information relating to the patient. The principle is based on the trusting attitude of the doctor and the patient to each other. The concept of MS includes: 1) information about the patient received from him, his relatives, people close to him; 2) medical knowledge that should not be trusted to the patient and other uninitiated. The requirement to save MS - the categorical imperative of medicine, which is an indicator of the moral culture of the physician as a professional and a person. Preservation of MS - one of the manifestations of medical duty, requiring from the physician a morally purposeful and professionally competent concern for the honor and dignity of patients and their loved ones. This is an adequate moral and ethical response of the physician to the trust and frankness of the patient, ensuring the reliability of the trusting relationship between the physician and the patient.

Thanatology (from Greek *thanatos* - death, *logos* - teaching) - a branch of medicine that studies the causes, signs and mechanisms of death, the course of the dying process, changes in body tissues associated with dying and death, as well as ethical issues of medical intervention in the processes of dying - revival of the body (resuscitation) and relief of the suffering of the patient before death (euthanasia).

Telemedicine (from Greek *tēle* - far away) - "remote", distant medicine, the provision of medical care using the latest computer technology and remote radio and telecommunications.

Body is a concept that has several meanings: 1) a living organism in its correlation with the soul; 2) natural bodies (endowed and not endowed with life, studied respectively by physics, chemistry, biology, physiology, etc.); 3) artificial bodies produced by man in the process of civilizational development. In modern bioethics, the most important problems associated with the concept of the body are the problem of organ transplantation, the use of the bodies of dead people and the bodies of animals in biomedical research.

Tolerance (from Latin *tolerantia* - patience) - tolerance for other views, opinions, norms of behavior, communication and activities that are different from those held by a particular person or society as a whole; endurance, self-control, the ability to mutual understanding and harmonization of heterogeneous interests. In medical ethics, *the* *principle of tolerance* implies concern for the preservation of human life and health, the prevention of disease and the alleviation of the suffering of patients, regardless of gender, age, race and nationality, social and financial status, political beliefs and religion.

Transplantation ethical problems (from Latin *transplantare* - to transplant) - transplantation of organs with their subsequent engraftment within one organism (autotransplantation), or from one organism to another of the same species (homotransplantation), or another species (heterotransplantation), or even within different classes and orders (xenotransplantation). The main ethical problems of TEP include, first of all, the problem of the donor and the recipient. Theoretically, subject to the observance of high moral principles by the doctor, the donors of the necessary organ can be: 1) relatives of the patient who voluntarily donate one of their organs; 2) an outsider who has given voluntary and conscious consent to the taking of organs or tissues from him; 3) the corpse of a person who has just died. At the same time, according to the law, an outsider cannot sell or donate his organ (even a pair) during his lifetime. This means that in the absence of relatives or their consent to the operation, the organ necessary for the patient can only be taken from a corpse, and the sooner the better. There is a serious ethical conflict between resuscitators trying to save the life of a dying person (even hopeless patient), and transplantologists who "wait" for his death, as it will give them the opportunity to save the life of another. In many countries, the problem of using the organs of a corpse for T. has already received a legal solution, which is possible in two ways: 1) legal registration of the transfer of one's organs to other persons - with a view to their subsequent use after death; 2) granting the doctor the legal right to "select" the organs of the deceased patient necessary for the purposes of TEP. Other ethical and philosophical problems of TEP are associated with the danger of donation turning into a commercial operation (purchase, sale of human organs or a priority right on the waiting list waiting for a donor organ), therefore, when TEP of organs and tissues, the deontological principle of collegiality must be observed when making a decision.

"Dying with dignity" - implies moral care for a dying patient, manifested in a respectful attitude to both his bodily and spiritual dignity. Includes psychological and aesthetic dimensions: respect for the personal uniqueness of the patient, his worldview, religious views and beliefs, his national identity; care for the hygienic and aesthetic condition of the body of the dying. “Dying with dignity” also implies a well-considered decision to leave the life of the patient himself, which should be considered as a manifestation of the self-respect of the individual, since it is associated with a value-based approach to life.

Vulnerability is a principle of bioethics that has two meanings. 1) V is a characteristic of any living being (not necessarily human), of each individual life, finite and fragile by its nature. In this sense, all progress in the field of medicine and biology can be seen as a fight against human vulnerability, caused by the desire to minimize or "push back" it. At the same time, V, including mortality and finiteness, is regarded as a circumstance that can and must be overcome, however, there is a danger of depriving a person of the experience of pain and suffering, which are very significant in our perception of reality. 2) V in a narrower sense - refers to certain human groups and populations (poor, semi-literate, children, prisoners, disabled people, etc.), which, being weaker and more dependent, require special care, responsibility, empathy, and also observance of another principle of bioethics - *the principle of justice.*

Fetotherapy ethical issues - transplantation of fetal (embryonic) cells; can be used in the treatment of such serious diseases as diabetes, Parkinson's disease, traumatic spinal cord injuries, liver and heart diseases, thmiodystrophy, osteogenesis imperfecta. The bioethical problem is the permissibility of using embryonic cells and material left after an abortion. age, race and nationality, social and financial status, political opinions and religion.

Hospices are special organizations for helping the dying, special medical and social institutions in which terminally ill people get the opportunity to end their lives with dignity. The environment and activities of the staff are aimed at creating human conditions for dying with dignity in H Their difference from other medical institutions for hopeless patients lies in a different technical and medical equipment and a different philosophy of healing, according to which a special “living space” necessary in his condition is created for the patient. The philosophy of H is based on the fact that death, like birth, is a natural process, and the dying person must be helped to cross the line between life and death. H is not a house for death, but a house for a quality life to the end, in which the relationship between patients and medical personnel is formed on the basis of the principles of the hospice movement: 1) control of pain syndromes, which makes it possible to qualitatively improve the patient's life; 2) the final stage of a person's life, aware that he is dying, should become for him a stage of intense spiritual work, full of deep meaning; 3) a special style of behavior of doctors and a special tact in dealing with doomed patients; 4) medical personnel should in no case demand or agree to take money from patients and their relatives; 5) there is a widespread civil initiative of volunteers - volunteers who selflessly help the dying; 6) psychological assistance and support for relatives of the dying; 7) denial of the "holy lie" tactics. The implementation of these principles depends on the training and personal qualities of medical personnel. For H service, a new medical specialty is being formed that studies the process of the end of life - a palliative care doctor.

Integrity is a principle of bioethics put forward by European scientists to denote that which ensures both the physical and mental identity of a person to himself, his self-identification, and therefore should not be manipulated or destroyed. I is associated with the "life history" of the individual, which is created by the memory of the most important events of one's own life, the interpretation of life experience, and the individual's self-identification. Some medical interventions aimed at restoring health and improving a person’s condition are often associated with a violation of the I, to the problem of using parts of the human body - organs and tissues, etc.

Value is a term used in philosophy and sociology to indicate the human, social and cultural significance of certain objects and phenomena, referring to the world of proper, purposeful, significant, absolute.

Value orientations are elements of the internal structure of the personality, formed and fixed by the life experience of the individual in the course of the processes of socialization and social adaptation. VO - these are, first of all, preferences for certain meanings, goals and basic means of achieving them; the hierarchy of ethical and social values shared by the individual, beliefs, life-organizing principles, the readiness to behave in accordance with them and therefore acquiring the function of the most important regulators of the social behavior of individuals.

Honor and dignity are ethical evaluative categories that reflect *the moral value* of the individual and represent a public and individual assessment of the moral qualities and actions of a person, and are a necessary condition for the doctor to fulfill his professional duty. H as a moral phenomenon is an external public recognition of a person's actions, his merits, manifested in veneration, authority, and glory. Therefore, the feeling of H, inherent in the doctor as a person, is associated with the desire to achieve a high assessment of u1089 from others, praise, fame. H is what a person must conquer, achieve in the course of his life.

Professional H is rewarded to the doctor in accordance with the assessment that his qualities as a person and as a representative of the medical profession who fulfills his duty receive. D is, first of all, an internal confidence in one's own value, a sense of self-respect, manifested in resistance to attempts to encroach on one's individuality and a certain independence. This is the objective value of a person, which belongs to a person by birthright, because he is a person (human D.). Therefore, all patients, regardless of their social status, mental and physical condition and behavior, have equal rights to the recognition of their D.

Schweitzer Albert (1875-1965) - German-French philosopher, doctor, theologian, world famous for his humanistic actions, Nobel Peace Prize winner, founder of free hospitals in Africa. Author of the ethical principle of reverence for life. According to Sch., morality is not only a law, but also a condition for the existence and development of life. The basis of the progress of mankind and the spiritual perfection of the individual is the organic unity of ethics and culture, the criterion for the development of which is humanism.

Euthanasia (from ancient Greek *eu* - good and *thanatos* - death) is a concept that means a voluntary painless death and reflects the natural desire for every person to die easily and calmly. The concept of E. was introduced by F. Bacon in the 17th century. It exists in two forms - passive and active. Passive E. - the decision to stop treatment due to the hopeless condition of the patient; active E. - the introduction of high doses of drugs, ending the suffering and life of hopeless patients. In modern literature, the typology is expanded by introducing the concepts of voluntary and unintentional E.: voluntary E. is carried out when informing the patient; unintentional E. - without his consent. The most debatable from a bioethical point of view is the issue of voluntary active E. Its supporters rely on two main ethical arguments: mercy and the “golden rule” of morality and consider it has all the rights inherent in a person, therefore, by depriving an embryo of life, we kill what can to become a person is a “conservative position”. The denial of E. p. is a “liberal position” that denies the fetus an independent status even at the very late stages of pregnancy and gives the mother or doctors the right to choose the fate of the embryo. The “moderate position” is based on the point of view of modern biology and embryology, according to which a person as a biological individual is formed immediately after the fusion of parental germ cells, when a unique set of genes is formed, and requires a responsible attitude to making a decision.

Embryonic stem cells (ESCs) use ethical concerns. ESCs are cells isolated from early embryos that can independently exist in an undifferentiated state, retaining the ability to differentiate into any tissue, due to which they are potential suppliers of tissues for transplantation and treatment of many diseases. The main ethical problem is that ESCs are obtained from embryos cultured in vitro for artificial insemination, while the use of human embryos for biotechnological purposes is unacceptable from the point of view of bioethics and is prohibited in most countries. Proponents of the use of ESCs refer to the fact that studies are carried out on "doomed" embryos, from which human life will never arise ("extra" during artificial insemination or obtained as a result of abortion).

Emotional contact is the unity and consonance of a person's feelings with the experiences of other people. EC between the doctor, the patient and his relatives - bilateral relations based on the principle of partnership - understanding and acceptance by each of them of each other as individuals. The objective basis of such contact is the psychological mechanisms of infection and imitation, as a result of which a high level of identification is achieved, identification of oneself with another, the opportunity to share one's experiences with him, as a result of which a person experiences psychological relaxation - relief. EC is formed through the patient's awareness of the level of professionalism of the doctor. The higher the professional level of the doctor, the more hope and confidence he inspires the patient.

Empathy is the ability to respond emotionally to the experiences of another, which is what patients need from medical workers. Empathy is manifested in sympathy and complicity. Listening attentively to the patient, sympathizing with him, the doctor, the sister give him the opportunity to speak out and thereby alleviate his state of mind.

Participation is the highest level of empathy, requiring great dedication - "to take the patient's pain upon yourself" and help him with actions. Empathic experiences can be adequate and inadequate, and their nature is determined not only by the quality of experiences (of the subject), but also to a large extent by the structure of the individual's personality.

Ethics (from Greek *ēthos* - character, disposition) - the doctrine of morality - a system of norms, principles, values and ideals that regulate the behavior and attitude of a person to society, another person and himself.

Authoritarian ethics (AE) - the highest value and the goal for it is not a person, but something external to him: the interests of society or the state, the highest idea, the leader, God, etc. A person loses his self-worth and is considered only as a means to an end. AE is based on irrational authority, the source of which is power over people, on the one hand, and fear, on the other; it is built on inequality and subordination, on the priority of authority, the recognition of his right to be approved or condemned from the standpoint of his own interest. The main method of moral regulation is external coercion, which is carried out through the mechanism of submission: fear, dependence and violence (physical or moral). Requires the individual to focus on the public interest (regardless of personal interest), subordination to the will of society (or the majority), strict subordination and unification of personal qualities, views and interests, including professional ones. AE does not accept democracy, individualism and "dissent". It is the methodological basis of the paternalistic approach in traditional medical ethics and deontology.

Ethics humanistic (EH) - focused on a person, his life, freedom and interests. Considers a person in his bodily and spiritual integrity, believing that the foundations of "virtue" are laid in the character of a mature and holistic personality, and "vice" lies in indifference to one's own Y. E. Fromm, the founder of EH, therefore argues that "not self-denial and self-love - but love for oneself, not the denial of the individual, but the affirmation of one's truly human self - these are the highest values of humanistic ethics. EH is based on faith in a person, his autonomy, independence, freedom and reason, the ability of a person to independently distinguish between good and evil and correctly give ethical assessments. For EH, a person, his life and freedom are the highest value and goal, and everything that serves the self-realization of the human essence is recognized as a means and guarantor of achieving the goal. The main method of moral regulation in EH is a free conscious choice by a person of his own line of behavior based on ethical competence, personal interests, the ability to foresee the consequences of his actions and readiness to bear responsibility for them. EH is based on the principle of individualism, understood as self-love, the desire for self-affirmation and self-realization, as a result of which a person acquires his “self”, presents himself to the world and bears responsibility for himself, recognizing the same rights for others. EH is the methodological basis of biomedical ethics in general and the principle of patient autonomy in particular.

Ethics of life is a direction of Russian ethical thought of the late 19th - early 20th centuries, focused on the realization of *inherent value of life* as a fundamental value filled with spiritual meaning. In various philosophical concepts, EL interpreted differently. *Russian religious Orthodox ethics* (N.F. Fedorov, F.M. Dostoevsky, V.S. Solovyov, N.A. Berdyaev) considered the problems of life and death, building a humanistic vector of a person’s attitude to the world, life, and the surrounding nature. *Living ethics* (N.K., E.I. Roerichs and others) defended the values of mutual solidarity, mercy and justice. *"Cosmic Ethics"* (K.E. Tsiolkovsky) developed the ideas of *panpsychism* and the immortality of spiritual atoms. *The naturalistic direction,* focused on the natural sciences, primarily on biology, substantiated ethics based on the understanding of the anti-entropy of life as a natural-historical phenomenon aimed at combating the forces of chaos, disorder, and death (N.A. Umov). *The ethics of altruism* (P.A. Kropotkin) was spiritualized by the fact that ethical norms are rooted in the natural world, and the origins of altruism are in the instinct of mutual assistance and sociability inherent in animals. *Separate problems of medical ethics* developed later in the works of V.F. Voyno-Yasenetsky, V.I. Vernadsky, A.A. Lyubishcheva, D.P. Filatov (ethics of love for life).

Ethics of non-violence is an ethical concept based on a humanistic attitude to life as an absolute value and the principle *of non-resistance to evil by violence,* expressed in one of the commandments of Jesus Christ: "Do not resist evil" (Matt. 5: 39). The religious and moral doctrine of non-resistance to evil was defended by L. Tolstoy, who considered non-resistance to be the only effective form of combating evil, the meaning of which is to reduce the *“quantity” of evil and increase the “quantity”* of good in the world. The main question is in what ways and ways to achieve this - with the help *of force* or through *non-violent struggle*. Supporters of non-violence consider it as the most effective and adequate means of resisting evil, as the only possible real path to justice, because all other paths (from a position of strength) turned out to be ineffective, since retaliatory violence does not reduce, but increases the amount of evil in the world, generates the effect of . *the danger of impunity for evil*. The confrontation between the positions under consideration is currently manifested in the solution of many topical issues: when considering the effectiveness and moral permissibility of various ways to combat terrorism; in relation to the conduct of wars and the positions of pacifism, calling for the complete renunciation of any participation in any wars and active non-violent resistance to them; in relation to the death penalty, etc. For bioethics, nonviolence is of interest from the point of view of ensuring the human right to life, in particular, in solving the problems of euthanasia, the problem of the rights of the embryo, etc.

Applied Ethics (AE) is a field of ethical knowledge that, in contrast to fundamental theoretical knowledge, takes into account the specifics of the object and goals as special normative and value subsystems that specify the fundamental theoretical principles and norms of morality in relation to certain situations and spheres of human activity. AE is more specialized and therefore more pragmatic than general ethics; is based not only on the foundations of the theory of morality, but also on a complex of non-ethical knowledge about morality (sociological, psychological, pedagogical, medical, etc.); includes a strong technological aspect (involves the development of methods and methods for introducing applied knowledge into practice in the form of projects, programs, standards, models, codes, etc.); it rethinks traditional and new value-imperative moral ideas, meanings and principles of activity and management both in individual professional-specific areas and in interdisciplinary areas. The structure of AE includes the following elements: 1) environmental ethics and bioethics, considering the norms of human behavior as part of the ecosystem in relation to the environment and the Other Living; 2) ethics of citizenship, which develops the norms of human behavior as a citizen in relation to society; 3) the ethics of interpersonal communication. The development of this trend presupposes a close “cooperation” of ethics with psychology, medicine, biology, and others. Among the public, the ethics of political public actions, mass meetings, and others stand out. The most “situational” element of E.is etiquette.

Ecological ethics is a branch of applied ethics, the subject of which is the most fundamental principles and problems of moral relationships in the triad "Man - Nature - Society", where all participants in the interaction are considered as autonomous and equal moral subjects and within which a new environmental consciousness, including all Nature - living and non-living - in the circle of its cares, attention and reciprocity

Iatrogenic (from Greek *jatros* - doctor and *gennao* - generated) - 1) disease, arising from the erroneous actions of a doctor, or misinterpreted medical prescriptions or medical literature; 2) a method of examination, treatment or preventive measures, as a result of which a doctor harms health of a patient.

APPENDIX 1
UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS

Conscious of the unique capacity of human beings to reflect upon their own existence and on their environment, to perceive injustice, to avoid danger, to assume responsibility, to seek cooperation and to exhibit the moral sense that gives expression to ethical principles,

Reflecting on the rapid developments in science and technology, which increasingly affect our understanding of life and life itself, resulting in a strong demand for a global response to the ethical implications of such developments,

Recognizing that ethical issues raised by the rapid advances in science and their technological applications should be examined with due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

Resolving that it is necessary and timely for the international community to state universal principles that will provide a foundation for humanity's response to the ever-increasing dilemmas and controversies that science and technology present for humankind and for the environment,

Recalling the Universal Declaration of Human Rights of 10 December 1948, the Universal Declaration on the Human Genome and Human Rights adopted by the General Conference of UNESCO on 11 November 1997 and the International Declaration on Human Genetic Data adopted by the General Conference of UNESCO on 16 October 2003,

Noting the United Nations International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights of 16 December 1966, the United Nations International Convention on the Elimination of All Forms of Racial Discrimination of 21 December 1965, the United Nations Convention on the Elimination of All Forms of Discrimination against Women of 18 December 1979, the United Nations Convention on the Rights of the Child of 20 November 1989, the United Nations Convention on Biological Diversity of 5 June 1992, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities adopted by the General Assembly of the United Nations in 1993, the UNESCO Recommendation on the Status of

Scientific Researchers of 20 November 1974, the UNESCO Declaration on Race and Racial Prejudice of 27 November 1978, the UNESCO Declaration on the Responsibilities of the Present Generations Towards Future Generations of 12 November 1997, the UNESCO Universal Declaration on Cultural Diversity of 2 November 2001, the ILO Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries of 27 June 1989, the International Treaty on Plant Genetic Resources for Food and Agriculture which was adopted by the FAO Conference on 3 November 2001 and entered into force on 29 June 2004, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) annexed to the Marrakech Agreement establishing the World Trade Organization, which entered into force on 1 January 1995, the Doha Declaration on the TRIPS Agreement and Public Health of 14 November 2001 and other relevant international instruments adopted by the United Nations and the specialized agencies of the United Nations system, in particular the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO),

Also noting international and regional instruments in the field of bioethics, including the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine of the Council of Europe, which was adopted in 1997 and entered into force in 1999, together with its Additional Protocols, as well as national legislation and regulations in the field of bioethics and the international and regional codes of conduct and guidelines and other texts in the field of bioethics, such as the Declaration of Helsinki of the World Medical Association on Ethical Principles for Medical Research Involving Human Subjects, adopted in 1964 and amended in 1975, 1983, 1989, 1996 and 2000 and the International Ethical Guidelines for Biomedical Research Involving Human Subjects of the Council for International Organizations of Medical Sciences, adopted in 1982 and amended in 1993 and 2002,

Recognizing that this Declaration is to be understood in a manner consistent with domestic and international law in conformity with human rights law,

Recalling the Constitution of UNESCO adopted on 16 November 1945, *Considering* UNESCO’s role in identifying universal principles based on shared ethical values to guide scientific and technological development and social transformation in order to identify emerging challenges in science and technology taking into account the responsibility of the present generations towards future generations, and that questions of bioethics, which necessarily have an international dimension, should be treated as a whole, drawing on the principles already stated in the Universal Declaration on the Human Genome and Human Rights and the International Declaration on Human Genetic Data and taking account not only of the current scientific context but also of future developments,

Aware that human beings are an integral part of the biosphere, with an important role in protecting one another and other forms of life, in particular animals,

Recognizing that, based on the freedom of science and research, scientific and technological developments have been, and can be, of great benefit to humankind in increasing, inter alia, life expectancy and improving the quality of life, and emphasizing that such developments should always seek to promote the welfare of individuals, families, groups or communities and humankind as a whole in the recognition of the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

Recognizing that health does not depend solely on scientific and technological research developments but also on psychosocial and cultural factors,

Also recognizing that decisions regarding ethical issues in medicine, life sciences and associated technologies may have an impact on individuals, families, groups or communities and humankind as a whole,

Bearing in mind that cultural diversity, as a source of exchange, innovation and creativity, is necessary to humankind and, in this sense, is the common heritage of humanity, but emphasizing that it may not be invoked at the expense of human rights and fundamental freedoms,

Also bearing in mind that a person’s identity includes biological, psychological, social, cultural and spiritual dimensions,

Recognizing that unethical scientific and technological conduct has had a particular impact on indigenous and local communities,

Convinced that moral sensitivity and ethical reflection should be an integral part of the process of scientific and technological developments and that bioethics should play a predominant role in the choices that need to be made concerning issues arising from such developments,

Considering the desirability of developing new approaches to social responsibility to ensure that progress in science and technology contributes to justice, equity and to the interest of humanity,

Recognizing that an important way to evaluate social realities and achieve equity is to pay attention to the position of women,

Stressing the need to reinforce international cooperation in the field of bioethics, taking into account, in particular, the special needs of developing countries, indigenous communities and vulnerable populations,

Considering that all human beings, without distinction, should benefit from the same high ethical standards in medicine and life science research,

Proclaims the principles that follow and *adopts* the present Declaration.

General provisions

Article 1

Scope

1. This Declaration addresses ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions.

2. This Declaration is addressed to States. As appropriate and relevant, it also provides guidance to decisions or practices of individuals, groups, communities, institutions and corporations, public and private.

Article 2

Aims

The aims of this Declaration are: (a) to provide a universal framework of principles and procedures to guide States in the formulation of their legislation, policies or other instruments in the field of bioethics;

(b) to guide the actions of individuals, groups, communities, institutions and corporations, public and private;

(c) to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms, consistent with international human rights law;

(d) to recognize the importance of freedom of scientific research and the benefits derived from scientific and technological developments, while stressing the need for such research and developments to occur within the framework of ethical principles set out in this Declaration and to respect human dignity, human rights and fundamental freedoms;

(e) to foster multidisciplinary and pluralistic dialogue about bioethical issues between all stakeholders and within society as a whole;

(f) to promote equitable access to medical, scientific and technological developments as well as the greatest possible flow and the rapid sharing of knowledge concerning those developments and the sharing of benefits, with particular attention to the needs of developing countries;

(g) to safeguard and promote the interests of the present and future generations;

(h) to underline the importance of biodiversity and its conservation as a common concern of humankind.

Principles

Within the scope of this Declaration, in decisions or practices taken or carried out by those to whom it is addressed, the following principles are to be respected.

Article 3

Human dignity and human rights

1. Human dignity, human rights and fundamental freedoms are to be fully respected.

2. The interests and welfare of the individual should have priority over the sole interest of science or society.

Article 4

Benefit and harm

In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.

Article 5

Autonomy and individual responsibility

The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

Article 6
Consent

1. Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.

2. Scientific research should only be carried out with the prior, free, express and informed consent of the person concerned. The information should be adequate, provided in a comprehensible form and should include modalities for withdrawal of consent. Consent may be withdrawn by the person concerned at any time and for any reason without any disadvantage or prejudice. Exceptions to this principle should be made only in accordance with ethical and legal standards adopted by States, consistent with the principles and provisions set out in this Declaration, in particular in Article 27, and international human rights law.

3. In appropriate cases of research carried out on a group of persons or a community, additional agreement of the legal representatives of the group or community concerned may be sought. In no case should a collective community agreement or the consent of a community leader or other authority substitute for an individual's informed consent.

Article 7
Persons without the capacity to consent

In accordance with domestic law, special protection is to be given to persons who do not have the capacity to consent:

(a) authorization for research and medical practice should be obtained in accordance with the best interest of the person concerned and in accordance with domestic law. However, the person concerned should be involved to the greatest extent possible in the decision-making process of consent, as well as that of withdrawing consent;

(b) research should only be carried out for his or her direct health benefit, subject to the authorization and the protective conditions prescribed by law, and if there is no research alternative of comparable effectiveness with research participants able to consent. Research which does not have potential direct health benefit should only be undertaken by way of exception, with the utmost restraint, exposing the person only to a minimal risk and minimal burden and, if the research is expected to contribute to the health benefit of other persons in the same category, subject to the conditions prescribed by law and compatible with the protection of the individual’s human rights. Refusal of such persons to take part in research should be respected.

Article 8

Respect for human vulnerability and personal integrity

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.

Article 9

Privacy and confidentiality

The privacy of the persons concerned and the confidentiality of their personal information should be respected. To the greatest extent possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to, consistent with international law, in particular international human rights law.

Article 10

Equality, justice and equity

The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.

Article 11

Non-discrimination and non-stigmatization

No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms.

Article 12

Respect for cultural diversity and pluralism

The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope.

Article 13

Solidarity and cooperation

Solidarity among human beings and international cooperation towards that end are to be encouraged.

Article 14
Social responsibility and health

1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.

2. Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance:

(a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;

(b) access to adequate nutrition and water;

(c) improvement of living conditions and the environment;

(d) elimination of the marginalization and the exclusion of persons on the basis of

any grounds;

(e) reduction of poverty and illiteracy.

Article 15
Sharing of benefits

1. Benefits resulting from any scientific research and its applications should be shared with society as a whole and within the international community, in particular with developing countries. In giving effect to this principle, benefits may take any of the following forms:

(a) special and sustainable assistance to, and acknowledgement of, the persons and groups that have taken part in the research;

(b) access to quality health care;

(c) provision of new diagnostic and therapeutic modalities or products stemming from research;

(d) support for health services;

(e) access to scientific and technological knowledge;

(f) capacity-building facilities for research purposes;

(g) other forms of benefit consistent with the principles set out in this Declaration.

2. Benefits should not constitute improper inducements to participate in research.

Article 16

Protecting future generations

The impact of life sciences on future generations, including on their genetic constitution, should be given due regard.

Article 17

Protection of the environment, the biosphere and biodiversity

Due regard is to be given to the interconnection between human beings and other forms of life, to the importance of appropriate access and utilization of biological and genetic resources, to respect for traditional knowledge and to the role of human beings in the protection of the environment, the biosphere and biodiversity.

Application of the principles

Article 18

Decision-making and addressing bioethical issues

1. Professionalism, honesty, integrity and transparency in decision-making should be promoted, in particular declarations of all conflicts of interest and appropriate sharing of knowledge. Every endeavour should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues.

2. Persons and professionals concerned and society as a whole should be engaged in dialogue on a regular basis.

3. Opportunities for informed pluralistic public debate, seeking the expression of all relevant opinions, should be promoted.

Article 19

Ethics committees

Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to:

(a) assess the relevant ethical, legal, scientific and social issues related to research projects involving human beings;

(b) provide advice on ethical problems in clinical settings;

(c) assess scientific and technological developments, formulate recommendations and contribute to the preparation of guidelines on issues within the scope of this Declaration;

(d) foster debate, education and public awareness of, and engagement in, bioethics.

Article 20

Risk assessment and management

Appropriate assessment and adequate management of risk related to medicine, life sciences and associated technologies should be promoted.

Article 21

Transnational practices

1. States, public and private institutions, and professionals associated with transnational activities should endeavour to ensure that any activity within the scope of this Declaration, undertaken, funded or otherwise pursued in whole or in part in different States, is consistent with the principles set out in this Declaration.

2. When research is undertaken or otherwise pursued in one or more States (the host State(s)) and funded by a source in another State, such research should be the object of an appropriate level of ethical review in the host State(s) and the State in which the funder is located. This review should be based on ethical and legal standards that are consistent with the principles set out in this Declaration.

3. Transnational health research should be responsive to the needs of host countries, and the importance of research contributing to the alleviation of urgent global health problems should be recognized.

4. When negotiating a research agreement, terms for collaboration and agreement on the benefits of research should be established with equal participation by those party to the negotiation.

5. States should take appropriate measures, both at the national and international levels, to combat bioterrorism and illicit traffic in organs, tissues, samples, genetic resources and genetic-related materials.

Promotion of the Declaration

Article 22

Role of States

1. States should take all appropriate measures, whether of a legislative, administrative or other character, to give effect to the principles set out in this Declaration in accordance with international human rights law. Such measures should be supported by action in the spheres of education, training and public information.

2. States should encourage the establishment of independent, multidisciplinary and pluralist ethics committees, as set out in Article 19.

Article 23

Bioethics education, training and information

1. In order to promote the principles set out in this Declaration and to achieve a better understanding of the ethical implications of scientific and technological developments, in particular for young people, States should endeavour to foster bioethics education and training at all levels as well as to encourage information and knowledge dissemination programmes about bioethics.

2. States should encourage the participation of international and regional intergovernmental organizations and international, regional and national non governmental organizations in this endeavour.

Article 24

International cooperation

1. States should foster international dissemination of scientific information and encourage the free flow and sharing of scientific and technological knowledge.

2. Within the framework of international cooperation, States should promote cultural and scientific cooperation and enter into bilateral and multilateral agreements enabling developing countries to build up their capacity to participate in generating and sharing scientific knowledge, the related know-how and the benefits thereof.

3. States should respect and promote solidarity between and among States, as well as individuals, families, groups and communities, with special regard for those rendered vulnerable by disease or disability or other personal, societal or environmental conditions and those with the most limited resources.

Article 25

Follow-up action by UNESCO

1. UNESCO shall promote and disseminate the principles set out in this Declaration. In doing so, UNESCO should seek the help and assistance of the Intergovernmental Bioethics Committee (IGBC) and the International Bioethics Committee (IBC).

2. UNESCO shall reaffirm its commitment to dealing with bioethics and to promoting collaboration between IGBC and IBC.

Final provisions

Article 26

Interrelation and complementarity of the principles

This Declaration is to be understood as a whole and the principles are to be understood as complementary and interrelated. Each principle is to be considered in the context of the other principles, as appropriate and relevant in the circumstances.

Article 27

Limitations on the application of the principles

If the application of the principles of this Declaration is to be limited, it should be by law, including laws in the interests of public safety, for the investigation, detection and prosecution of criminal offences, for the protection of public health or for the protection of the rights and freedoms of others. Any such law needs to be consistent with international human rights law.

Article 28

Denial of acts contrary to human rights, fundamental freedoms and human dignity

Nothing in this Declaration may be interpreted as implying for any State, group or person any claim to engage in any activity or to perform any act contrary to human rights, fundamental freedoms and human dignity.

APPENDIX 2

WMA DECLARATION OF LISBON ON THE RIGHTS OF THE PATIENT

Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981
and amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995
and editorially revised by the 171st WMA Council Session, Santiago, Chile, October 2005
and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

PREAMBLE

The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.

PRINCIPLES

1. Right to medical care of good quality

a. Every person is entitled without discrimination to appropriate medical care.

b. Every patient has the right to be cared for by a physician whom he/she knows to be free to make clinical and ethical judgements without any outside interference.

c. The patient shall always be treated in accordance with his/her best interests. The treatment applied shall be in accordance with generally approved medical principles.

d. Quality assurance should always be a part of health care. Physicians, in particular, should accept responsibility for being guardians of the quality of medical services.

e. In circumstances where a choice must be made between potential patients for a particular treatment that is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination.

f. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

2. Right to freedom of choice

a. The patient has the right to choose freely and change his/her physician and hospital or health service institution, regardless of whether they are based in the private or public sector.

b. The patient has the right to ask for the opinion of another physician at any stage.

3. Right to self-determination

a. The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions.

b. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

c. The patient has the right to refuse to participate in research or the teaching of medicine.

4. The unconscious patient

a. If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative.

b. If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.

c. However, physicians should always try to save the life of a patient unconscious due to a suicide attempt.

5. The legally incompetent patient

a. If a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity.

b. If the legally incompetent patient can make rational decisions, his/her decisions must be respected, and he/she has the right to forbid the disclosure of information to his/her legally entitled representative.

c. If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution. In case of emergency, the physician will act in the patient's best interest.

6. Procedures against the patient's will
Diagnostic procedures or treatment against the patient's will can be carried out only in exceptional cases, if specifically permitted by law and conforming to the principles of medical ethics.

7. Right to information

a. The patient has the right to receive information about himself/herself recorded in any of his/her medical records, and to be fully informed about his/her health status including the medical facts about his/her condition. However, confidential information in the patient's records about a third party should not be given to the patient without the consent of that third party.

b. Exceptionally, information may be withheld from the patient when there is good reason to believe that this information would create a serious hazard to his/her life or health.

c. Information should be given in a way appropriate to the patient's culture and in such a way that the patient can understand.

d. The patient has the right not to be informed on his/her explicit request, unless required for the protection of another person's life.

e. The patient has the right to choose who, if anyone, should be informed on his/her behalf.

8. Right to confidentiality

a. All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death. Exceptionally, descendants may have a right of access to information that would inform them of their health risks.

b. Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other health care providers only on a strictly "need to know" basis unless the patient has given explicit consent.

c. All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must be likewise protected.

9. Right to Health Education

Every person has the right to health education that will assist him/her in making informed choices about personal health and about the available health services. The education should include information about healthy lifestyles and about methods of prevention and early detection of illnesses. The personal responsibility of everybody for his/her own health should be stressed. Physicians have an obligation to participate actively in educational efforts.

10. Right to dignity

a. The patient’s dignity and right to privacy shall be respected at all times in medical care and teaching, as shall his/her culture and values.

b. The patient is entitled to relief of his/her suffering according to the current state of knowledge.

c. The patient is entitled to humane terminal care and to be provided with all available assistance in making dying as dignified and comfortable as possible.

11. Right to religious assistance The patient has the right to receive or to decline spiritual and moral comfort including the help of a minister of his/her chosen religion.

APPENDIX 3

A Declaration on the Promotion of Patients' Rights in Europe: Principles of the Rights of Patients in Europe: A Common Framework Amsterdam Declaration of Patients' Rights, Endorsed by the World Health Organization European Consultation on The Rights of Patients, 28-30 March 1994

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9. HUMAN RIGHTS AND VALUES IN HEALTH CARE

The instruments cited in the Introduction should be understood as applying also specifically in the health care setting, and it should therefore be noted that the human values expressed in these instruments shall be reflected in the health care system. It should also be noted that where exceptional limitations are imposed on the rights of patients, these must be in accordance with human rights instruments and have a legal base in the law of the country. It may be further observed that the rights specified below carry a matching responsibility to act with due concern for the health of others and for their same rights.

1.1 Everyone has the right to respect of his or her person as a human being.

1.2 Everyone has the right to self-determination.

1.3 Everyone has the right to physical and mental integrity and to the security of his or her person.

1.4 Everyone has the right to respect for his or her privacy.

1.5 Everyone has the right to have his. or her moral and cultural values and religious and philosophical convictions respected.

1.6 Everyone has the right to such protection of health as is afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health.

10.INFORMATION

2.1 Information about health services and how best to use them is to be made available to the public in order to benefit all those concerned.

2.2 Patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment.

2.3 Information may only be withheld from patients exceptionally when there is good reason to believe that this information would without any expectation of obvious positive effects cause them serious harm.

2.4 Information must be communicated to the patient in a way appropriate to the latter's capacity for understanding, minimizing the use of unfamiliar technical terminology. If the patient does not speak the common language, some form of interpreting should be available.

2.5 Patients have the right not to be informed, at their explicit request.

2.6 Patients have the right to choose who, if any one, should be informed on their behalf

2.7 Patients should have the possibility of obtaining a second opinion.

2.8 When admitted to a health care establishment, patients should be informed of the identity and professional status of the health care providers taking care of them and of any rules and routines which would bear on their stay and care.

2.9 Patients should be able to request and be given a written summary of their diagnosis, treatment and care on discharge from a health care establishment.

11.CONSENT

3.1 The informed consent of the patient is a prerequisite for any medical intervention.

3.2 A patient has the right to refuse or to halt a medical intervention. The implications of refusing or halting such an intervention must be carefully explained to the patient

3.3 When a patient is unable to express his or her will and a medical intervention is urgently needed, the consent of the patient may be presumed, unless it is obvious from a previous declared expression of will that consent would be refused in the situation.

3.4 When the consent of a legal representative is required and the proposed intervention is urgently needed, that intervention may be made if it is not possible to obtain, in time, the representative's consent.

3.5 When the consent of a legal representative is required, patients (whether minor or adult) must nevertheless be involved in the decision-making process to the fullest extent which their capacity allows.

3.6 If a legal representative refuses to give consent and the physician or other provider is of the opinion that the intervention is in the interest of the patient, then the decision must be referred to a court or some form of arbitration.

3.7 In all other situations where the patient is unable to give informed consent and where there is no legal representative or representative designated by the patient for this purpose, appropriate measures should be taken to provide for a substitute decision making process, taking into account what is known and,, to the greatest extent possible, what may be presumed about the wishes of the patient

3.8 The consent of the patient is required for the preservation and use of all substances of the human body. Consent may be presumed when the substances are to be used in the current course of diagnosis, treatment and care of that patient.

3.9 The informed consent of the patient is needed for participation in clinical teaching.

3.10 The informed consent of the patient is a prerequisite for participation in scientific research. All protocols must be submitted to proper ethical review procedures. Such research should not be carried out on those who are unable to express their will, unless the consent of a legal representative has been obtained and the research would likely be in the interest of the patient. As an exception to the requirement of involvement being in the interest of the patient, an incapacitated person may be involved in observational research which is not of direct benefit to his or her health provided that that person offers no objection, that the risk andfor burden is minimal, that the research is of significant value and that no alternative methods and other research subjects are available.

4.CONFIDENTIALITY AND PRIVACY

4.1 All information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death.

4.2 Confidential information can only be disclosed if the patient gives explicit consent or if the law expressly provides for this. Consent may be presumed where disclosure is to other health care providers involved in that patient's treatment.

4.3 All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of their storage. Human substances from which identifiable data can be derived must be likewise protected.

4.4 Patients have the right of access to their medical files and technical records and to any other files and records pertaining to their diagnosis, treatment and care and to receive a copy of their own files and records or parts thereof. Such access excludes data concerning third parties.

4.5 Patients have the right to require the correction, completion, deletion, clarification and/or updating of personal and medical data concerning them which are inaccurate, incomplete, ambiguous or outdated, or which are not relevant to the purposes of diagnosis, treatment and care.

4.6 There can be no intrusion into a patient's private and family life unless and only if, in addition to the patient consenting to it, it can be justified as necessary to the patient's diagnosis, treatment and care.

4.7 Medical interventions may only be carried out when there is proper respect shown for the privacy of the individual. This means that a given intervention may be carried out only in the presence of those persons who are necessary for the intervention unless the patient consents or requests otherwise.

4.8 Patients admitted to health care establishments have the right to expect physical facilities which ensure privacy, particularly when health care providers are offering them personal care or carrying out examinations and treatment.

5. CARE AND TREATMENT

5.1 Everyone has the right to receive such health care as is appropriate to his or her health needs, including preventive care and activities aimed at health promotion. Services should be continuously available and accessible to all equitably, without discrimination and according to the financial, human and material resources which can be made available in a given society.

5.2 Patients have a collective right to some form of representation at each level of the health care system in matters pertaining to the planning and evaluation of services, including the range, quality and functioning of the care provided.

5.3 Patients have the right to a quality of care which is marked both by high technical standards and by a humane relationship between the patient and health care providers.

5.4 Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care.

5.5 In circumstances where a choice must be made by providers between potential patients for a particular treatment which is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination.

5.6 Patients have the right to choose and change their own physician or other health care provider and health care establishment, provided that it is compatible with the functioning of the health care system.

5.7 Patients for whom there are no longer medical grounds for continued stay in a health care establishment are entitled to a full explanation before they can be transferred to another establishment or sent home. Transfer can only take place after another health care establishment has agreed to accept the patient. Where the patient is discharged to home and when his or her condition so requires, community and domiciliary services should be available.

5.8 Patients have the right to be treated with dignity in relation to their diagnosis, treatment and care, which should be rendered with respect for their culture and values.

5.9 Patients have the right to enjoy support from family, relatives and friends during the course of care and treatment and to receive spiritual support and guidance at all times.

5.10 Patients have the right to relief of their suffering according to the current state of knowledge.

5.11 Patients have the right to humane terminal care and to die in dignity.

6. APPLICATION

6.1 The exercise of the rights set forth in this document implies that appropriate means are established for this purpose.

6.2 The enjoyment of these rights shall be secured without discrimination.

6.3 In the exercise of these rights, patients shall be subjected only to such limitations as are compatible with human rights instruments and in accordance with a procedure prescribed by law.

6.4 If patients cannot avail themselves of the rights set forth in this document, these rights should be exercised by their legal representative or by a person designated by the patient for that purpose; where neither a legal representative nor a personal surrogate has been appointed, other measures for representation of those patients should be taken.

6.5 Patients must have access to such information and advice as will enable them to exercise the rights set forth in this document. Where patients feel that their rights have not been respected they should be enabled to lodge a complaint. In addition to recourse to the courts, there should be independent mechanisms at institutional and other levels to facilitate the processes of lodging, mediating and adjudicating complaints. These mechanisms would, inter alia, ensure that information relating to complaints procedures was available to patients and that an independent person was available and accessible to them for consultation regarding the most appropriate course of action to take. These mechanisms should further ensure that, where necessary, assistance and advocacy on behalf of the patient would be made available. Patients have the right to have their complaints examined and dealt with in a thorough, just, effective and prompt way and to be informed about their outcome.

7. DEFINITIONS

In these Principles of the Rights of Patients in Europe, the following terms have been used with the meanings given:

PATIENT(S). User(s) of health care services, whether healthy or sick, DISCRIMINATION Distinction between persons in similar cases on the basis of race, sex, religion, political opinions, national or social origin, associations with a national minority or personal antipathy.

HEALTH CARE. Medical, nursing or allied services dispensed by health care providers and health care establishments.

HEALTH CARE PROVIDERS Physicians, nurses, dentists or other health professionals.

MEDICAL INTERVENTION. Any examination, treatment or other act having preventive, diagnostic, therapeutic or rehabilitative aims and which is carried out by a physician or other health care provider.

HEALTH CARE ESTABLISHMENT Any health care facility such as a hospital, nursing home or establishment for disabled persons.

TERMINAL CARE. Care given to a patient when it is no longer possible to improve the fatal prognosis of his or her illness/condition with available treatment methods; as well as care at the approach of death.

CONTENT

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BIOETHICS

TEXTBOOK FOR MEDICAL STUDENTS

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