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CONTENTS СОДЕРЖАНИЕ

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THE FATE OF BIOETHICS IN MEDICAL EDUCATION OF CONTEMPORARY RUSSIA IS UNDER THREAT

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Teaching bioethics in medical universities in Russia is currently artificially restricted. This is due to the financial problems of universities. But solving them we provoke the appearance of distant negative consequences. They will be expressed in the ethical incompetence of future doctors to which patients are already complaining. In connection with the introduction of new biotechnologies into medical practice the role of the ethical expertise of their application sharply increases. The lack of bioethical training among university graduates will not allow to carry out this expertise qualitatively. This entails risks for both individual patients and the health care system as a whole. It is necessary to raise the status of bioethics as a compulsory discipline in the training of future doctors, create scientific and methodical support for the training courses in this discipline that is adequate to modern requirements, agree on model programs and organize the training of qualified teachers. The author proposes to hold a meeting of the heads of social and humanitarian disciplines of medical universities to discuss these and other similar problems of the humanitarian training of future doctors.

Key words: medical education, social and humanitarian disciplines, bioethics, exemplary programs, professional competences, social risks of dehumanization of medical education.

СУДЬБА БИОЭТИКИ В МЕДИЦИНСКОМ ОБРАЗОВАНИИ СОВРЕМЕННОЙ РОССИИ ПОД УГРОЗОЙ

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Преподавание биоэтики в медицинских вузах России в настоящее время искусственно ограничивают. Это связано с финансовыми проблемами вузов. Но, решая их, мы провоцируем появление отдаленных негативных последствий. Они будут выражаться в этической некомпетентности будущих врачей, на которую уже сейчас жалуются пациенты. В связи с внедрением в медицинскую практику новых биотехнологий резко возрастает роль этической экспертизы их применения. Отсутствие биоэтической подготовки у выпускников вузов не позволит проводить такую экспертизу качественно. Это влечет за собой риски как для отдельных пациентов, так и для системы здравоохранения в целом. Необходимо повысить статус биоэтики как обязательной дисциплины в подготовке будущих врачей, создать адекватное современным требованиям научно-методическое обеспечение учебных курсов по данной дисциплине, согласовать примерные программы и организовать подготовку квалифицированных кадров преподавателей. Автор предлагает провести совещание заведующих кафедрами социальных и гуманитарных дисциплин медицинских вузов для обсуждения этих и других аналогичных проблеем гуманитарной подготовки будущих врачей.

Ключевые слова: медицинское образование, социально-гуманитарные дисциплины, биоэтика, примерные программы, профессиональные компетенции, социальные риски дегуманизации медицинского образования.

Recently a strange process has been observed in Russian medical universities. This process cannot be called any otherwise than dehumanization of medical education. This is reflected in the reduction of teaching hours, literally, for all humanitarian disciplines, not excluding the compulsory in uniting humanitarian subjects and departments, the arbitrary placement of these disciplines in curricula on

the «residual principle», thus violating the logic of the humanitarian education

The reason for this attitude to the humanities disciplines in medical universities is obvious: the increase in the salaries of university teachers to 200 % of the average for the region, which provided by the May Presidential Decrees, is realized in organizations due to the reduction in the number of jobs. In the universities it is also expected to reduce the number of entrants (a generation will come from the «demographic pit»). One of the directions to cut jobs is an attack on «non-core» disciplines in medical universities. This is, above all, a socio-humanitarian block.

The socio-humanitarian block includes compulsory disciplines (modules): Foreign language, History, Philosophy, Life safety and Physical training. The total number of credit units for these disciplines (except for physical education) is not defined by standards. But the basic educational program for each discipline indicates their recommended number. Practice shows that at the level of the university this number is accepted as compulsory. Three credit units are defined for Physical training individually. The remaining disciplines of the block receive hours by the decision of each particular higher educational establishment. Of course, they need to coordinate their actions and preferably receive recommendations. From whom? There are no working groups on humanitarian disciplines in five «medical» Federal educational and methodical associations, it is not known whether exemplary educational programs are being developed and by whom. Some universities initiate the teaching of bioethics in the form of an elective, although the hours for electives are not included for specialist degree [1].

Exemplary basic educational programs are formed in accordance with professional standards, in all of them there are indications of the mandatory assimilation of ethical competencies and skills [2]. But! Who develops POPs for humanitarian disciplines for medical schools? Now – no one (see http://reestr.fgosvo.ru/ugs/3/2). Currently the section of the website of the Ministry of Education and Science «Actual exemplary curricula of disciplines» contains only 1 curriculum for pedagogy for bachelors (http://fgosvo.ru/ppd/11/11). The administration of the site reports that «The resource is at the stage of formation, and as it develops we will inform the academic community» (http://reestr.fgosvo.ru//).

A particular danger of reducing the humanitarian training of future doctors is the ignoring of such an important course as Bioethics. The result of any reduction of this course will be the ethical illiteracy of graduates of medical schools, which is unacceptable at present due to existing social risks, to which we refer the following

• Dissatisfaction of patients with the attitude of medical workers to them when providing medical care;

• Violation of the rights of subjects in clinical trials;

• Violation of ethical standards in pre-clinical studies;

• Inability to assess the ethical and social consequences of the introduction of new biotechnologies (ART, exocortex, gene therapy, personalized medicine, regenerative medicine, nanomedicine, neurotechnologies, electronic implants, etc.).

The lack of knowledge and skills in the field of biomedical ethics will not allow the graduates of medical universities to fulfill those ethical duties that are entrusted to them by the Federal laws of the Russian Federation and other legal documents:

Federal Law of the Russian Federation of 12 April 2010, Federal Law No. 61 «On the circulation of pharmaceutical products»

Federal Law of the Russian Federation of November 21, 2011, Federal law No. 323 «On the fundamentals of protecting the health of citizens in the Russian Federation»

Federal Law of the Russian Federation of November 29, 2010, Federal Law No. 326 «On compulsory medical insurance in the Russian Federation»

Federal Law of the Russian Federation of June 23, 2016, Federal Law No. 180 «On biomedical cell products»

The order of the Ministry of Health of the Russian Federation No.200n dated 01/04/2016 «On approval of the rules of good clinical practice», etc.

The editorial staff of the journal «Bioethics» is ready to provide a venue for the All-Russian meeting of heads of the departments of socio-humanitarian disciplines of medical universities, and to participate in the organization of working groups on humanitarian education in all medical Federal educational and methodical associations. Support us, colleagues! Together we will save national bioethics and will not allow violating the principles of the «Universal Declaration on Bioethics and Human Rights» (UN on education, science and culture, 2006), which relates the education in the field of bioethics to the tasks of each state's policy.

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TRANSFORMATION OF ETHICAL NORMS IN SOCIETY IN THE ERA OF IMPLEMENTATION OF THE LATEST TECHNOLOGIES[1]

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The development of modern medicine today directly depends on biomedical technology. Human life begins to depend more and more not only on the physician's personality (his knowledge and experience), but also on the level of technology development, availability of access to them. In this regard, the entire picture of the interaction between the doctor and the patient is gradually changing, ethical norms regulating these relationships are being transformed. Mostly clear and impressive these changes can be observed in the field of transplantology and organ donation. Dependence of the development of organ donation on the human factor, namely the presence / lack of donor organs, sets a special ethical tension. Hopes and fears associated with the implementation of the latest technologies, reflected in the cinema and literature, including science fiction.

How will the future medicine deal with ethical issues related to organ donation, will an alternative be found – a question that excites not only physicians, but also philosophers and ethics.

Key words: biomedical technologies, bioethics, transplantology and organ donation, cyborgization, future medicine, ethical and philosophical problems of perception of corporeality.

ТРАНСФОРМАЦИЯ ЭТИЧЕСКИХ НОРМ В ОБЩЕСТВЕ В ЭПОХУ ВНЕДРЕНИЯ В ЖИЗНЬ НОВЕЙШИХ ТЕХНОЛОГИЙ[2]

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Развитие современной медицины напрямую зависит сегодня от биомедицинских технологий. Человеческая жизнь начинает все больше зависеть не только от личности врача (его знаний и опыта), но и от уровня развития технологий, наличия доступа к ним. В связи с этим постепенно меняется вся картина взаимодействия врача и пациента, трансформируются этические нормы, регулирующие эти взаимоотношения. Наиболее ярко и выпукло эти изменения можно наблюдать в области трансплантологии и органного донорства. Зависимость развития органного донорства от человеческого фактора, а именно наличия/нехватки донорских органов задает особую этическую напряженность. Надежды и опасения, связанные с внедрением в жизнь новейших технологий, отражаются в кино и литературе, в том числе научной фантастике.

Каким образом медицина будущего будет решать этические проблемы, связанные с органным донорством, будет ли найдена альтернатива – вопрос, волнующий не только медиков, но и философов и этиков.

Ключевые слова: биомедицинские технологии, биоэтика, трансплантология и органное донорство, киборгизация, медицина будущего, этико-философские проблемы восприятия телесности.

Introduction. The goal, which was the motive in choosing this topic, is the search for a correct and harmonious correspondence between the practical knowledge existing in modern medicine and fundamental philosophical knowledge about human nature and the system of humanistic values. The problem of a correct understanding by the society of the development and use in the medicine

[1]The article was prepared with the financial support of the RNF, grant No. 17-18-01444
[2]Статья подготовлена при финансовой поддержке РНФ, грант № 17-18-01444.

of the newest technologies and the transmission of this knowledge becomes more and more urgent.

The task of this article is to investigate how the notions of the achievements of science and modern medicine, in particular transplantology, are formed in the public consciousness, and also how the ethical norms that regulate the relationship between doctors and patients are transformed.

The ways and ways of obtaining information, the formation of beliefs about biomedical technologies, the influence of the scientific community on the formation of these beliefs and moral values – all these aspects of the problem require, in turn, an additional interdisciplinary study.

Modern biomedical technology through the eyes of an ordinary person

Impressive successes of modern science, in particular modern biomedical technologies, designed to help people improve their health and quality of life, often face an incorrect, sometimes very bizarre understanding of the essence of these discoveries. An ordinary person (not a scientist, not a physician or philosopher), usually guided in the decision-making process by intuition and scrappy scattered information obtained from the media, often refers to new biomedical technologies with a great deal of mistrust or even apprehension, believing at times that harm from them can be more than good. Especially acute is the branch of medicine, such as transplantology. A number of social prejudices, including religious ones, have a negative impact on the work on organ donation. As a result, in most countries (including Russia) the picture is as follows: a huge number of patients who could have been saved by organ transplant surgery stand in line for donor organs. Many still do not live up to the operation; at the same time it is extremely difficult to obtain permission for both the removal of organs from a dying relative, and the consent of a seriously ill person for their own posthumous donation.

The path of scientific knowledge to the ordinary person is thorny: knowledge is distorted, simplified, undergoes an incredible transformation, accumulating unprecedented details, and therefore, when it comes to modern technology, ordinary people are guided not so much by scientific information as by half-knowledge drawn from the media and films, and myths, rumors and science-like information introduced into the information space for advertising purposes. Thus, there is a huge gap between the scientific and practical knowledge existing in modern medicine, and what ordinary people know and think. How to overcome this gap is a matter worthy of special attention.

The existing mistrust and heightened skepticism towards doctors and scientists combined with sometimes extremely dangerous prescriptions for home treatment, all kinds of «miracle-working» diets, methods of cleansing the body, etc., which unhindered pass the obstacles of critical thinking and continue to have a huge impact even on quite intelligent and educated people, show that modern enlightened society in many aspects, alas, is very far from this title. Various dubious sources of information (in particular, TV, the Internet), from where people derive information and are guided by them in making crucial decisions regarding their health and life, are many, and they are easily accessible.

As a result, we get a society that, living in the age of science and technology, often does not fully understand how these technologies work or what they mean for the future of mankind. However, as stated by experts, often this is not only a lack of knowledge, but also a lack of systematic efforts by society and the state, and insufficient attention to the popularization of science by the scientists themselves. The development of the industry is impossible without adequate information and scientific and educational work. Take for example Spain. This is a recognized world leader in the number of donors and transplants, where the idea of posthumous voluntary donation is very developed and there is a presumption of consent. However, the country took 15 years for information training, the implementation of educational programs, social advertising. An example for other countries can be considered a clear system of transplant coordination, which in Spain is developed at an exceptionally high level. Practical applicability of the Spanish model was demonstrated by Croatia and Belarus, which achieved significant success due to the implementation of the Spanish model and the introduction of appropriate changes in the legislation.

The foregoing suggests that values, beliefs, even prejudices, which are sometimes very persistent, can change if the social environment changes, because a person, being a social being, cannot help reacting to changes that occur in society, especially if he gets a correct explanation of the new laws and phenomena and has the opportunity to see the results. It can be assumed that in the minds of the inhabitants of these countries there are not so many fears and prejudices concerning organ donation that exist among residents of countries where the problem of shortage of donor organs is much more acute.

The problem of deficiency of donor organs. Ethical and psychological aspects

The problem of lack of organs for transplantation is one of the most serious and difficult to solve in transplantology. According to the organization Donor's Gift of Life Program, more than 122,000 people in the world are waiting for

the organs they need (including the heart). In the US, according to OPTN[3] for 2017, an average of 20 people die each day (including children) awaiting transplantation, which is not carried out because of a shortage of donor organs. At the same time, there is an entire army of highly skilled transplant surgeons armed with modern technologies and ready to save lives. They again and again bitterly state that the potential recipient of the donor organs has died, the next opportunity to save the patient has been missed.

The solution should be sought not only in the medical field. In this problem are hidden complex ethical and philosophical questions related to the perception of the human body, its integrity, dignity, including after death. Attitude to the body (even the deceased person) as to a set of organs contradicts our deep, not always realized convictions. From a philosophical and ethical point of view, a person cannot be a simple functional set of organs and systems. Such a reduction of the concept of a person is able to open the practice of using the body as a set of spare parts that threatens humanity. Here we run into the classical Kantian moral law, which prohibits to treat humanity, whether in ourselves or in others, as a means. This law extends to the human body. Let the life activity of the organism is maintained artificially, let the doctors state the death of the brain – all the same our moral intuitions rebel against the removal of organs from the body, in which the heart is still beating.

Probably, people with greater understanding would react to the removal of organs after cardiac arrest, but explanting of donor organs is possible only if the natural blood flow is preserved, otherwise they will be unsuitable for transplantation. This applies to the liver, heart, lungs, pancreas. The only exception can be kidneys that can be used, explanting them in time after cardiac arrest, but it is still worse for the recipient and is fraught with additional complications.

Such kind of information is very emotionally charged, especially if it's not about abstract medical cases, but about a close person. In critical situations, face to face with death, a person begins to believe in God (if not previously believed), and in extrasensory, and in shamans with clairvoyants, and simply in elementary luck. Fears also include: what if suddenly doctors make mistakes or, worse, deceive, because they want to quickly remove organs?

Against the backdrop of such fears, the darkest myths about «black» transplantologists and the black market of donor organs are born, which is replenished at the expense of people killed on demand, about special places where they keep «consumables», etc. There are books and movies in which this theme develops, such as, for example, the film «Island» (USA, 2005, directed by Michael Bay), and similar in plot, but perhaps deeper and more multilayered, though not so the famous film «Never Let Me Go» (UK, USA, 2010, directed by Mark Romanek) based on the novel of the same title Kazuo Ishiguro[4]. In these films, we see a society in which people are specially cloned and grown for organs that are used later to save lives of «genuine» people, since clones are not considered full-fledged people, they are just living «factories of organs». However, clones also think and feel, know about their doom and at the same time cannot do anything with the system: they do not have the rights of an ordinary person, and under the law they are not citizens, by and large not even people, and the meaning of their existence is to give back «normal» people their bodies (and life), when the hour comes. If the heroes struggle in the first film (they arrange an escape, fight and eventually change their destiny), then the second film is much more sad and hopeless: the characters unsuccessfully try to find and pass a secret test, after which (according to vague rumors) one can get a special permission not to go immediately on «excavation» of organs, and live a little longer. Among the clones there is a legend that it is possible if you prove that you are able to feel and create like a normal, full-fledged person. The film's characters do not even pretend to be bigger. However, even such a modest dream – to get several years of quiet life – turns out to be unrealizable for clones, and as a result, a ruthless system gradually takes away the lives of young donors. And the worst thing is not even that they live so briefly and know that their bodies and lives are designed to take away organs for transmission to other people, but that they guess that after the first two or three «excavations» they will not be able to die, that is, «complete». And then the most terrible thing will come: they will no longer be taken care of, because officially they will cease to be considered alive, but, remaining conscious, they will have to observe how from the still living body others continue to take the organs («donation-by-donation»), and this personal hell is infinite...

Such works of art reflect the fears in the public mind, and people are more likely to believe such a gloomy dystopia than medical facts and sociological studies.

[3]Organ Procurement and Transplantation Network. URL: http://optn.transplant.hrsa.gov (reference date: 01.10.2017).
[4]Ishiguro K. Never Let Me Go. M., 2017.

Analysis of artistic texts, science fiction is an extremely fertile topic of research[5], because they can reflect existing in society views, beliefs, including moral standards, desired (or, conversely, criticized by the authors) relationships between people, an image of the possible in the future moral collisions[6].

Against the backdrop of all these contradictions, the existing request in the medical community and in the patient community to preserve and increase the donor resource leads to a very ambiguous pressure on public authorities. A number of measures are called for to change the state of affairs, but we must take into account that public mores, values, opinions and perceptions of ordinary people about transplantology are touched upon, which, as mentioned above, are often extremely bizarre.

Cyborgization: a dream or an alternative to organ donation?

According to experts, the world transplantation makes great strides. Successfully transplanted not only the various internal organs, but also limbs (arms and legs), the face. An important event in transplantology was the fact of a uterus transplantation with successful gestation and the subsequent birth of a child.

In the United States, 65,000 amputations are performed every year[7]. In 80 % of cases, patients are over 50 years old. The most common amputation is below the knee[8]. The main cause of amputation is vascular disease and trauma. Only 4 % live with congenital absence of limbs. All these people are saved by prosthetics.

According to the Federal State Statistics Service[9] for the year 2016, there are 12.8 million disabled people in Russia. Among them are disabled people of the 1st group – 1.3 million people, II group – 6.3 million people, III group – 4.6 million people, disabled children – 617,000. According to the estimates of the Ministry of Labor[10] (data for 2015), 86.6 % of disabled people are provided with rehabilitation appliances. In the same year, the state allocated 676,743 prostheses, 2408 devices for dressing, undressing and seizing objects.

The manufacture of prostheses began long ago, and at first, several centuries ago, they were fastened to the human body with the help of belts, they were quite inconvenient and, of course, there was no talk of any connection with the nervous system. However, in the 1960s, the industrial production of myoelectric prosthetic forearms began in the USSR, and this was a serious breakthrough. In 2014, the US created a bionic prosthetic hand DEKA Arm[11], which bent, turned and carried grips with sensors attached to the patient's stump. In 2015, prostheses began to print on a 3D printer, and American biotechnologists first used reprogrammed stem cells to grow bones suitable for replacing their damaged analogues in the human body. From year to year, prostheses are becoming more convenient and comfortable. Some prosthetics make it possible to feel touching an object, there are also cosmetic prostheses of the face, the eye. It is already widely used prostheses that are implanted inside the human body, – with the help of prosthetics, bioengineers can replace bone tissue, joints. In June 2008, the world's first operation for the transplantation of a trachea, grown from stem cells, was carried out[12]. Professor Martin Birchall, who participated in its cultivation, says that for twenty years with this technology people will learn to create almost all transplanted organs. Perhaps the transhumanists' dreams about the human body, in which it will be possible to replace the diseased, lost or worn out organs with new ones, like spare parts of the mechanism, are approaching implementation.

Biohacking, or New cyborgs

The idea of changing the human body and expanding its capabilities through technology is very inspiring and attractive for many people. With the development of technology, some people are trying to become a kind of cyborg, «crack» their body and expand opportunities. This movement

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[10]Report on the implementation of the state program of the Russian Federation «Affordable Environment» for 2011-2020 in 2015. URL: http://rosmintrud.ru/docs/mintrud/handicapped/130 (reference date: 08.10.2017).

[11]Innovation. Improving the way we live. URL: http://www.dekaresearch.com/innovations/ (reference date: 08.10.2017)

[12]Bioengineering. Cultivation of the trachea. Paolo Macchiarini. « URL: http://lionessk.livejournal.com/159700.html (date of circulation: 08.10.2017).

has received the name «biohacking». Biohacker Amal Graafstra[13] implanted between his fingers RFID chips, which allow him to unlock the doors and log in to his computer. On one of the chips in his hand is also stored the encrypted key to the electronic wallet. Although in general, the implantation of chips is still a very rare phenomenon, extravagant personalities tend to change their bodies not so much by medical indicators as from curiosity, risk appetite and the desire to shock. Perhaps in the near future biohacking will become as common among fashionable men and women as tattoos or plastic surgery. Such a radical attitude to his own body reflects, in our opinion, the desire of human to change and improve himself, which is dictated, perhaps, by deep dissatisfaction with his personality, destiny and rejection of his present body. Unlike moral improvement and painstaking psychological work on one's own personality, radical changes in the body can give a quick result and play a kind of therapeutic role, which is currently performed by cosmetology and plastic surgery. However, if the cause of discontent with your body and the desire to change it are not real physical defects, but self-disapproval, the lack of inner harmony, even a complete replacement of all parts of the body will give only a temporary effect.

At the same time, you can only rejoice at such original and positive people as the Canadian director and producer Rob Spence, who at the age of nine lost his eye and in his place wore an implant, and now replaced the cosmetic implant with a miniature video camera[14] and with its help makes unhackneyed movies. The ability to transform a body flaw or mutilation into an advantage and the possibility of creativity is admirable and allows us to believe that a future, even such an unusual for us, will not be deprived of humanity and a sense of humor. People with physical disabilities due to the development of technology can live a full life.

In October 2016, Zurich hosted the first Olympics «Cybathlon» for people with disabilities, on which, unlike the Paralympic Games, people compete in technical terms, they use high-tech devices. It is planned that such an Olympics will be held every four years, and with each new Cybathlon we will be able to see more and more perfect devices designed to help people.

Meanwhile, cyborgization is gradually becoming a part of our everyday life. If ten years ago bionic hands, called by developers «the hand of Luke Skywalker», were inaccessibly expensive, massive and created in a single copy, today some models will cost several thousand dollars, which means that at least in developed countries they are already accessible to ordinary people. Judging by the analogy with first introduction of mobile phones, which cost three decades ago 4000 dollars and weighed a kilogram, and today every schoolkid has it, we can hope that in the future, in 20–30 years, such services as transplantation , implantation of chips, artificial organs, will become basic and can be accessed in almost any clinic. Bioengineering, bionics are today the fastest growing movement even in comparison with industrial robotics.

It can be assumed, that the splicing of the human body with high-tech mechanisms will lead to the emergence of a new human. Will its nature change as a result? What will be the psyche of this person, social skills, morality? The answers to these questions not only excite philosophers, anthropologists, psychologists, they have universal significance.

Conclusion

As a conclusion, I want to return once again to the problem mentioned at the beginning of the article: the existence of a huge gap between the scientific and practical knowledge existing in modern medicine and the level of understanding that society and ordinary people have. Meanwhile, the fate of these technologies depends on formed in the society ideas about science, modern scientific discoveries, medical technologies, and ways of their implementation. What is the role of experts in all this difficult situation: philosophers, psychologists, ethics, physicians, biologists – those who are directly connected with the problems of development and implementation of the latest technologies? Tracking changes in public morality amid changing living conditions, exploring the relationship between beliefs and existing mores and customs, monitoring opinions, and researching the factors of influence on them – all these tools of humanities are designed to improve and clarify the transfer of knowledge in the system of science-society.

The popularization of science, the dissemination of correct knowledge about modern scientific discoveries, including in the field of medicine, are important not only for the purpose of raising the level of education of the population, but also for the development of medicine itself and technology, and consequently, the future progress of society. Definitely, the creation of new connections between modern science and society is what modern philosophy can (and should) do.

[13]Custom gadgetry for the discerning hacker. URL: http://amal.net/ (reference date: 08.10.2017).

[14]«Bionic eye camera. Shoot as you see». URL: https://www.popmech.ru/technologies/12034-kino-glaz-snimat-kak-videt/ (reference date: 08.10.2017)

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УДК 17.7

ABOUT CONTRADICTORY CONNECTION OF BIOETHICS AND EVENT (OF MEDICALIZATION OF SOCIETY AND SOCIALIZATION OF MEDICINE)

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The article demonstrates that there is contradictory connection of bioethics and event. This principle is conditioned by the event of the medicalization of society on the one hand and socialization of medicine on the other hand. The conceptual elaboration of the problem of the connection of event and bioethics, of the definition of hermeneutics of this connection from the point of view of existentially-ontological phenomenology is supposed. The connection of bioethics and event is revealed with the aid of intuition, which is discovered phenomenologically. Their connection appears as contradictory unity of two sides. Their contradiction is existential-and-dialectical. It means, that essentially-ontological pattern of their connection is existential. Event and bioethics appear as existentials. But their existential

qualities must not be generalized, for quite often the essentially-existential disintegration of the connection takes place. The event is the cause of disintegration and divergence, what supposes human participation. Bioethics and event are anthropologoessential existentials. They are connected between each other by essential connection. And here the traditional question about essence of anthropologoessential arises. The latter is guaranteed by the experience of its existential basis. This leads to the original essence of the event and bioethics. The existence manifests itself here. It is the basis for the possibility of the essential connection of bioethics and event. The essence of their connection is defined by existential essence of anthropologoessential. It is interpreted as dependent on existence of anthropologoessential, on its existential behavior. Anthropologoessential is the ontological totality of the existential acts-behavior of each human and all humankind. At the same time bioethics is the existentially-ontological phenomena intrinsic in living world of anthropologoessential. The conclusion is that contradictory and united continuum of event-bioethics exists existentially. Bioethics and event take place in each other. And their relations are asymmetrical and accompanied by tension, which initiates their interaction.

Key words: event, bioethics, existentially-ontological phenomenology, intercommunication, contradiction, principle.

О ПРОТИВОРЕЧИВОЙ СВЯЗИ БИОЭТИКИ И СОБЫТИЯ (МЕДИКАЛИЗАЦИИ СОЦИУМА И СОЦИАЛИЗАЦИИ МЕДИЦИНЫ)

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В статье показывается, что существует противоречивая связь биоэтики и события. Это положение обусловлено событием медикализации социума и социализацией медицины, с одной стороны, и существованием биоэтики, с другой. Предлагается концептуальная разработка проблемы связи события и биоэтики, определения герменевтики этой связи с позиций экзистенциально-онтологической феноменологии. Связь биоэтики и события выявляется с помощью интуиции, которая распознается феноменологически. Их связь выступает как противоречивое единство двух сторон. Их противоречие экзистенциально-и-диалектично. Это означает, что сущностно-онтологический строй их связи экзистенциален. Событие и биоэтика выступают как экзистенциалы. Но их экзистенциальные качества не должны обобщаться, ибо нередко имеет место сущностно-экзистенциальная расщепленность связи. Причиной расщепленности и расхождения является событие, что предполагает человеческое участие. Биоэтика и событие являются антропологосущими экзистенциалами. Они связаны между собой сущностной связью. И здесь возникает традиционный вопрос о сущности антропологосущего. Последняя гарантируется опытом ее экзистенциальной основы. Это приводит к первоначальной сущности связи события и биоэтики. Здесь проявляется экзистенция. Она является основанием для возможности сущностной связи биоэтики и события. Сущность их связи определяется экзистенциальной сущностью антропологосущего. Она понимается как зависимая от экзистенции антропологосущего, от экзистенциального его поведения. Антропологосущее есть онтологическая совокупность экзистенциальных поступков-поведения каждого человека и всего человечества. При этом биоэтика является экзистенциально-онтологическим феноменом, присущим жизненному миру антропологосущего. Делается вывод о том, что противоречивый и единый континуум события-биоэтики существует экзистенциально. Биоэтика и событие участвует друг в друге. А их взаимоотношения ассиметричны и сопровождаются напряжением, которое инициирует их взаимодействие.

Ключевые слова: событие, биоэтика, экзистенциально-онтологическая феноменология, взаимосвязь, противоречие, принцип.

I feel that J could not escape contradictions. Complete, well-balanced system did not come out. But if true contradictions came open and not forced, then may be it is better any making both ends meet.

D. A. Granin

There is event of «medicalization» [5] of the society and socialization of medicine. There is bioethics. Principle: there is connection of bioethics and event. There is existentionally-ontological phenomenology. There is no conceptual elaboration of the problem of mutual connection of the event and bioethics. According to principle the problem is supposed: to elaborate phenomenologically conception of their intercommunication and try to define its hermeneutics in terms of existentionally-ontological discourse.

The connection of bioethics and event is intuitively-grasped-by notice. Notice is intuitive, intuition notices. Intuitively-grasped-by notice connection (correctly) reaches consciousness. Intuition, notice, consciousness are phenomenological categories.

Thus, connection can be directly contemplated-and-noticed, in a word, intelligible to intuition. How one can recognize it? Phenomenologically. The gist of the phenomenological matter of the recognition of connection: intuitively grasped, not to let it go; to hold in the field of vision of consciousness all the time; to apprehend it by all consciousness; to reflect consciously; to express reflection, as far as possible, in terms of existentinally-ontological hermeneutics. At least two problems accompany phenomenology in this matter (and how many in passing arising questions, thoughts, hints, conclusions).

The first. Correlation of intuitive and discoursive in definition of interconnection of event and bioethics, what is actually intuitive and what is actually discoursive in phenomenological work concerning connection. It is special theme and is not subject of this article.

The second takes its source from the first. It is very hard to describe the connection. One must look at it with own eyes, listen with own ears, grasp with own intellectual intuition and notice with own mind. All this must be synthesized in the experience of phenomenological consciousness. Phenomenology must find corresponding language and form for the rendering of this experience. And the connection of bioethics and event is «vivid-essentially-existentially-mobile» [2], never stands still, flows all the time as Heraclitus's water. That is why there is no finished intuition in phenomenology, no finished idea, no finished notice, no finished consciousness, no finished form and language for the description of connection. Phenomenology does not give (since it itself is rather art then science) exclusively exact description of it, but gives something more- existentially-ontologically-essential pattern. Language of phenomenology is not exact hermeneutic discourse, but existential tissue.

The connection of bioethics and event is contradictory unity of two sides. Their contradiction is «existential-and-dialectical at the same time» [3]. This bilateral unity objectively is based on the principle of preservation of this connection as itself. The unity will be torn and existential essence of their connection as itself will be broken; essence will be broken, unity will de torn. Bioethics and event are not connected according to the principle of homogeneity and (formal) logic, essentially-ontological pattern of their connection is existential. The law of Hume- there is no transition from being as being to ethical proper – is correct. If they would meet, being as being-in-itself and ethical proper as ethics-for-us, in life, in vital world of anthropologoessential, among-people-in-human-environment, they would have nothing to do together. They do not meet, for there is no joint course, unless in theoretical ontology and metaethics. But the courses-transitions from bioethics to event and on the contrary are possible. Of course, telling about interconnection of bioethics and event it is not allowed to generalize their qualities. Measure, proportion, harmony, equality are categories of ontology. But these main ontological characteristics between two sides of this connection-relation are not always maintained.

Event and bioethics are existentials. In spite of that one should not generalize their existential qualities. Why? Because their existential qualities can be in relation of the largest opposition and contradiction at the same time. Event can have negative «quality»; bioethics claims positive quality. The event of the «medicalization of society» [1] and of socialization of medicine of course, has got the most «quality», if it was realized in such manner that it crippled and ruined human body, soul, destiny, did harm and evil to human, animal, nature. And it is happens. It means, that society was medicalized abominably and medicine was socialized abominably, that socialization as itself of the event accomplished abominably, in vain. Such «quality» contradicts and directly opposite to the positive quality of the claim of categorical imperatives of bioethics, such, for example, as principle «do not harm», principle «do good» and all its principles. But and in such case the connection of bioethics

and event do is not broken off. And how many them, such cases. On can call them metaphorically: God his own, devil his own. But connection is not broken, however it can break down and very hard. In such cases connection as itself gets another existential quality: ambivalentness of the connection and as the result, ambivalentness of impression, perception, notion, senses and thoughts, intuitive and discoursive produced by this. The essential-existential disintegration of the connection takes place. Disintegration passes through all connection in concrete case, of course, through all its essential-existentially-ontological pattern. Ambivalentness spreads in any sides of connection, but it as two its sides, links up every time from new point to it as itself. But connection becomes two-faced, because sides disperse. But they are not simply different-they are opposite and contradict each other. Divergence tells on the relation of bioethics and event. However bioethics is not the cause of the divergence, on the contrary, bioethics struggles against it from own part. The cause of the divergence is event usually, more exactly, its executors, people and its execution by them.

The concept of relation-connection or, what is the same, connection-relation is not conventional figure. This is mental image, existentially-ontological eidos, if to use language of eidetical phenomenology, It is necessary for the opening of the complexity of interconnection between bioethics and event, for the opening of the dialectics of their relation, contradictory-their-unity, unity-these-oppositions. Bioethics and event are anthropologicallyessential existentials, existential phenomena, not always proportionate, sometimes quite disproportionate. Sometimes they contradict each other openly; sometimes they clash not so obviously; sometimes they exist one in other, exist jointly; sometimes bioethics gives rise to the event and event gives rise to bioethics. Sometimes these existentials are at daggers drawn irreconcilably; sometimes they become reconciled; sometimes they are the complement of one another existentially; sometimes their existential symmetry or, on the contrary, asymmetry are broken by anthropologoes-sentialhandmade but gone out of control of anthropologoessential accordingly uncontrolled by it force. It happens that it is broken by some third unforeseen, impersonal force, acting by its nonanthropologoessential laws natural disasters. At all events people, animals suffer always.

Bioethics and event are connected by essential connection. One must define it. Definition of their essential connection leads us to the old as the world question about the essence of anthropologoessential. This leads in that direction, which guaranties us the experience of existential basis of its essence. This guaranties so, that it will lead us, first of all, to the field of the original essence of the connection of bioethics and event. The existence discovers itself here. It is the basis for the inner possibility of the essential connection of bioethics and event. It is the basis, because it ensure the essence of their connection by itself. Their connection gets it own essence from original essence from existential essence of anthropologoessence. Its essence is the essence-for-essence of their connection and is defined the same: essence of anthropologoessence is the essence-for-essential their connection. The essence of their connection is defined by existential essence of anthropologoessence. This one defines their essential connection.

How then even if as a preliminary one should understand the essence of the connection of bioethics and event? The essence of their connection is existentially anthropologoessence. It is understood is dependent on the existence of anthropologoessence, on its existential behavior. But would this principle about the essence of their connection replace by something other? No. That is why given affirmation does not seem strange. Behavior and connection are mutually connected themselves, interact. Interacting, they tell on each other, influence each other. Connection-relation, relation-connection, in a word, mutual relation, interaction, they are essential. To put essence of the interaction of bioethics and event in existence of anthropologoessential – does not mean this – to give their relation in existential behavior and authority of anthropologoessential? Yes. It is. After all if people-anthropologoessential behave as like-minded persons, unanimously agree with each other in the community of interests, united by combined responsibility, connected by the unity of views and actions, coordinate their acts with established moral standards, polite, friendly, quietly, in short, their behavior is existentially-essentially united and correct, then the relations of bioethics and event are the same. But which force is able to create such human behavior and such relation of the event and bioethics? That is why, what was said is not idealization. People do everything themselves. They get according their deeds. Is it always? According to the unwritten law of life, almost always, only in other, different from once made, form. At any rate: the essence of the interaction of bioethics and event is existential-by existentiality-existentially-anthropologoes-sential. The connection-of-their-connection with the behavior of anthropologoessential is the same. Anthropologoessential unites bioethics and event, however and it separates them. It unites or separates even and especially when people does not know, what they do exactly connecting or separation.

Yes, their connection-relation essentially belongs to anthropologoessential. Yes, they by it-interacting pair. But one can not remove their connecting/separation from its being.

Interaction is complex, contradictory, changeable. But the living anthropologoessential origin is in it. Life is dynamic, living world of people is dynamic, interaction of bioethics and event is dynamic. What was said in another manner above, without changing essence, is re-changed here. The essence of their interaction reduces to the existentiality of anthropologoessential, to its existence. Interaction, essentially based in the existence of anthropologoessential, existentially develops instantly-together-in concert with anthropologoessential. Existentially developing together with it, it remains anthropologoessential and in behavior of anthropologoessential. Existentially-anthropologoessential character of their contradictory interaction ontologically proves existentially well-founded essence of their relation-connection. The essence of interaction of bioethics and event is well-founded by existence of anthropologoessential, existentially well-founded by its behavior. The behavior of anthropologoessential is existential. Now it's the very moment to define anthropologoessential: anthropologoessential is the ontological totality of existential acts-behavior of each human and all people in the world.

The difference of bios and ethos is phenomenologo-existentially-ontological difference of «living world» (terminology of E. Husserl) of «man-people» (terminology of M. Heiddeger), man-people-anthropologoessential-living-world: from conception and birth (or non-birth) to death and funeral (burial). The difference of life and ethics-phenomenological difference of all forms of existential knowledge. The difference of living and ethical experience is ontological difference as itself of the existence of the living world of people. Whatever difference, it is one of the fundamental philosophically-worldoutlooking problems. This difference is fundamental, key problem of phenomenologo-existentially-ontological philosophy.

Bios... ethos, life... ethics, experience of life... ethical experience – this dichotomy is subject to doubt. The search of «the missing link» between them was crowned with success. Bioethics was discovered and exists. In existential plan it means hermeneutics of bioethics as: phenomenon of consciousness; «essence» of the existence of the living world of anthropologoessenntial; it regional ontology; event, involved in society. The term «bioethics» can preserve dichotomy, but can be interpreted as unity. However which experience in general does make it possible to speak about «unity»? Etymology does not solve else the question about experience where «essence» of such kind and the attempt to think unity rise, where the components of dichotomy become one.

Bios... Ethos, Life... Ethics. What is between them, connects and unites in one, though contradictory, but nevertheless the whole?

The answer is «simple»: consciousness: consciousness corresponding ontologically to the existential experience of anthropologoessential. Consciousness is ontological to the experience. The source of the problem of their connection and union in one whole – in phenomenological form, the name of which is bioethics is just in existential experience of anthropologoessential. Bioethics is problematic phenomenological form; and the starting-point of this problem ontologically is in existential experience of anthropologoessential. Point is ontological to experience. The talk is not about abstraction «bioethics», not about bioethics in general, but about bioethics as the part of existential experience, about among-people-in-human-environment born phenomenon, that is about the phenomenon of the living world of anthropologoessential. Bioethics is existentially-ontological phenomenon, inborn to the living world of anthropologoessential.

In phenomenologo-existentially-ontological aspect the question arises: does bioethics essentially correlate with or existentially with the essence of anthropologoessential? And first, and second. The essence of anthropologoessential is existential, existence is social and bioethics, no matter how to define it, is «social phenomenon» [4]. Using language of phenomenological sociology one can say, that bioethics is existentially-essential form of social consciousness and at the same time ontologically problematic phenomenological form of it.

Conclusions

In the living world of anthropologoessential there is existentially united, though contradictory, continuum of event-bioethics.

Bioethics takes place in event, event in bioethics: they-collaborators.

Their relations are asymmetric and tense, tension between them motive power of their interaction.

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PRINCIPLE «ETHICAL EQUALS PRECISE» AS BASIS FOR ETHOS OF BIOMEDICINE

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The principle of «ethical-means precise» suggests that only if ethically correct approaches to a living object are observed, it is possible to obtain accurate information about it. Previously, the problem of following ethical norms in biology has traditionally been examined in the context of the requirements of ethical committees on observance of certain formal rules for working with animals. In the present work, an attempt is made to justify the necessity of observing ethically adequate approaches to biological experiment as a necessary condition for obtaining accurate scientific information about a living object. Ethical approaches are considered ethical, which considers an animal in natural, natural conditions. This approach goes back to the ethics of naturalism, which means the return of remote monitoring of a living object as the basis for obtaining precise information about its structure and function.

Key words: ethical equals precise, ethological approach, 3R principle, principle of additionality, non-invasive technologies, study of weak and superweak influences in biology.

ПРИНЦИП «ЭТИЧНОЕ – ЗНАЧИТ ТОЧНОЕ» КАК ОСНОВА ЭТОСА БИОМЕДИЦИНЫ

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Принцип «этичное – значит точное» предполагает, что только при соблюдении этически правильных подходов к живому объекту возможно получение точной информации о нем. Ранее проблема следования этическим нормам в биологии традиционно рассматривается в контексте требований этических комитетов по соблюдению определенных формальных правил работы с животными. В настоящей работе предпринята попытка обоснования необходимости соблюдения этически адекватных подходов к биологическому эксперименту как необходимого условия получения точной научной информации о живом объекте. Этически адекватными предполагаются подходы этологии, которая рассматривает животное в естественных, природных условиях. Этот подход восходит к этике натуралистики, что означает возвращение дистанционного наблюдения за живым объектом как основание получения точной информации о его структуре и функции.

Ключевые слова: этически адекватные подходы, биологический эксперимент, научная информация, живой объект

When speaking about extensive use of bioethical concepts in experimental science we usually discuss the regulations of scientific research on vertebrates. This undoubtedly important aspect of scientific experiments in biology normally results just in observing so-called «protocols». Apart from that the range of interest within biologists' community in deep understanding of required ethics and, as a result, in compliance to these ethics, remains at the level of nominal perception of the problem. There are no reasonable grounds for the inner rejection of ethically non-appropriate experimental procedures. And this issue is not connected with the existence of an ethics committee in an institution and not with obtaining a certain permission from such a committee, in most cases

a phantom one. No one could be happy with the obvious and inevitable necessity of using quite a number (in many cases a big number!) of vertebrates for biomedical research and especially in preclinical trials. Still there is no rational appreciation of the importance of compliance to certain ethics in biomedical research.

We suggest a turning point in biological experimental research for clear understanding of the importance of compliance to ethical procedures in experiments on living organisms can take place only when we realize that this is closely connected with reaching the research objectives. Firstly, we can speak of the case when obtaining precise research data is possible or not possible outside the observation of relevant ethical approaches.

In this article, we present a detailed structure of a leading principle of biological ethics – «ethical equals precise» [1,2]. In full it reads – «ethical knowledge is precise (knowledge)», as we mean that compliance to ethical procedures in work with living organisms is necessary for obtaining precise scientific knowledge, which presents the aim of positivist science.

We show the place and volume of ethical component in modern biomedical research as essential part in obtaining a precise result. Thus, observation of ethical procedures in research work with animals stops being a moral imperative and becomes an obvious requirement for fair research practice. Then we could expect biologists and medical researchers to comprehensively, not formally, observe the requirements of ethical (humane) expertise of scientific research which bioethics is calling for [3, 4].

1.Introduction. Issues of ethical conduct in biomedical research in the aspect of history of science.

In the history of biological research has been inevitably connected with tragic circumstances – destruction of objects used for experiments. Nevertheless, until now this obvious fact has not been decently accompanied by ethical expertise. At the beginning of XXIst century only we see first publications devoted to negative psycho-emotional background for daily biological experiments and its influence on the emotional condition of researchers [1]. This negative phenomenon occurs in context of remarkable progress in modern biology and biomedicine, which meets the demands of modern society in new more effective targeted medicine. At the same time the society persistently demanding new medicine equally and more persistently criticizes the biomedical community for the «reverse side» of the progress in biomedicine – use of millions of vertebrates (rodents) in the process of creating new medicine. Omitting the obvious fact of double dealing here we still realise that the issue of use and destruction of animals in biomedical experiments by itself poses a challenge for biomedicine. Public criticism of biomedical research is a fact of life in western society as in European Community only the number of animals used for preclinical trials reaches 20 million subjects per year. This is one of major challenges for modern biomedicine.

In practice the so-called approach 3R (refine, reduce and replay) has been applied for quite a long time in biomedical experiments [5]. This approach specifies the improvement of conditions for biological research including total usage of anodynes when carrying out acute and subacute experiments – ***refine***. Besides, efforts are made to minimize the number of animals used for experiments: firstly, new statistical verification methods on even smaller groups of animals are being developed – ***reduce***. Third principle of good practice means replacement of vertebrates by cellular or molecule-based models or by invertebrates – ***replace***. This approach, which appeared in the end of 50s of XXth century, significantly improved good practice in all the three lines of biomedical research. Still we do not see any progress in biologists' understanding that such bioethical principles are reasonable grounds for their good practice.

The position in seeing principles of good bioethical practice just as a nominal procedure of preparing reference notes and reports for ethics committees still dominates. Biologists refer to such procedures as «management imposed» requirements, which they observe anyway. Truly if we take the ethics committee requirements as formal procedures, many researchers see them as bureaucratic, not connected with real work and complicating the mode of carried research by excessive completion of research protocols.

In Russia, the issue of ethics control of biomedical research has its own distinctive history. We must admit that in Russian and Soviet society there has been a clear understanding of the use of superior vertebrates in experiments. I.P. Pavlov argued with representatives of the Society for protection of animals about their requirement for public participation (!) in biomedical research. In 1904 the representative of the headquarters of Russian Society for Patronage of animals Baroness fon Meierdorf published a paper with the title «Vivisection as Outrageous and Useless Scientific Activity». In result, a Committee on Vivisection was organized in Military Medical Academy. Professor I.P. Pavlov, future Nobel Prize laureate, expressed his own view of this issue and supported the rights of medical researchers to use vertebrates in experiments especially not connected with vivisection.

Professor Pavlov strongly opposed Baroness fon Meierdorf's idea expressed in her paper that

are experiments with animals counterproductive. Pavlov insisted that medical researchers are quite capable of estimating ethical risks in experiments with animals and absolutely denied the possible participation of animal rights activists in biomedical experiments [6]. Nowadays this position can be viewed as accurate: discussions of biomedical experiments with the public is now part of modern biomedical research. Though, even today animal rights activists do not take part in carrying out biological experiments.

On the other hand, in Soviet Union biology as science concentrated on the study of fundamental laws of biology. Reaching the practical outcomes and application of research results was not a priority. The changes are taking only now which requires revision of stereotypes, in biomedical education as well.

At present, the system of bioethical protocols is applied to biomedical experiments on vertebrates. At the same time, we can observe quite a formalistic attitude of Russian researchers to the requirements of ethics control to experiments. There is no real comprehension of the importance of such protocols. This can be explained by not quite a responsible attitude to procedures and rules generally approved in Russian (Soviet) society.

It might also be explained by continuous lack of resources for carrying out research at higher standards, which the author of this article could witness in the times of Soviet science when starting his scientific work after graduating from the university. A typical situation, when an experiment was prepared was the following – according to the procedure, we need a certain chemical reagent, we do not have it, we replace it by an "analogue" with similar activity. The same situation could occur in other aspects of work, for example, choice of animals for experiments: we need linear mice but there is no financial resource for buying them and we take «ordinary» mice... As a result, majority of Russian techniques were quite authentic and did not allow for objective comparison of experiments results to ones obtained by colleagues from other countries.

On the other hand, this practice had not a negative meaning only. Using a new technique possesses a chance of obtaining completely new knowledge, which is positive. In fact, even when we just check the experiments results of colleagues from other countries and use «modified» techniques we get absolutely new information.

Nevertheless till a certain moment, when experiments were carried out at milli- and micromolar level to study «strong» impact on biological objects results in research protocols did not differ much from those obtained in experiments when the authentic technique was used. At present biology studies weak and superweak impacts at nano and femto scale, which are basic levels for regulating biological processes. Observance or non-observance of standard procedures in this case can seriously affect the experiment protocol and result in lack of quality of the obtained research result. For example, when working with planarians in order to get reliable (repeated) results we had to create a whole new system of standard working procedures [7]. It allowed for obtaining pioneer results about the weak and superweak impact of chemical and physical factors on the process of planaria regeneration.

At present, many factors contribute to obtaining precise results – pure lines of animals, observance of standard conditions for keeping these animals during the experiment procedure, required feeding and qualified veterinarian support (including biological sampling and preparation of experimental models). It is highly important to realize that these procedures of planned experiments are crucial for adopting new ethics of good biological research. Apart from that, use of higher vertebrates for biological experiments requires a profound zoological and psychological study of their behavior. It specially concerns the work with vertebrates in conditions of their free behavior.

It seems that the experimental paradigm must correspond to ethologically verified ideas about the behavior of animals. Then there appear prerequisites for obtaining precise knowledge about a living object. To account for animals' behavior becomes crucial as only the conditions of free behavior can contribute to objective monitoring of any biological indicators of the animal's condition. Thus, the principle «ethical equals precise» is based on the ethological approach takes account of the specifics of animals' free behavior: ethics of biology comes up from the ethics of ethology.

Major science objective and its application in modern biomedical research

Aim of science means obtaining a precise result verified by various procedures. At present the frameworks of biological experiment consists in carrying out a research of a biological model using a set of various techniques: molecular and genetic, biochemical, physiological, morphological. When results of using such complex research techniques coincide, this allows for verification or non-verification of the suggested hypothesis. At the same time the type of interaction between a researcher and the object of research, type of intervention, the object condition and the conditions of experiments normally are not described in scientific papers. The complementarity principle firstly adopted in physics in order to estimate the degree of external interference into the object has

not been considerably valued by biologists [8]. As biological research now operate at nanoscale we should realize that when we study weak and superweak impact on the object the risk of obtaining non-precise results increases considerably and greatly depends on the conditions of the object under research.

In biological research, such dependences can present a special value as a biologist deals with a living organism, which has a wide range of reactions when treated in different ways. The dependence of the quality of obtained results on conditions of study of live biological model used for experiment increases accordingly. Nowadays ethology as science of free behavior of animals adopts naturalistic approach when the research of an object is carried out distantly without interference in its behavior. At best, an ethologist studies an animal in its free behavior. During experiments, it is quite difficult, sometimes impossible, to observe such conditions as creating of biological model is often connected with a certain degree of interference (not only surgery). The best conditions for experiments would be conditions of free behavior. Here at least we can establish certain working standards for experiments with animals.

In the Institute of Theoretical and Experimental Biophysics RAS, A. Azarashvili, PhD in Biology, managed to carry out a research on rats in a mode when the rats left their cages without distress and allowed to be made an injection. That demonstrated an established trust between a researcher and the animals and the creation of favourable conditions for the objects. Such procedure is preferable both from scientific and ethics perspectives as animals stayed at comfortable conditions of free behavior [9]. In case of our experiments with planaria when creating their behavior reflex we minimized the external impact on objects to allow them to move freely on the experimental area. It was especially laborious and important when training the regenerating objects. Still we managed to create ethically accepted procedures when intact and regenerating objects were held in similar conditions [10].

Later this approach was applied to developing a method of intravital computer morphometry when regrowth of regenerating blastema was registered only in free movement of planaria in ocular view [7].

One of unique features of planaria biology is their ability to move to the head end of the body not only in intact, undamaged, condition but even after resection of the head end with central ganglion. A researcher gets an opportunity to register the dynamics of regeneration process in identical conditions (at disengaged, free, movement) during the whole time of the process and in the same group of planaria. Thus we can provide identical conditions for obtaining morphological data in the whole continuous process of regeneration. If we aim to get exact dimensions of an animal's body it would be better to provide such conditions when it will show its morphology by itself in free behavior. This way the researcher would be able to register its image in noninvasive way.

Thus, observing biological features of planaria we could provide identical conditions of registration of behavior and morphogenesis it being necessary for obtaining precise research results. Understanding of animal behavior complies to basic ethics requirements to research work and contributes to obtaining precise research results: here the principle «ethical equals precise» works. We must admit that both experiments – training behavior reflex and intravital registration of planaria regeneration – present an example of work with most complex objects in experimental biology.

When we analyse this experimental approach from ethics perspective, its humane expertise (B.G. Yudin and P.D. Tishensko term), we see that such precise results were obtained under conditions of disengaged observation specific to classical naturalism [2, 7]. On the other hand, animals' rights for ethically appropriate treatment during experiment were observed. Owing to this we obtained most precise data about regeneration process and results concerning training behavior reflexes in a limited time scale of the experiment (we aimed at training a reflex of regenerating animals within one day of the experiment) [10]. Here the principle «ethical equals precise» is confirmed again.

The peculiarity of the practice of biological research in the conditions of the digital revolution is the need for distant interaction

Nowadays modern digital non-invasive methods of monitoring the condition of living organisms allow for complete compliance to ethical principles of naturalism: observation without interference into an object's structure. Thus, for the first time in 150 years we can «go round» the dominating principle of complementary and can minimize the impact of such interference [8].

Issue of outer interference into experiment conditions was first raised in nuclear physics. The question whether we study the atom or the result our interference into it gave birth to complementarity principle [11]. Miniscule atom nuclei encounter in gigantic particle accelerators at great energy deposition, then their ray paths are registered. Naturally, scientists raised an urgent issue of conformity of obtained results with the aim of studying the delicate structure of an atom nucleus after such neglecting impact. It became obvious

that the results obtained in such conditions could not be considered as precise. Simultaneously «area of application» of complementary principle did not cover the wide area of classical physics where experiments were not carried out under conditions, which destroyed the object of research.

Quite on the opposite in experimental biology where any treatment of the object is ***a priori***, it means nonreversible interference into a living organism structure and most often leads to fatal consequences. In fact, experimental biology always applied the complementarity principle as all experiments on creating biological models were connected with surgery. Only in the time of computer (digital) biology with application of non-invasive methods of research and observation, we can witness the decrease in use of the complementarity principle in biology [1, 11].

We should also distinguish the issue of validity and precision in scientific research, especially in neurobiology and animal behavior. Aiming at estimating cognitive functions scientists face the contradiction between ***reliability*** of knowledge and its ***validity***. Reliability characterizes the repeatability of a certain method of registration and assessment of behavior reaction, validity shows degree of compliance of the parameter measured to the certain generalized image of the object [12]. Here we can again refer to comparisons between ethology approaches and research in the area of higher nervous activity. Where an ethologist studies the animal behavior in its natural environment researchers of higher nervous activity when applying methods for training conditioned and even unconditioned reflexes use artificial signals. Thus, when analyzing reasons of failures in training conditioned reflexes with planaria we had to compare non-comparable modes of training used by various authors [10].

The issue of interaction and validity in studies of behavior is quite urgent nowadays. It is obvious that validity of ethological approaches is much higher than in classical techniques of training conditioned reflexes. This is directly connected with the major methodology principle of ethology – to study animal behavior in their natural environment. This is also ethically appropriate for interaction between a researcher and an object. Here we can provide the reliability of obtained results as an object is in natural environment and we observe standard conditions for work with a live object. In experiments on planaria it was necessary to be ultimately distant from applying invasive manipulations and provide standard working conditions used for studying behavour and training conditioned reflexes [7, 10].

Further development of methods of digital biology will contribute to decrease in degree of invasion into biological object and restrain the previously dominating complementarity principle in biology. This way biology returns to ethics of naturalists, ethics of observing an object in a new computer era [1]. This «new and old» ethics complies with the principle «ethical equals precise».

Conclusion. Ethics of biology: from emotional (ethical) to rational

We suggest that one of major reasons for «complicated» attitude of professional biological community to bioethics lies in its special attitude to the issue of interaction between a researcher and an object of research: «emotion» vs «ratio». On one hand, everyone accepts 3R principles, which refer to application of advanced anesthesia techniques and new methods of research results analysis – adoption of these principles extends the opportunities for work with smaller groups of animals. On the other hand, we see lack of understanding that compliance to ethics of good laboratory practice is not so much a moral challenge but an obvious provision for good faith experiment.

We see compliance to ethics procedures for work with animals as basics for quality of obtained data. This way issue of ethics of experiment stops being a moral issue and becomes a feature of professional activity. This reflects the main aim of bioethics – to bring «harmony» into the interaction between a researcher and an object of his research. Obtaining precise results is directly connected with developing non-invasive methods, which got promotion by extensive use of digital imaging. Progress in digital technologies for work with living organisms facilitates the process of obtaining ethically supported research results [2].

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MEDICAL LAW, BIOETHICS AND MULTICULTURALISM: POINTS FOR CLOSE COOPERATION OF UNESCO AND WAML

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Medical Law and Bioethics are new scientific disciplines appeared in the end of the last century as response to the challenges and technological innovations coming to the human activities related with health and biology. To respond these challenges on the global level scientists and experts come together within different organizations on international level in attempt to find out possible suggestions and solutions, appropriate in the different parts of the world. World becomes smaller nowadays and international cooperation starts to play crucial role for future success. This increases role and importance of Multiculturalsim as approach based on general and global human values with respect to the diverse cultural needs and particularities. World Association of Medical Law (WAML) was created in 1967 in Gent, Belgium with purpose to focus on multicultural issues in the filed of Medical Law. UNESCO as one of the largest UN organizations is a key international organization in the field of science, education and culture, which declared Bioethics and Multiculturalsim as own priorities. The first session of the General Conference of UNESCO took place in Paris in 1946. Despite WAML has indirect associate membership at UNESCO as non-governmental non-profit professional organization, in recent years cooperation of these two influential organizations has not been strongly seen. The 23rd WAML Congress in Baku, Azerbaijan in July 2017 was named «Medical Law, Bioethics and Multiculturalism» and brought together these international organizations.

Key words: Medical Law, Health Law, Bioethics, Multiculturalsim.

МЕДИЦИНСКОЕ ПРАВО, БИОЭТИКА И МУЛЬТИКУЛЬТУРАЛИЗМ КАК СФЕРЫ ТЕСНОГО СОТРУДНИЧЕСТВА ВАМП И ЮНЕСКО

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Медицинское право и биоэтика – это новые научные дисциплины, появившиеся в конце прошлого столетия как ответ на вызовы и технологические преобразования в сфере человеческой деятельности в областях медицины, здравоохранения и биологии. Для консолидации усилий ученых на глобальном уровне очень важным является совместное обсуждение актуальных проблем в рамках различных международных организаций в целях поиска общих решений и предложений, которые могли бы быть полезны в различных странах и во всем мире. Активное международное научное сотрудничество становится ключевым инструментом для успешного решения многих проблем в сегодняшнем быстро меняющемся мире, что актуализирует значение Мультикультурализма как платформы уважения общечеловеческих ценностей совместно с особенностями различных культур. Всемирная Ассоциация Медицинского Права (ВАМП) была создана в 1967 году в Генте, Бельгия с целью подробного изучения мультикультуральных вопросов в области медицинского права. ЮНЕСКО – одна из самых больших организаций ООН и самая авторитетная международная организация в области науки, образования и культуры, провозгласившая биоэтику и мультикультурализм своими приоритетами деятельности. Первая сессия Генеральной Конференции ЮНЕСКО прошла в Париже в 1946 году. Несмотря на непрямое ассоциативное членство ВАМП

в ЮНЕСКО в качестве неправительственной профессиональной международной организации, активного сотрудничества и взаимодействия между этими двумя организациями в последние годы не наблюдалось. 23-й конгресс ВАМП в Баку, Азербайджане в июле 2017 года под названием «Медицинское право, биоэтика и мультикультурализм» стал важной вехой для активного взаимодействияэтих международных организаций.

Ключевые слова: медицинское право, здравоохранительное право, биоэтика, мультикультурализм.

World Association of Medical Law (WAML) was created in 1967 in Gent, Belgium by group of dedicated professionals with purpose to focus on multicultural issues in the filed of Medical Law. Honorary Founder of the WAML, professor of Law Faculty in Gent University Robert Dierkens has focused his researches on actual matters on the boarder of the law and medicine and found big support from leading forensic medical specialists. Ever since creation of association, its main purposes and objectives have been:

- to encourage the study and discussion of problems concerning health law, legal medicine and ethics, and their possible solution in ways that are beneficial to humanity and advancement of human rights;
- to promote the study of the consequences in jurisprudence, legislation and ethics of developments in medicine, health care and related sciences, and
- to address any matters that involve issues of health law or legal medicine [1].

It is worth to mention that Forensic Medicine had a key role in creation and development of Medical Law on national and international level. In many other countries as in Belgium, Medical Law has been supported by leading forensic medical experts that gave it faster development and right direction because they have unique vision from both legal and medical perspectives.

The WAML makes arrangements for consultation and cooperation with international and national organizations and also sponsors institutes or centers concerned with particular areas of Medical Law or Health Law. The Association has been pursuing its purposes by, inter alia, organizing a World Congress on Medical Law triennial, then at two-year intervals, encouraging regional congresses on Medical Law, supporting National Associations for Medical Law, and promoting their affiliation to the association. Starting from 2014, according to decision of Board of Governors, WAML is organizing now annual world congresses.

UNESCO is one of the largest United Nations organizations with focus on science, education and culture. UNESCO declared Bioethics and Multiculturalism as priorities. The Constitution of UNESCO was signed in London on 16 November 1945 by 37 countries and came into force on 4 November 1946 after ratification by twenty countries: Australia, Brazil, Canada, China, Czechoslovakia, Denmark, Dominican Republic, Egypt, France, Greece, India, Lebanon, Mexico, New Zealand, Norway, Saudi Arabia, South Africa, Turkey, United Kingdom and United States. The purpose of the Organization was defined as: «to contribute to peace and security by promoting collaboration among nations through education, science and culture in order to further universal respect for justice, for the rule of law and for the human rights and fundamental freedoms which are affirmed for the peoples of the world, without distinction of race, sex, language or religion, by the Charter of the United Nations». The first session of the General Conference of UNESCO took place in Paris in 1946 with the participation of representatives from 30 governments entitled to vote. Today, after more than 60 years of existence, UNESCO functions as a laboratory of ideas and a standard-setter to forge universal agreements on emerging ethical issues. The Organization also serves as a clearinghouse – for the dissemination and sharing of information and knowledge – while helping Member States to build their human and institutional capacities in diverse fields. For all of UNESCO's major areas of focus (Culture, Education, Natural Science, Social and Human Science, and Communication and Information), it is possible to trace the ideas on which UNESCO was based to the Organization's present activities [2].

From values and purposes of both organizations it is clearly seen that both are promoting international collaboration among nations through education and science in order to respect for justice, for the rule of law and for the human rights without any discrimination and respect to multicultural approaches. This is a good platform for cooperation of WAML with UNESCO. This is why from 80-s of last century the WAML gets associate membership in Council For International Organizations of Medical Science (CIOMS). CIOMS is an international, non-governmental, non-profit organization established jointly by WHO (World Health Organization) and UNESCO in 1949 and represents a substantial proportion of the biomedical scientific community through its member organizations, which include many of the biomedical disciplines, national academies of sciences and medical research councils [3]. However, during last decade close collaboration of WAML neither with UNESCO or CIOMS and WHO has not been noticed until its 23rd World Medical Law Congress in Baku, Azerbaijan.

Azerbaijan is a country with about 10 million population situated at the eastern boarder of the Europe at the seaside of the biggest lake of the world – Caspian Sea, on the geographical crossroad of Europe and Asia, West and East, North and West. This is the middle of the different routes of the Great Silk Way connecting China with European countries. Historically this geographical crossroad turned into the crossroad of civilizations and different cultures and religions. So, both historically and geographically Azerbaijan has turned into the one of the global lands of Multiculturalism and Tolerance and continues this life style today. Different religions and nations live in this part of land for centuries. Year 2016 was year of Multiculturalism in our country announced by President of Azerbaijan Mr. Ilham Aliyev. Many International Humanitarian Forums, UN Inter-civilization Dialogue Alliance meetings, UNESCO International Bioethics Committee sessions have been implemented in Baku in recent years. Heydar Aliyev Foundation led by The First Vice-President of Azerbaijan, UNESCO and ISESCO Goodwill Ambassador M-me Mehriban Aliyeva pays much attention to science, health, humanitarian and social projects.

The 23rd WAML Congress was held in Baku during 9-13 July 2017 under the main theme «Medical Law, Bioethics and Multiculturalism» and had 3 subthemes:

- Bioethics and Medical Law Education,
- Bioethics, Religion and Multiculturalism,
- Challenges of Medical Law and Legal Medicine in the XXI Century.

The Congress became an historical event both for WAML and Azerbaijan:

- 1/ this was a celebration of the 50th, Golden, Anniversary of the Association.

- 2/ this was for the first time in the 50 year history of the Association that the World Congress was held in this part of the post-soviet world: in the middle of Eurasia, at the Eastern edge of Europe and the cusp of Central Asia, where West meets East and North with South.

- 3/ this was the first time, that specialists from CIS (Commonwealth of Independent States), Turkish speaking countries, Arab world, Middle East, and Central Asia had such a significant representation at a WAML congress. This stressed once again the role of Azerbaijan as the bridge between civilizations and religions, a unique place for multicultural dialogue. Multiculturalism, being one of the main objectives of WAML, is also one of the core objectives of the modern state policy of Azerbaijan.

- 4/ finally, this was historical first international scientific event on the World Congress level in Azerbaijan. For the first time world professionals of certain scientific fields selected Baku as the venue for their World Congress. Baku has hosted numerous big international scientific, cultural, political, humanitarian, and sport events in recent years, but never before, neither in the Soviet period or post-Soviet independence years, a World Scientific Congress.

380 leading specialists met together to exchange their experiences and knowledge in medical law, bioethics and legal medicine to start another 50-year history of WAML here. About 300 abstracts were collected and 235 of them from 50 countries were selected for the Program: Algeria, Australia, Azerbaijan, Bangladesh, Belarus, Belgium, Bosnia and Herzegovina, Brazil, Bulgaria, Canada, Chili, China, Croatia, Czech Republic, France, Egypt, Ethiopia, Ghana, Hong Kong, Hungary, Italy, India, Indonesia, Iran, Iraq, Israel, Japan, Jordan, Kazakhstan, Macao, Malaysia, Netherlands, New Zealand, Nigeria, Oman, Pakistan, Peru, Poland, Portugal, Qatar, Russian Federation, Saudi Arabia, Slovenia, South Africa, Sudan, Tunisia, Turkey, UK, Ukraine, USA. The largest delegations of 10-48 participants were from Russian Federation, Azerbaijan, China, USA, Turkey, Israel, Saudi Arabia, Belgium, Indonesia and Kazakhstan. This was a unique and outstanding opportunity to bring together people working in the same disciplines who have never met before. To achieve this target, the 23rd WCML was promoted at 6 National and International Conferences in China, Russia, Saudi Arabia and Kazakhstan during the October 2016 – March 2017 period:

- Silk Road Forensic Consortsium Symposium at Xi'an Jiaotong University and Xi'an International Studies Universities in China.

- National Conference of Medical Law of Russian Federation and National Congress of Forensic Medicine in Moscow, Russia.

- 2nd Saudi International Conference of Forensic Medicine and Sciences in Riyadh, Saudi Arabia.

- 1st International Conference on Medical Law in Astana, Kazakhstan.

3 Scientific Committees (Honorary, International and Local), an Abstracts Review Committee and an Award Committee were formed. One of the world's foremost forensic scientists and founder of the Henry C. Lee Institutes of Forensic Science in USA and China, Prof. Henry Lee has become a key-note speaker and made an excellent talk «New Concepts in Criminal Investigation» at the opening ceremony. The second key-note speech «The Medieval Contribution of Arabs and Muslims in Forensic Medicine and Toxicology» was delivered by Dr. Suha Al-Fehaid from Saudi Arabia. In the Opening Ceremony, formal greeting and welcome

from the Azerbaijan State was given to the Congress by Minister of Health of Azerbaijan, Prof. Oqtay Shiraliyev. Taking into account the great contributions of Mrs. Mehriban Aliyeva, The First Vice-President of Azerbaijan, UNESCO and ISESCO Goodwill Ambassador, and President of Heydar Aliyev Foundation into the development of Medical Law, Bioethics and Multiculturalism, WAML awarded Mrs. Mehriban Aliyeva the «WAML 50th GOLDEN ANNIVERSARY AWARD» and WAML Diploma to acknowledge her unique excellent achievements in these fields and recognition of enormous efforts invested in serving to promote multicultural dialogue between different religions and civilizations in order to enhance the spirit of tolerance and strengthen global peace and security. Mrs. Aliyeva is one of the first scientific researchers of the region on bioethical and medico-legal issues of Euthanasia and WAML holds in high esteem and strongly values her pioneering scientific results and involvement in the fields of health, science and education.

First time ever WAML Congress was also endorsed by UNESCO. Assistant Director General of UNESCO, Head of Social and Human Sciences Sector, M-me Nada Al-Nashif wrote in her letter of the 2nd June 2017, addressed to the name of Prof. Thomas Noguchi, President of WAML «UNESCO attaches great importance to Bioethics and Multiculturalism, which are crucial to the achievement of our mandate. Therefore, we wish to express our appreciation and support for this Congress, which puts these matters at the core of the international debate». Three members of UNESCO International Bioethics Committee, who are Bioethics experts appointed by UNESCO Director General, representing Turkey, Iran and Oman have been attending Baku Congress and after congress reflected it to UNESCO in very positive way.

In general, post-congress survey organized by WAML administration revealed that 100 % of the respondents found scientific program fully met the stated objectives. Among responses to Question «What was the most important feature of this program for you?» the most were «emphasis on multiculturalism», «diversity of topics and papers presented», «discussion on a range of topics and learning the different perspectives from differing countries», «impressive multinational and multicultural event». Generally, organizing committee collected 148 positive feedbacks from the colleagues after their departure like:

«Baku Congress of 50th Golden Anniversary of WAML was a successful meeting. People enjoyed. This was beyond our expectations!» Prof. Thomas Noguchi, WAML President, University of Los Angeles, California, USA

«Baku Congress was a very important meeting for WAML to celebrate 50th Golden Anniversary. I want specially to underline that it was the first World Congress on the territory of the post-soviet world. So the largest delegation among 400 participants from 51 countries was the Russian delegation with about 50 people. Azerbaijan does a lot for development of multiculturalism so the main theme of the congress was correctly selected. Program Chair made an outstanding job in building scientific program and organizing excellent event for all participants and guests. We enjoyed being in Baku, meeting our old friends and making new ones». Acad. Yuri Sergeyev, Sechenov's First Moscow Medical University, Russia.

«We enjoyed attending Baku 50th Golden Anniversary WAML meeting. A long time ago, I made a talk at a WAML meeting and was pleased now to be invited and to make a presentation at the Opening Ceremony. This was a wonderful meeting; we enjoyed the Congress and the Country». Prof. Henry Lee and Margaret Lee, University of New Heaven, Connecticut, USA.

«...The conference was a tremendous success and it received National News media coverage. That speaks volumes alone...». Ken Berger, WAML SG, University of Toronto, Canada

«The attractive Country and venue made the 50th Golden Anniversary Meeting a big success». Oren Asman, WAML EVP, Tel-Aviv University, Israel.

«It was a very nice meeting you made at the bioethics conference in Baku. It was a great conference». Prof. Atsun. Z. Guo, Chairman of IRB of China National Gene Bank, Chairman of BGI-IRB.

«...The conference was fabulous and it was really so well organized as an event... We enjoyed a very good scientific program. Country is so beautiful and the people are so hospitable». Prof. Osama Al Madani, Chief Forensic of the Ministry of Health, Dr. Manal Bamousa and Dr. Suha Al-Fehaid, Saudi Arabia.

«Excellent job in planning and managing the recent World Association for Medical Law Meeting in Baku, Azerbaijan. Excelled all expectations, with excellent content, a well-organized agenda, enjoyable social program and excellent complementary tours in the Baku area. It was truly a wonderful educational experience. Bravo!!». Prof. William Hinnant, President of American College of Legal Medicine, USA.

«Have enjoyed the excellent meeting». Dr. Richard Wilbur, Chairman, American Medical Association, USA.

«...This was fabulous, fabulous work to collect so many countries and participants». Prof. Roy Beran, University of New South Wales, Australia.

«...The WAML meeting was a great success». Prof. John Conomy and Dr. Jill Mushkat-Conomy, University of Cleavland, USA.

«...my compliments for the WAML 2017 conference! It was excellently organized and there were many interesting presentations...». Prof. Henriette Roscam Abbing, University of Maastricht, Netherlands.

«Most successful and enjoyable Congress. It's been stimulating from an academic perspective, friendly and welcoming and facilities were excellent. High standards of presentations with a good variety & the facilities are first class». Prof. Melinda Truesdale, University of Melbourne, Australia.

«Amazing Congress. We were very pleased to participate in excellent Congress which was an inspiring and very successful meeting. We had a great time and were very touched by warm hospitality». Prof. Cemal and Prof. Ayse Guvercin, Dokuz Eylul University, Izmir, Turkey.

«Everything was just so perfect and excellent. So memorable...Please use Baku standard in organizing future conferences as a yardstick...». Prof. Puteri Kassim, International Islamic University, Kuala Lumpur, Malaysiya.

«...thank you for great possibility to attend so interesting and successful event. Enormous work to make it of the highest level. It was well done and very professional. Thank you for invitation and support of Kazakhstan team» Svetlana Saukenova, Kazakhstan State of Law and Humanity Sciences, Astana, Kazakhstan [4].

In conclusion, synergy among international organizations with common purposes and objectives is important. We think UNESCO and WAML should cooperate more closely in the fields of Bioethics and Medical Law. Bioethical values and principles from 2005 UNESCO Universal Declaration on Bioethics and Human Rights will be better realized on international and national level if they will be framed properly in legal frameworks and find adequate attention from lawyers [5]. WAML as international organization covering all continents may be an excellent partner for UNESCO to provide legal support for bringing mentioned bioethical values and principles to the focus of the health lawyers and national legislations. From other side, close cooperation with such highly reputable organization like UNESCO brings much respect to WAML.

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ETHICAL PROBLEMS WHEN CONDUCTING HYGIENE STUDIES IN MODERN RUSSIA

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Ethical problems arising from hygiene research in modern Russia are considered in the article. Changes in socio-economic conditions in the country (emergence of enterprises of various forms

of ownership, employer's disinterest in assessing working conditions and, in fact, development of measures for prevention of diseases, primacy of the concepts of «human rights» and «voluntary consent» in organization of hygienic research; sometimes the lack of interest of administrative structures in obtaining real indicators of the health status of those surveyed, which often entails the need to develop in accordance with the laws of the country and the introduction of activities that require organizational and additional material costs) was the reason for the formation of new approaches and new conditions for solving scientific problems in the system hygienist (researcher) – the tested (healthy person). The authors determine ethical problems that arise from conduct of sanitary-hygienic, physiological, sociological and mathematical methods in the real conditions of production and human activity. It is the lack of interest of the subject in the research and the possibility of effective belief in the necessity of the research because of insufficient level of education and motivation. And it is the reluctance of the employer to show the real situation due to the negative results of hygienic studies in the dynamics of health status and the identification of risk factors for health at work, educational establishment etc. The solution to these problems is based on informal communication with the subjects, its encouragement in the form of various bonuses and in the absence of official permissive document. The relevance of the discussion about the ethical principles of research in preventive medicine is argued in the article.

Key words: Hygienic research, modern socio-economic conditions in Russia, ethical problem in the hygienist (researcher) – the tested (healthy person0 system, ethical problems arising from the conduct in the real conditions of production and human activity, various bonuses in preventive medicine.

ЭТИЧЕСКИЕ ПРОБЛЕМЫ ПРИ ПРОВЕДЕНИИ ГИГИЕНИЧЕСКИХ ИССЛЕДОВАНИЙ В СОВРЕМЕННОЙ РОССИИ

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В статье рассматриваются этические проблемы, возникающие при проведении научных гигиенических исследований в современной России. Изменение социально-экономических условий в стране (появление предприятий различных форм собственности, незаинтересованность работодателя в оценке условий труда и, соответственно, разработке мероприятий по профилактике заболеваний; главенство понятий «права человека» и «добровольное согласие» при организации гигиенических исследований; иногда отсутствие заинтересованности административных структур в получении реальных показателей состояния здоровья исследуемых, что зачастую влечет необходимость разработки в соответствии с законодательством страны и внедрения мероприятий, требующих организационных и дополнительных материальных затрат) явилось причиной формирования новых подходов и новых условий для решения научных задач в системе гигиенист (исследователь) – испытуемый (здоровый человек). Авторы определяют этические проблемы, возникающие при проведении? (применении?) санитарно-гигиенических, физиологических, социологических и математических методов в реальных условиях производства и жизнедеятельности человека. К ним относятся, например, отсутствие заинтересованности испытуемого в проведении того или иного исследования и, часто, возможности эффективного убеждения в необходимости проведения той или иной исследовательской процедуры в связи с недостаточным уровнем образованности и мотивированности. Часто это нежелание работодателя «выносить сор из избы» при получении по результатам гигиенических исследований негативных результатов в динамике состоянии я здоровья или при выявлении факторов риска здоровью работающих на производстве, в учреждениях образования и т.п. Решение этих проблем зачастую базируется на неформальном общении с испы-

туемым, его поощрением в виде бонусов различного характера и при отсутствии официальных разрешительных документов. В статье аргументируется актуальность дискуссии об этических принципах проведения научных исследований в профилактической медицине.

Ключевые слова: гигиенические исследования, современные социально-экономические условия России, этические проблемы в системе «гигиенист (исследователь) – испытуемый (здоровый человек)», реальные условия производства и жизнедеятельности человека, поощрительные бонусы при выполнении гигиенических исследований.

Hygiene is the most important branch of preventive medicine, which focuses not on diseases or a sick person, but health and a practically healthy person. In theory, paradigms of health studies suppose researches how environmental and social conditions affect people's health, analysis and assessment of health risks [3, 4]. The aim of hygiene research is to obtain a probative database how environmental conditions (chemical, physical, social, etc.) affect people's health and on the ground of the data obtained to develop standards and measures either to eliminate or to decrease hazardous factors, as well as improvement of working conditions, life and health. Solution of specific problems of hygiene is associated with certain ethical problems due to some specific features of hygiene research.

1. The end result in hygiene is to prevent a disease, not to treat a patient. Accordingly, to solve specific tasks in clinical medicine, a model of interrelationship in the «physician – patient» system is built. In various cultures and various societies relations between a medical doctor and a patient are formed and understood in a different way. Robert Veatch, an American expert in bioethics, singles out four models of physician-patient relations typical of modern culture: engineer, paternalistic, collective and contract /citation after B.G.Yudin. P.D. Tishenko/ [9]. There are authors' models of concepts of 'physician-patient' interrelations. For example, monological (subject – object) and dialogical (subject-subject), where activity of the participants is a criterion [1]. V.I.Petrov and N.N.Sedova [6], who devote their work to the problem of application of principles and standards of bioethics in medical institutions in Russia, suggest a model of ethical teams, which is adequate to needs of domestic medicine taking into consideration peculiar ethic regulations of medical activities. Though, for all various approaches to the character of interrelationship in the 'physician-patient' system, its obligatory component is a mutual responsibility and interest in results of 'co-work' (health improvement, recovery, etc.)

On doing hygiene researches, the 'researcher (hygienist) – observable (a health person) system is formed. This system lacks any interest on the side of the observable and quite often there was no possibility of effective belief that this or that research procedure is necessary due to a low level of the observable's education and motivation. In such situation trust relationship with the observable or some bonuses, raising interest (increased break by agreement with the employer, free meal, souvenirs, such as pens, stickers, etc.) are important The staff of our department participated in the joint project with the Royal College of London and a non-profit organization Mary and studied prevalence of risk behavior associated with drug use and sexual practice. After questioning of women engaged in commercial sex service 11], they were given a present (a can of condensed milk and condoms). A similar survey in London among drug addicts using injection drugs ended in a bonus of condoms and amphetamine [10].

2. In clinical medicine a physician works with an individual (patient). In hygiene, in order to develop measures to decrease hazardous effect of the environment, health improvement in people having common work or life conditions, it is necessary to conduct group, cohort and population studies. Therefore, another difference between clinical medicine and hygiene is not assessment of an individual but of a group of depersonalized observables (personal data, as name and address are not considered but age, work experience and life in a certain territory, etc. are of importance). To obtain representative data, a large array is necessary, such as professional groups, children's population of a certain age, etc.

3. Complex approach on choosing the method of study. At the modern stage a hygiene study includes:

a) the method of **sanitary-hygienic examination** means examination and description of various objects using specially developed programs: industrial enterprises, living spaces, public catering establishments, etc. On the ground of conducted examination, quantitative factors of the environment are established, their comparative assessment with hygiene standards is done and measures to eliminate the revealed shortcomings. In today's socio-economic conditions sanitary examination for research purposes has become too difficult because managers of industrial enterprises (employers), heads of educational institutions (public officers). etc, do not permit a researcher to conduct any examinations. Quite often the problem is solved only due to personal trust contacts not with top management but with employees, for example with a school nurse who allows copying depersonalized data of

school students' physical development. An informative example of approach to this problem is the Department of General Hygiene and Ecology of VolSMU in 2017 that developed new standards of school students' physical development in Volgograd. The standards are used for preventive medical check-ups and filling children's case histories (Order N 241 of 3.07.2000). Previous standards were issued in the year 2000. Most authors hold the opinion that regional standards of children's physical development should be specified once every 10–15 years, as indices of physical development change due to constant changes in the material and cultural life of people as well as unfavorable environment [2]. Then a dilemma arises: health workers must have new standards for preventive examinations and evaluation of physical development, hygienists must have access to educational institutions for anthropometric measurements to develop new standards. However, educational bodies are not competent enough to allow such examination in educational institutions which gave rise to numerous administrative barriers and sometimes unwillingness to help conduct such researches. The way out of this situation is to establish trust contacts between the university and school staff to solve personal health problems of the latter that presents in our opinion a certain ethical problem.

b) **experimental methods** – to determine the intensity factor degree of industry or environment and the character of their influence on the human body. Most often hygienists use the method of **physiological observance** to evaluate a functional state of the person (working in specific industrial conditions, going to educational institutions of different type and with different teaching load, people living in different anthropogenic conditions, etc.) In this case, as we mentioned above, the researcher works with a presumably healthy person and it requires some efforts to convince them to be voluntarily examined (e/g. urine test, collecting hair and nails to determine accumulation of toxic substances in biologic fluids and derivatives, measuring rectal temperature during a work shift to assess the worker's heat condition, etc.). It takes a lot of emotional efforts and communicative skills to convince the observable how important this work is.

c) method of **clinical observance** – this method supposes in-depth clinical examinations in accordance with goals set, as well as results of preventive medical check-ups and follow-up which makes it possible to compare dynamics of people's health in a certain territory or group. Unfortunately, official data and results of in-depth medical examinations quite often differ significantly, which presents certain ethical difficulties dealing with health care officials and researcher hygienists. So, data for children's health groups obtained by follow-up during many years differ: according to the official statistics about 20 % of children refer to the first health group healthy children) and in-depth research shows that only 5–7 % of children refer to this group.

d) **method of sociological research (questioneering in the first turn) (involving a sufficient number of respondents and interviewers to obtain reliable results) and sanitary-statistical** methods (while researching into morbidity, complaints of poor health, etc.) make it possible to analyze changes taking place in groups and society. A large amount of work necessary for obtaining representative data, as well the character of questions (private questions, questions concerning bad habits, etc., often confused the respondents or caused a negative emotional response) shows necessity of a specially positive style of the interviewers' work and thorough validation of the results obtained, usually up to 20 % of the data. One of directions of the Department of General Hygiene and Ecology of VolSMU is the research into men's reproductive health among those who either work in harmful conditions or live in territories with expressed anthropogenic load [4]. To reveal risk factors in lifestyle of "healthy" men (not patients who require a specialized medical aid) referring to their private life, caused significant ethical problems.

e) method of **mathematical modeling and forecasting including methodology of risk assessment**. In this case difficulties arise to involve mathematicians who have experience in physiology and hygiene to adequately interpret the data obtained. The latter fact proves the appropriateness of assessment of expected models realization and calculated risks, as well as verification of the data obtained. The author of this article acted as opponent to the person who was defending a PhD dissertation on hygienic assessment of risk criteria for consumers' health of modern construction and finishing materials [5]. The mathematical model created made it possible to forecast an additional cancerogenic risk of the respiratory system impairments in people living in skeleton-section houses built on the basis of some types of polymer-containing construction and finishing materials which discharge formaldehyde into the air. This fact supported the necessity of thorough verification of the forecast and assessment of risk realization calculated by mathematicians which is complicated by laborious medical-biological researches done by hygienists and clinicians and the author of the dissertation accomplished using clinical, immune-biological, biochemical and physiological methods.

Thus, hygienic researches in today's social-economic conditions is associated with a number of ethical hardships and problems which are difficult

to resolve at the administrative-official level (unwillingness of public officers, managers (owners) of enterprises, managers of companies to provide access to the information and doing surveys).

In common medical practice decision is taken by two people – a physician and a patient. In this dialogue the third person is «an odd man out», if only he is not invited. This third party is ethical committees or/and ethical counseling [7]. In hygiene researches ethical counseling can answer the question of appropriateness and correspondence to ethical principles of the methods used but, unfortunately, it cannot overcome organizational and administrative-legal barriers. In connection with the above peculiarities of doing hygiene researches moral obligations put a question to researchers: what should be done so that their actions do not contradict morality, ethics and law. These questions arise in connection with the tasks which the science of prevention tries to solve and philosophical-ethical challenges of social and cultural character which politicians and the society face [8]. This argument proves the topicality of the discussion about ethical principles of researches in preventive medicine.

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LEADERSHIP IN MEDICINE: RISKS OF ETHICAL CONFLICTS

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The article deals with the problem of ethical conflicts in medicine. The growth of legal conflicts in medical practice is largely conditioned by increase of ethical conflicts. As the leader of a medical staff is the central figure, we've conducted the research of his/her personal features with the aim to reveal risk factors of ethical conflicts. The carried out literature review of the mentioned problem defined that leadership in medicine has its own peculiarities, connected with specificity of activity, gender asymmetry of a professional sphere. The research of role-playing features of a head in the medical staff was conducted on the example of physicians who performed leading duties with work experience in a senior post of 7 ± 1,3 years. The research was carried out in the categorical field of sociology of medicine using methods of content-analysis, participant observation, sociological inquiry and interviewing, and psychodiagnostic techniques (by Sinyavsky V.V. and Fedorishina B.A., Raygorodsky D.Y., Shubert, Boiko B.B., Snider M. etc.). The research results made it possible to determine ethical risk factors in 20–25 % of leaders. It was concluded that there is a need to institute a bioethical methodical block to the system of continuing professional education of medical specialists, which can make it possible to form leader's necessary ethical values and attitudes in conditions of educational sphere.

Key words: leadership, ethical conflicts, personal features, medical staff, style of leadership, bioethics.

ЛИДЕРСТВО В МЕДИЦИНЕ: РИСКИ ЭТИЧЕСКИХ КОНФЛИКТОВ

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В статье обсуждается проблема этических конфликтов в медицине. Рост юридических конфликтов в медицинской практике во многом обусловлен ростом этических конфликтов. Поскольку центральной фигурой медицинского коллектива является его руководитель, мы провели исследование его личностных качеств с целью выявления факторов риска этических конфликтов. Проведенный обзор литературы в рассматриваемом проблемном поле показал, что лидерство в медицине имеет свои особенности, связанные как со спецификой деятельности, так и гендерной асимметрией профессионального поля. Изучение ролевых характеристик лидера в медицинском коллективе проведено на модели врачей, стаж работы в руководящей должности которых (7 ± 1,3) лет. Исследование выполнено в категориальном поле социологии медицины с использованием методов контент-анализа, включенного наблюдения, социологического опроса и интервьюирования, а также психодиагностических методик (В.В. Синявского и Б.А. Федоришина, Д.Я. Райгородский, Шуберта, В.В. Бойко, М. Снайдера и др.). Проведенное исследование позволило выявить этические факторы риска у 20–25 % руководителей. Сделан вывод о необходимости внедрения в систему непрерывного профессионального образования медицинских специалистов методического блока биоэтической направленности, позволяющего формировать необходимые этические ценности и установки лидера в условиях образовательной среды.

Ключевые слова: лидерство, этические конфликты, личностные качества, медицинский коллектив, стиль руководства, биоэтика.

One of the burning issues of practical medicine in Russia is ongoing growth of legal disputes. The amount of appeals and requests from citizens to the courts on so-called «medical cases» is increasing. Patients or their relatives are not satisfied with the result of treatment, fatalities and low quality of health-care services. However, despite the validity of numerous claims, the most part of them is of ethical nature.

The analysis of reasons of these appeals revealed the top complaints:

1. Violation of professional ethics: physician's hostility, reluctance to explain the risks or comment on the patient's health status, or inform about alternatives etc.

2. Legal and illegal charging for medical services that are included in core program of state guarantees.

3. Complains about the quality of medical service, concerning medical errors, harm to health or life.

The scientists in this field fully share the view that almost all disputes arise because of carelessness of both sides, irresponsibility of medical staff or lack of etiquette, or disagreement of patients and physicians.

Among the catalysts of the conflict are offenses, emotions, pain. Not so many conflicts arise due to objective reasons such as lack of equipment or medicine etc.

In this context, the research of leadership in medicine has practical advantages. The head, his or her social position, personal features, skill level and focus of work largely determines socio-psychological climate in the staff and its satisfaction with a job. In this regard, one may suppose that role-playing characteristics of the head can shape possible risk factors as well as for development of ethical conflicts in medicine.

Socio-economic environment in Russia has been significantly changed in recent decades. One can monitor an active integration of market relations in the sphere of medicine, which reflects in development of private health sector, broadening the range of fee-paying medical services and change of doctor-patient relationship. There is a growing demand for a professional activity of physicians, their role-playing functions are expanding and nervous strain is rising. It can be particularly evident when a physician is performing the duties of the head of a health-care institution [3, 7].

The analysis of contemporary researches in this sphere revealed that socio-economic health reforms initiate higher requirements to professional competences of a head-physician that result from certain factors such as estrangement of a head from the staff, loss of professional duties, prevalence of administrative duties over professional ones, need for solving problems connected with a conflict environment inside the staff.

The aim of our research is to evaluate socio-psychological competences of a head of the medical staff from the point of risk factors of ethical conflicts in medicine.

In this respect, we have done a research of role-playing features of a head in the medical staff on the example of physicians who performed duties of heads of wards in hospitals, polyclinics, with an average age of 39,7 ± 2,8, work experience of 20,2 ± 3,2 years, work experience in a senior post of 7 ± 1,3 years. A comparative analysis of similar features of a control group of therapists has been made to identify a role-playing complementarity in a medical profession.

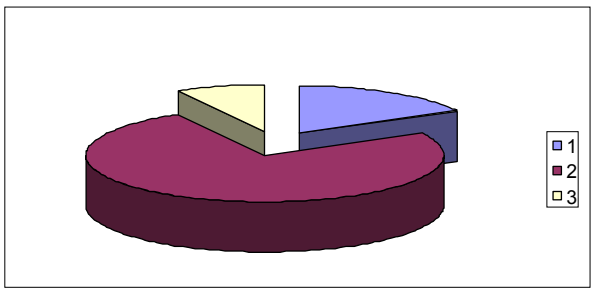
The research was conducted in the categorical field of sociology of medicine using methods of content-analysis, participant observation, sociological inquiry and interviewing, and psycho-diagnostic techniques (by Sinyavsky V.V. and Fedorishina B.A., Raygorodsky D.Y., Shubert, Boiko B.B., Snider M. etc.).

The analysis of curricula vitae of physicians in authority makes it possible to conclude that leadership in medicine according to the traditional classification of power (French & Raven, 1960) is the power of an expert, based on experience adopted from the colleagues, knowledge and abilities of an individual. Whereas the expert's competence in other professions may not influence the interpersonal relationship holding informal leadership, it is exactly the kind of influence that shapes a leader from a head-physician. In the sphere of medicine, there is such a corporate concept as «concilium», which means that a decision made is based on the referent influence of more experienced and competent colleagues.

Despite the legitimate origin, leadership in medicine has an expert nature. A head in medicine is usually a professional physician with no less than 10–15 years of service and with certain leadership qualities and skills.

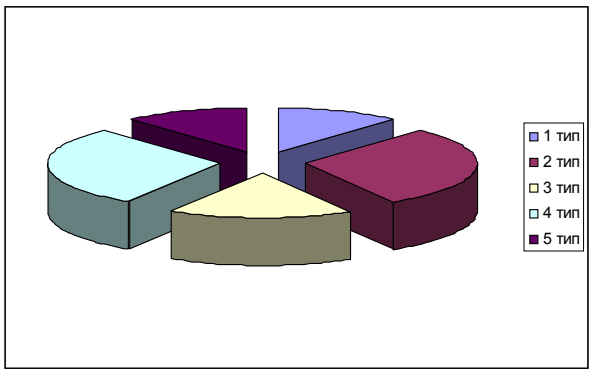
Therefore, our research showed that most head-physicians had high and very high levels of communicative and organizational qualities, higher than their colleagues from the monitoring group did. The results proved that most head-physicians (67,2 %) had high rates of organizational qualities (with 33,6 % of a high rate and a 33,6 % of a very high rate), half of them had communicative qualities (with 16,6 % of a high rate and 33,4 % of a very high rate, $p > 0,05$). The amount of respondents with a low level of above mentioned qualities was small (communicative – 8,3 %, organizational – 16,4 %, $p > 0,05$). The levels of communicative qualities with "high" and "very high" rates occurred more often than among therapists (14,2 % against 7,1 %, $p > 0,05$).

The analysis of predominance of communicative or organizational qualities in the structure of an individual (picture 1) showed that 74,5 % head-physicians had organizational qualities superior to communicative, and 17,2 % vice versa ($p \leq 0.01$).



Picture 1. Placement of respondents according to their personal features (in %): 1 –prevalence of communicative qualities, 2 – organizational qualities, 3 – joint development of mentioned qualities

At the same time, about 15–25 % of head-physicians (by different figures) had conflict risk factors according to Boiko V.V. technique of evaluation of communicative interferences. A detailed analysis of *etiology of communicative problems* (picture 2) did not reveal prevailing types of communicative interferences for head-physicians ($p > 0,05$). At the same time, the most widespread types were «inadequate display of emotions» (29,6 %) and «dominance of negative emotions» (29,4 %) with a direct correlation link ($r = 0,65$). It should be mentioned that interferences of the 5th type – «refusal to get close to people on the emotional base» – happens more rarely among head-physicians (only 11,6 %), than among the monitoring group of therapists ($p < 0,05$). This fact is absolutely favorable in evaluation of leadership qualities.



Picture 2. Placement of respondents with interferences of different types in the group of head-physicians: 1 – inability to control emotions, 2 – inadequate display of emotions, 3 – inflexibility, immaturity of emotions, 4 – dominance of negative emotions, 5 – refusal to get close to people on the emotional base

The diagnostics of *socio-psychological facilities of personality in the sphere of motivation and requirements* was conducted according to Potemkina O.F. technique, which enabled to reveal the degree of display of socio-psychological facilities, conditionally named "altruism-egoism" and "process-result". The result showed explicit altruism orientation of an individual in most heads (66,4 %), $p < 0,05$.

The average of altruism (5,32 ± 0,56) is higher than egoism (3,76 ± 0,89), but these differences may be not accurate ($p > 0,05$). At the same time, 25,3 % of heads have more rates in egoism. Some researches justify a «rational» egoism because of peculiarities of a social status as a head. In particular, A.Menegetti considers leadership as satisfaction of egoism through realization of social interest. In our opinion, egoistic orientation may be regarded alongside as a predictor of possible role-playing expansion. A number of researchers (Yukl & Van Fleet, 1992) also point out that emotional maturity is important for a successful leadership, which excludes egocentrism and tendency to defensive responses.

An integral part and the main characteristic of leadership efficiency is the style of leadership, which

manifests itself in encouraging techniques for the staff to initiative and creative work and controlling the results of the staff's activity. The style of leadership may serve as the quality characteristic of the head's activity, his or her ability to maintain efficient managing activity and also to create an atmosphere for development of favorable relationship and behavior.

The style of leadership that was chosen right to appropriate to the situation is capable of overcoming insurmountable obstacles. The leadership style is mainly shaped by individual features of a leader, though personal characteristics do not exclude other important things which account for external influence of micro-society.

Russian scientists always group the leadership style on different grounds. An individual leadership style is based on different proportions of social facilities and personal features of a head such as economic, organizational, ethical, moral and professional. The specificities of style are formed depending on domination of one of five components prevailing in a person.

The style of work does not only characterizes the head, but affects all the activities inside the structure and directly subordinates. There are three main leadership style in accordance with the most popular classification: democratic, authoritarian and liberal. *Democratic* or ***collegial*** leadership style. Organizations where this type of style prevails can be characterized by a high level of decentralization of authority, active participation of staff in decision-making. The performance of duties seems to become an appealing job and a successful result is a reward. The head is oriented on capacities of subordinates, their creative initiatives, makes decisions with their help, creates necessary conditions for timely work performance, evaluates the results fairly, financial and mental promotion.

Authoritarian or administrative leadership style is characterized by extreme centralization of authority, dedication to one-man management and independent decision making of most administrative problems. Under market-oriented conditions purely administrative leadership style becomes hardly acceptable, however, may be efficient in the short term.

Authoritarian leadership style as an ideal model of one-man management has the following variants: dictatorial, autocratic and bureaucratic styles. The latter is typical for the Soviet system.

Liberal leadership style differs from the others in absence of a head's own initiative and reluctance to be responsible for administrative decisions, especially connected with a certain risk. The liberal style head is excessively cautious and incoherent in everyday behavior, interaction with subordinates. Such head is not demanding enough and does his or her best to please everyone.

The successful choice of a leadership style depends on how a head evaluates his or her abilities such as educational background, work experience, personal characteristics and also determination of subordinates to complete assignments or traditions of the staff.

Our research revealed that certain leadership style never occurs by itself. In real life, every leadership style has common features of different styles with a prevailing one. Possibility and relevance of style components combination depends on presence of certain traits, role-playing functions in the style that vary in every case.

Extrapolation of the results in our sociological research allows describing contemporary style-forming tendencies in the sphere of medicine management activity.

In our research 67,2 % of heads had high rates in communicative qualities, 8,3 % of respondents had low rates which contribute to development of an authoritarian style. It may be supposed that most head-physicians (91,7 % of respondents had medium and high rates of communicative qualities) developed a democratic or liberal leadership style. The *Democratic* style implies that a head has confidence and mutual understanding with a subordinate. In this case, the head is a member or the group, and other staff members are free to express their opinion on different questions without being punished.

At the same time, taking into account that 17,7 % of head-physicians had prevailing communicative and organizational qualities in dichotomy, it may be supposed that a liberal leadership style was formed in this monitoring group of residents. The liberal style is described as non-initiative and non-interfering into the work process. A liberal head undertakes any actions only on the orders of a superior, avoiding responsibility. Usually these are not competent enough people, who are not sure in their official status.

74,5 % of head-physicians had organizational qualities prevailing over communicative ones, so revealing in 25,6 % of them serious communicative obstructions (level 3 prevents building emotional contacts), we may predict the development of an authoritarian leadership style. The authoritarian leadership style is the reason of most conflicts because of one-man management. The claims of an autocrat concerning competence in all spheres leads to chaos and finally affects efficiency.

At the same time, only 16,7 % of respondents did not have any communicative problems, so a democratic style may be stated in less than one fifth of this percentage.

Taking into account all the described styles, we may conclude that most appropriate democratic leadership style for heading a medical staff appears

in average in 16,7 % of head-physicians. Most conflict, the authoritarian one, occurs in 8,3–25,6 % of cases.

Our sociological research of leadership styles has proved earlier observations concerning the need for optimization of organizations to develop leadership qualities among head-physicians. Revealed in some head-physicians low rates of communicative control and emotional obstructions in communication are risk factors for subordinate opposition, and as the result, ethical conflicts.

Conclusions. The research results make it possible to emphasize the following peculiarities of personal characteristics of a head-physician as risk factors of ethical conflicts:

- ✓ Low rates of communicative control (15,4 %);
- ✓ Inadequate display of emotions (29,6 %);
- ✓ Prevailing of negative emotions (29,4 %);
- ✓ Egocentric settings (25,3 %);
- ✓ Refusal to get close to people, egocentric setting, found out almost in one fourth of respondent of the monitoring group;
- ✓ Prevalence of authoritarian leadership style features.

The obtained results show the need for development of certain leadership culture, a social position, and communicative skills in the context of continuing professional education.

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THE DEBRIEFING AS PSYCHO-TECHNOLOGY ASSISTANCE TO VICTIMS OF WAR, TERRORISM AND DISASTERS: BIOETHICAL ASPECTS

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The article is devoted to psychological support and rehabilitation of military personnel and victims of war. The possibilities and limitation of debriefing as a form of psychological support and prevention last heavy military stress, post-traumatic stress disorder and other disorders. Examines the main mechanisms of debriefing and its functions. Particular attention is drawn to the problem of social exchange of experiences, its role in overcoming the negative effects of war trauma, and the role and functions of social exchange of experiences in the reconstruction of the events of wars, disasters, and terrorist attacks. Describes the conditions of the effectiveness of psychological debriefing and its problems. The experience of trans-ordinal events, including a long stay in them, can be very valuable for the individual and the community, requires research, reflection, not only leads to non-healing wounds and psychosomatic disorders and mental type, but with proper work with him,

identifies new opportunities of moral and psychological development of man as the Creator of the surrounding reality. We analyzed the results of studies of social exchange (separation) of experiences in debriefing and other studies of socio-psychological counseling. In the considered works he acts as a process of social exchange or «division» by the subjects of the meanings of his life activity, experiences and perceptions about it. The success of such an exchange, its effectiveness and productivity is associated with the formation and development of partnerships and mutual support. Very important are the conditions for achieving psychological security and the focus on the development of subjects of dialogue. The central bioethical aspect of assistance to the victims of wars, terrorist acts, disasters and other psychotrauma events is the consideration of the interests of the victims themselves and the protection of the interests of the society, the preservation and development of social relations.

Key words: debriefing, war stress, survivor's guilt, war, terrorist act, accident, PTSD, trauma, psychological counseling, social sharing experiences.

ДЕБРИФИНГ КАК ПСИХОТЕХНОЛОГИЯ ПОМОЩИ ЖЕРТВАМ ВОЙН, ТЕРРОРИСТИЧЕСКИХ АКТОВ И КАТАСТРОФ: БИОЭТИЧЕСКИЕ АСПЕКТЫ

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Статья посвящена проблемам психологической поддержки и реабилитации военнослужащих и жертв войны. Анализируются возможности и ограничении дебрифинга как формы психологической поддержки и профилактики тяжелых последний военного стресса, посттравматического стрессового расстройства и других нарушений. Рассматриваются основные механизмы дебрифинга, его функции. Особое внимание обращается на проблему социального обмена переживаниями, ее роль в преодолении негативных последствий военных травм, а также роль и функции социального обмена переживаниями в реконструкции событий войн, катастроф и терактов. Описываются условия эффективности психологического дебрифинга, его проблемы. Отмечается, что опыт переживания трансординарных событий, в том числе длительного пребывания в них, может быть весьма ценным для человека и сообщества, требует своего изучения, осмысления, не только приводит к хронической травматизации и нарушениям психосоматического и психического здоровья, но, при правильном осмыслении, определяет возможности нравственно-психологического развития человека как творца своей жизни. В статье проанализированы результаты исследований социального обмена (разделения) переживаний в дебрифинге и других исследованиях социально-психологического консультирования. В рассмотренных работах он выступает как процесс социального обмена или «разделения» субъектами смыслов своей жизнедеятельности, переживаний и представлений о ней. Успешность такого обмена, его эффективность и продуктивность связана с формированием и развитием отношений партнерства и взаимной поддержки. Очень важными являются условия достижения психологической безопасности и направленности на развитие субъектов диалога. Центральный биоэтический аспект помощи жертвам войн, террористических актов, катастроф и иных психотравмирующих событий – учет интересов самих пострадавших и защита интересов социума, сохранение и развитие социальных отношений.

Ключевые слова: дебрифинг, военный стресс, война, террористический акт, катастрофа, вина выжившего, посттравматический стресс, травма, психологическое консультирование, социальный обмен переживаниями.

Most of the participants, primary and secondary victims of wars, terrorist attacks and catastrophes that have experienced trans-ordinary events of varying intensity, duration and unfolding, events related to mass deaths and death threats, treachery and deprivation, a complete violation of human rights and moral relations, equilibrium. This particular complex of psychological problems was call «post-traumatic stress syndrome». For the first time, post-traumatic stress disorder was describe in the US after a lengthy study of the mental state of US soldiers returning after a defeatist anti-human war in Vietnam. Psychiatrists and lawyers in the United States drew attention to the fact that a significant proportion of those serving sentences in US prisons at the end of the twentieth century participants in the Vietnam War. There were expressions «Vietnamese syndrome», «syndrome of

war participants». With similar mental disorders people who survived such cataclysms, especially in the case of the acute experience of inhumanity, immorality, betrayal of injustice, encountered domestic experts who surveyed participants in military operations in various «hot spots» of the former USSR – in Afghanistan, in Chechnya. Destructive for the human psyche consequences begin after a month of direct participation in battles. The sense of unfairness of war, betrayal and immorality is so exacerbating the negative impact of trans-ordinary events and situations that we can assume: it is this, and not in itself, the «stress of survival» that makes a major contribution to the stability, duration and intensity of post-traumatic disorders. As a result, a large number of victims, trying to reconcile the ordinary «civilian» experience and experience of war, with its «extra-moral» components, often have mental disorders and diseases of varying severity. Victims have deformations of representations about the boundaries of human and moral behavior. They try to live as if «nothing has changed» those who have given rise to social isolation as unwillingness of society and the state to deal with the victims, buying off with lump sum or constant payments. These violations do not allow us to rework the experience of the trans-ordinary situation, to integrate into everyday life, the life of «ordinary people». Trans-ordinary event changes the scale of understanding reality. It translates it, in whole or in part, into the sphere of spiritual and moral relations. Since the crisis of these relations affects the whole person in one way or another, the consequences of this event can manifest in a very plentiful variety of symptoms. The state of people was further aggravate by the fact that the victims, despite the development of their psychogenic disorders, remain for some time in a life-threatening situation and even participate in the elimination of the consequences of the calamity that has befallen them, military «shares» of various types. Besides, the victims can and should be perceived as survivors of death – their own death, however, just as people who have experienced a clinical death resist parting with the past, so the survivors resist holding on to the already ramshackle shell of moral and other ideas about yourself and the world. From the internal point of view, the collision with the trans-ordinary experience, however cruel and difficult it may seem, can and should was understand by a person as an experience necessary for his development.

In the 1980s, «posttraumatic stress disorder» was recorded as a diagnostic category as a condition that develops in a person experiencing a stressful event of a menacing or catastrophic nature capable of causing general distress. If a person suffers from post-traumatic stress, this means that he has experienced a traumatic event or a series of events, i.e. experienced something terrible, intense trauma or a series of injuries that do not often happen to other people. This is a traumatic event that «transcends normal human experience». Since in the modern practice the number of trans-ordinary situations is expanding (experience of violence and torture, imprisonment, etc.) is becoming more common, then it can was say that trans-ordinariness is a characteristic of the «typical – atypical» experience of a given person in a given social group. Unfortunately, or fortunately, a person adapts to the most diverse living conditions and the buildup of a «civilized» «military presence», the accompanying devastation and poverty, for example, in Africa and Asia, the former CIS, etc., has made habitual the experience of inhuman, inhumane relationships between people ordinary. Fascism and genocide have become a daily occurrence. Therefore, certain events or incidents are only part of the overall picture, an external circumstance that has played a role in the painful process. The Horrors of wars, disasters and terrorist acts have an effect not only their intensity and frequency. Injuries follow one another, so that man is not the time «to recover». They have their own eccentricity, excessive violations of the ideas of man about the normal, everyday life.

This aspect of post-traumatic stress refers to the inner world of the individual and is associated with the person's reaction to the experiences experienced. We all react in different ways: a tragic incident can cause serious trauma to one and almost not affect the psyche of another. It is also very important, at what time the event occurs: the same person at different times can react in different ways. Thus, speaking of post-traumatic stress, one usually means that a person experienced one or several traumatic events that deeply affected him: spiritually, mentally and physically. These events differed so sharply from all previous experience or caused so much suffering that the person answered them with a stormy system of tentative and then negative, destructive reactions, including for himself. The normal psyche in such a situation naturally tends to soften the discomfort: a person who has experienced such a reaction fundamentally changes his attitude to the surrounding world, in order to live at least a little easier. An abnormal, sick psyche can was even more damage: border agents in the territory of military operations, catastrophes and terrorist acts are especially dangerous – «dangerous type personalities». Personalities of the «safe type» have experience in transforming trans-ordinate situations and preserving the spiritual and moral guidelines in them. Motivation for self-preservation (need for safety) and safe behavior skills are very

important defensive entities of the individual, their implementation and use in both everyday and transnational situations is the main and necessary condition for a harmonious existence. The motives (intentions) of understanding of oneself and of the world, the motives of relations with people, and the motives for transforming oneself and the world were connect with it. The «invulnerability paradigm», which characterizes everyday life, assumes the fulfillment of the security condition in the ordinary and transnational situation as a matter of course. However, a person of a safe type knows that this is not so: «Invulnerability» is more an illusion than a fact. Man only believes himself to understand the world, which has satisfying his relations with people and is able to influence the world, to change. Therefore, in a transnational situation, where the fulfillment of this condition is problematic, the understanding of oneself and the world, the illusions of control, and many illusions of relations are usually lost. One of the leading problems is the problem of death as a problem of human choice: to live, trying to find a new meaning and new life strategy, to correct the «mistakes» of a past life, or to die, refusing to return to the already familiar pain, suffering, habitual way of life and the old meaning. Studying these problems on the example of the world wars of the twentieth century, psychiatrists described the symptoms of military neurosis and proposed the concept of «shock-shock», which explained its symptoms because of mental trauma received during explosions and bombardments. They described the symptoms and the long-term consequences of a psychological trauma received during the fighting – military psychosis («combat exhaustion» – exhaustion from military operations). When studying the state of political and criminal criminals, prisoners and prisoners of war, E. Minkovskiy syndrome was identified [2, 3] (concentration camp syndrome). It includes such symptoms as apathy and depression, irritability, sleep disorders, accompanied by difficulties in work and family life. It includes the syndrome of «emotional anesthesia» («l'anesthesie affective»), which combines the phenomena of a kind of insensitivity due to the prolonged moral and physical suffering of many prisoners of Nazi concentration camps and modern prisons (destroying the person, narrowing the circle of interests, the predominance of primitive, instinctive reactions). The duration, type and number of symptoms depends on the time spent in extreme conditions, such as stress and care. It should was note that, since in ordinary situations such as imprisonment, and also after a person returns «to a citizen», these stresses were most often not monitor. The violations were not record, then, as a rule, people choose for themselves the path of self-destruction (suicides and drug addiction) or «emotional anesthesia», stupefaction and cynicism, which provokes active desocialisation and human involvement in the destruction of the community (recidivism or primary crime, political opposition, terrorism, etc.). Thus, a society that refuses to help the victims of terrorist attacks, catastrophes and wars, migrants escaped from them, convicted, etc., provokes new processes of desocialisation and resistance. It is obvious that the growth of crime and terrorism, catastrophes are not priorities of the state, however, the example of modern Russia shows that this problem is still included in the zone of the «blind spot». Its silence is the – part of the corruption processes of society, long lived the «ideals» of social consumption and repression. Parallel to the research-findings, assistance techniques were develop, including debriefing. Debriefing is currently a relatively common form of socio-psychological counseling for victims of terrorist attacks, disasters, wars and other intense, massive or individual stresses. Even in the work of S. Marshall, who sought to understand the «historical truth» of military operations through their comprehensive description of the survivors of the hostilities, was note the need to create an atmosphere of support and goodwill. He was note the importance of providing an opportunity to share their experiences contributing to the restoration of harmony of intrapersonal and intragroup relations [3, 7]. In most cases, the purpose of debriefing is to reduce the psychological damage caused to the victim – the subject of military stress – by explaining to the person what happened to him and listening to his point of view. This is a crisis intervention designed to weaken and prevent the post-traumatic stress reaction caused by trauma in normal people. This reaction is typical for people who are in an extreme, stressful situation (survived a traumatic event). Intervention allows preventing and reducing the likelihood of development of the consequences of psychological trauma by its comprehension: awareness, and processing experiences of a traumatic event [10, 11, 14]. The concept of «debriefing» was take by psychologists from military terminology. In it, it denotes the procedure the «briefing» (briefing). The task of debriefing, especially in dealing with the military in the course of ongoing military actions and actions – is to alleviate psychological stress and help the subject to return to normal life. Currently, debriefing as a method of emergency social and psychological assistance involves working with individual or group psychic trauma, is a form of crisis intervention, a specially organized and structured work with people who have experienced a tragic event. Its purpose is to reduce the severity of the psychological consequences of the stress

experienced, to minimize psychological suffering in the short and long term by (a) «working out» the cognitive organization of the experience experienced by understanding the structure and meaning of the events that occurred, experiences about them, and (b) intensive «exchange of experiences») information about change management. Noting the existence of different types of debriefing, the researchers state that it is used both as an individual and as a group intervention. However, group classes are more effective because they help to recreate the «initial situation». They provide an opportunity to understand what happened: to understand yourself, others and the situation. They also provide an opportunity to resolve or prevent such problems as disclaimers and experiences of «survivor's guilt», prisoner's syndrome and «Stockholm syndrome». In addition, the group becomes a place for communication, trust and a sense of security, and also – the restoration of order. Debriefing contains, as the main element, defusion or verbalization aimed at re-experiencing (re-experiencing, rethinking) the non-traumatic aspects of an experienced event, investigating traumatic experiences in the context of encouraging (confirming) and defending group support, «normalizing» reactions, including experiencing and understanding occurring and stimulating the comprehension of experiences (at the cognitive level). It also includes informing about the options for a psychological response after a psychotraumatic event, that is, in effect, training in ways of understanding the traumatic situation, debriefing itself and their consequences. In the process of sharing experiences in a psychological safe environment, when the acceptance and attention of others become the backbone of the need to restore internal order, security and overcome fear of insecurity, a more or less implicit transfer of the role of the «knowing» to the suffering person itself was realize. This leads to a decrease in the individual and group voltage. The sensations of the uniqueness and abnormality of one's own experiences decrease. There is a mobilization and integration of internal and external resources of the individual and the group. Personality overcomes the barriers of relationships as barriers to misunderstanding of oneself and other people. Researchers and practitioners have seen an increase in mutual support as solidarity and mutual understanding. A person has the opportunity to «close» or let go of the past, and they can summarize (search for the final meaning) of the experience. «A new beginning» arises, involving the creative use of experience in later life in the process of developing an understanding of oneself and the world. Therefore, the method of crisis intervention and the prevention method. He gives as «defusing» – the ability «to talk» (talking it out). It is important to vent in order to relieve stress in people (trainees) to identify the arisen experiences and the changes that have occurred with people, build relationships psychological safety and support.

It makes it possible to clarify the events (at the level of facts), to analyze why the events took place in this way, and not otherwise, to eliminate the misunderstandings and correct mistakes; and also to improve the skills of conducting included monitoring, introspection, to enable participants to develop the ability to reflect and manage change. On the example of defusing, such a component of productive debriefing as an intensive «exchange of experiences» is especially noticeable. The phenomenon of social exchange ensures the satisfaction of various needs for human interaction and development, in particular, the need for separation (not alone and support), the need for understanding and the need for subjectivity (the possibility of influencing, controlling what is happening). Psychological intervention, including after trauma, military stress, meets the needs of the victims in overcoming feelings of helplessness, disorientation and misunderstanding, isolation, etc. in connection with the experienced traumatic situation. Psychological debriefing was also aim at helping clients respond more adequately to the sufferings of other victims, to understand them, to take them out of isolation and to maintain their own faith. This method was bas on a hypothesis and social norm, suggesting the need for immediate assistance to victims of psychological trauma (arising from disasters and various forms of violence) on the part of society. It was generally accept that debriefing as an answer in terms of security, support and confidentiality is related to the awareness of the normality (uniqueness) of one's own experiences, the mobilization of internal resources to prepare for the delayed consequences of the event [5]. Therefore, it should be done preferably immediately after a traumatic situation, by the time when participants in the events will be capable of reflection, understanding the situation and self-understanding. It is believed that in cases when debriefing is postponed for one reason or another, the traces of the traumatic experience (meaningless or misinterpreted fragments of the situation) are consolidated, accompanied by a number of violations in the socio-psychological and other spheres, up to the psychopathology and deformities of the life activity of the subject. However, delayed and intensive debriefing often does not fully take into account factors such as mechanisms for restoring and transforming traumatic experiences. He does not read the style of psychological overcoming (protection, coping or self-realization) of the difficult

situation of processing experience. He also does not take into account previously suffered injuries and mental disorders in the victim, which are activated along with dissociative manifestations, with a misunderstanding of themselves and the world around them due to a current psychological trauma. Therefore, the crisis debriefing was included in the list of procedures that could additionally («secondarily») injure the victims. Among the important little learnable factors, it turns out to be as important as the loss of a loved one. a complex of «guilt of the survivor», other syndromes, distorting the habitual representations of a person about himself and the world, moral values. it is especially difficult for a man to experience the emergence of a hyperactivity state in the process of helpless observation of the deaths of others. These factors act as additional stress factors, many require different in form, time and place of intervention. Forcing the victims to discuss the traumatic event, not giving them enough time to get used to the experience, to independently find approaches to their comprehension, specialists cause the effects of «immersion» and «secondary victimization». In addition, the practice of forced debriefing, can lead to the passivity of participants, cause their discontent and, consequently, intensify the barriers of understanding. Psychological assistance cannot and should not was use as a repressive measure. It does not matter at the same time as often to the measures of this type the surrounding victims are accustomed to resort (including the heads of aid services and the state as a whole). They should not do this if they want to get a healthy society, help people and themselves. A person who has survived death and has seen it, not so much clings to life, how much respects the moral foundations that structure it. Immoral and cruel treatment of victims on the one hand, serves as secondary victimization and suppression of activity. It leads to the formation of states of learned helplessness and self-cognition. At the same time, it activates the state of intensive struggle and protection of scorned morality, justice, humanity. That is – social confrontation and in varying degrees of local social conflicts (up to riots and civil wars). And, as is known, the strongest protest comes from the weakest and «crushed» layers. Questions of life and death, their choice after experiencing a traumatic event, orders and pressure are not productively resolved. Therefore, often used multi-level debriefing, in which psychologists and their clients, other professionals working directly at the site of the event, subsequently themselves receive psychological, including supervisory, assistance from their colleagues. In modern studies, in particular, in the theory of social exchange or separation of experiences, reflecting the results of numerous theoretical and empirical studies of the transmission of experiences from one person to another [9, 12, 13, etc.], it is emphasized that the «needs of social separation are based on the» cathartic effects of expressing experiences. Development and maturity, however, from the point of view of classical theories of growing up, suggest that a person as a «lone ranger» must cope with life's difficulties independently, regardless of external interference, and coping focused on experiences is unproductive: autonomy as independence and separation were consider more productive relationships [1, 2. 13]. It was assume that the social exchange of experiences disappears in adolescence [12]. However, there is another process in which children initially limited by parental education are gradually included in an ever wider circle of communication, especially in adolescence and adulthood [12, 13]. In friendly and loving relationships, social exchange as a collective construction of experiences that occurs as a child continues, strengthening mutual dependence and forming «traditions of interconnectedness» (social exchange), which form the basis of adult experiences, their comprehension, division, transformation.

Adult people, comparing themselves with others, strive for self-understanding [4]. They turn to their social environment in search of explanations when they face obscure or confused situations or experiences. After participating in military operations, as well as after natural disasters, disasters or other traumatic and life-altering events, people tend to talk about their experiences and reveal their experiences. B. Rome and colleagues singled out the characteristics of this phenomenon: the experience is recreated in a dialogue, within the framework of creating or using a «socially common language», the experience is recreated in order to share with the addressee (real or symbolic) and change anything – in himself or the addressee [13]. Motives and goals of social exchange [12, 13] are as follows:

- express the pent-up experiences to try to facilitate them or achieve catharsis, recall or re-experience the event in order to find an explanation and clarify the meaning of the situation;
- «gluing together», getting closer to others and reducing feelings of loneliness, facilitating social interaction, getting solace;
- finding ways to solve problems, managing, seeking advice, getting help, supporting, legitimizing to test their experiences, approve them and confirm by society;
- entertainment, the desire to draw attention to getting attention from others, perhaps to impress others.

However, instead of social integration and strengthening of ties, revelations about certain events

can be harmful to human relations to oneself and the world, his understanding of himself and the world, lead to social and personal disintegration, therefore some situations are not discussed and, probably, purposefully kept secret [3, 4, 6, other]. In addition, the problem of secondary exchange, he suggests that the listener shares his experiences and experiences of the narrator with other people [5, 7, 8], and there is a paradox: social exchange presupposes confidentiality, but in most cases, the experiences of the narrator become the subject of secondary and subsequent exchanges with other people. Confidentiality becomes an illusion: rather an exception than a rule. And yet debriefing is bearing fruit. Productive coping with stress, the transformation of life values and life activity of the subject as a whole in the process of debriefing was carry out in conditions of mutual understanding. In the situation of debriefing, there is an exchange and coordination, confrontation and research, co-creation of the meanings of the vital activity of the subjects.

These subjects seek to understand and be understood by each other psychologically safe (host, confirm, facilitating self-disclosure and aimed at mutual disclosure) counseling atmosphere. Consulting acts as a partnership, aimed at cooperation on the study and resolution of specific issues and situations, and frustrating everyday patterns of life, communication. This is communication with a significant other. The other one is really present, sincere and authentic. He is included in the dialogue as a person, affirms and confirms the significance and very existence of himself and the other. In the content plan, psychological assistance to victims of military stresses, disasters and terrorist acts presupposes the realization that the values of the cognizing subject play a huge role in understanding and productive experience of what is happening, in the process of coping with life's difficulties. In the situation of wars, terrorist attacks and disasters, the survivor often remains practically alone with experience that does not have any formal past, as well as among other people who do not have similar experience in the past and experience what is happening next to and with it. Nearby sometimes there is simply no person who would have experience of survival in such situations. Especially strongly negative impact affects, as is known in young people: not having a significant experience in solving life's difficulties.

And vice versa, the existence of a large and varied life experience, acceptance of what happened «just with me» as a fact (and not punishment for any «bad», made in the previous catastrophe of life factor), a detailed understanding of traumatic experience helps a person to survive. Thus, a consultant working with this category of clients faces a very clear task: to help the client to understand the traumatic experience of experiencing a social disaster, to form a stable awareness of the client not as an «innocent» or «guilty» victim, but as a person «who managed to survive». In difficult conditions. On the one hand, it is important that the client is able to realize the value of the experience given to him as an «existential message» or a vital «challenge». On the other hand, it is very essential to improve the effectiveness of the assistance provided, the client is aware that it is not possible for him to become the same as he was before, for him, as for all other people who have gone through a severe psychological shock. Any attempt to return to the past will have a negative impact on the rehabilitation process. However, changing – does not mean to become «worse» or «weaker». «Negative» experience remains as long as it is not meaningful. Thorough study of life experience is one of the main conditions of any personal development in general: the lion's share of a person's life experience consists of experiencing a nominal «unpleasant» moments in various degrees. The mastering of such situations usually ends with their significant semantic transformation: a positive re-registration, or at least acceptance as a fact leading to changes in the human personality.

The next important point is the comprehension and development of scenarios and life goals of a person's life after the war, a catastrophe, a terrorist attack. This aspect was closely relate to the previous ones. The productive rethinking of traumatic experience presupposes a change in the temporal perspective of its analysis: a reorientation from the search for objectively nonexistent internal causes (past) to build the future – with «Why?» on «Why?» Psychotherapists who survived the experience of concentration camps, psychiatrists who worked with the military, always noted the importance of urgent psychological assistance in war, in the zone of combat operations, in the concentration camp, etc., the importance of its spiritual component preserving and developing the person's dialogue with itself and the world. One of the fundamental life, ontological issues related to the survivor's situation is the question of the invasion of non-being into being, the question of the completeness of the person's exercise and authenticity, the harmony of the individual. The survivor is one who, confronted with the experience of non-being, continued to be. The existential situation of the survivor is existence in a trans-ordinate situation. Or, otherwise, the trans-ordinary existence of a person: «the being of a person in the face of a threat of non-existence», a dialogue contrary to its impossibility. Contradictions between trans-ordinary experience and ordinary existence were manifest as:

1) the existential crisis – the conflict between the actualized possibility and the impossibility of realizing its possibility in ordinary (existential fault),

2) existential enlightenment – the person becomes wise in the light of trans-ordinary experience, despite trials, adversity and finds higher levels of realization of being.

There are two main types of personal response to the experience. The first – the past does not let go of a person, traumatic pictures and persistent thoughts about «what was» come back persistently and persistently. Unbidden memories cause repeated stress. Second – traumatic experience was deliberately oust; a person tries to avoid thoughts and memories of what he has experienced.

However, transnational existence actively invades the ordinary existence, giving it the features of anomaly, catastrophism [2]: «The threat of non-existence becomes a nonspecific characteristic of not only the extreme situation, but also of the everyday life situation and determines the existence of man». A person who survived wars and catastrophes often embraces a feeling of alienation from people, from the world around them, a hard-lived loss of the ability to establish close relationships with people around him: to experience feelings of love and joy, of creative uplift. A person with pain experiences change, alienation to himself and other people, misunderstanding, badly needs self-understanding and – almost unattainable – mutual understanding. However, mutual understanding can was find: on the way of listening and integrating the experience of listening, respectful and loving co-existence of the secret of personal transformation, spiritual rebirth: the new birth of a person meaningfully related to life, appreciating it and himself. The great experience with surviving military and other people's crisis situations are accumulated in the works of practical psychologists dealing with the problems of psychological and physical (including sexual) violence, problems of psychological survival and transformations of the lich in the framework of studies devoted to the psychological rehabilitation of patients who have endured lethal diseases (cancer, etc.). In fact, it is easy to see the presence of significant similarity in the models they offer and typical scenarios for experiencing traumatic experiences. In any of these cases, there is a universal pattern: the need to separate the «spheres of influence» of an objective (physical, external) threat or traumatic situation and a zone that can be controlled by the client. The second point is the essential, qualitative difference acquired during the wars, catastrophic situations and events, terrorist acts, life experiences. This experience goes beyond the ordinary and is potentially creative, destroying the habitual patterns and worldviews and life activities of the subject. This experience requires a special value attitude, which often cannot was directly transferee and combined with the norms and experience of everyday life.

Thus, psychological debriefing contains elements of social support, exchange of meanings and rethinking (within the framework of processes of reaction, reassessment and information), management of behavior (changes). These elements as factors in the success of aid and its mechanisms – the social exchange of experiences and mutual learning – should be studied not so much as isolated, but together. The question of what will be the result of assistance to a specific client by a particular consultant in a given situation is determined in large part by what the circumstances will be-the general conditions for carrying out these procedures. Mutual understanding is one of such conditions: the dialogue, carried out in the atmosphere of a dialogue aimed at understanding the traumatic situation (experience), presupposing not only the exchange of experiences and experience, but its joint semantic processing aimed at transforming the relationships and life activities of the client. The mutual understanding is formed in the process of social exchange) experiences, their meanings, develops in the process of transforming the meanings of communicating subjects as the construction and development of the helping relations, the exchange of get feedback, etc. We analyzed the results of studies of social exchange (separation) of experiences in debriefing and other studies of socio-psychological counseling. In the considered works he acts as a process of social exchange or «division» by the subjects of the meanings of his life activity, experiences and perceptions about it. The success of such an exchange, its effectiveness and productivity is associated with the formation and development of partnerships and mutual support. Very important are the conditions for achieving psychological security and the focus on the development of subjects of dialogue.

The central bioethical aspect of assistance to the victims of wars, terrorist acts, disasters and other psychotrauma events is the consideration of the interests of the victims themselves and the protection of the interests of the society, the preservation and development of social relations. In cases where assistants pursue their own interests, as well as the interests of the state and others guilty of causing and continuing the suffering of people, neither debriefing nor other procedures help. Society and people suffer from help that attempts to hide the true meaning and scale of catastrophes and military operations. The state, units and services involved in the liquidation of the consequences of emergencies and military conflicts receive only a temporary and partial benefit from the secondary victimization of

their population. Attempts to deceive the population, to silence it, to suppress a surge of reciprocal resistance threaten the state with collapse, and society – with schism, riots, civil wars.

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RELIGIOUSNESS AS A FACTOR FOR FORMING THE BIOETHICS IDEOLOGY OF PATIENTS

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The aim of the study was to explore the moral and ethical and bioethical representations of believers and non-believers among patients in order to assess the influence of religiosity on the formation of a bioethical ideology and morally responsible attitude to the use of medical services. Study participants were divided into two groups in accordance with religious belief – believers (53,0 %) and non-believers (47,0 %). We found that there is a difference in all variables related to moral and ethical state of the patients between believers and non-believers. Moreover, we observe differences in the attitude of patients to all 7 analyzed biomedical technologies: in vitro fertilization, surrogate motherhood, human cloning, organ transplantation, fetal cell therapy, abortion and euthanasia. The attitude to the biomedical technologies of religious patients is bioethically responsible and is built on moral grounds, has a moral value and is filled with moral meaning. Religiousness promotes a deeper understanding by patients of the meaning of bioethical dilemmas and morally responsible attitude to medical interventions in the life and death of a person. The results obtained make it possible to assert that religiosity, acting as a factor in the formation of the bioethical ideology of patients, is an ethical regulator of the practice of using biomedical technologies.

Key words: religiosity, bioethical ideology, biomedical technologies, patients.

РЕЛИГИОЗНОСТЬ КАК ФАКТОР ФОРМИРОВАНИЯ БИОЭТИЧЕСКОГО МИРОВОЗЗРЕНИЯ ПАЦИЕНТОВ

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В статье изложены результаты исследования морально-нравственных и биоэтических представлений верующих и неверующих пациентов для оценки влияния религиозности на формирование биоэтического мировоззрения и морально ответственного отношения к использованию (потреблению) медицинских услуг. Проведенный компаративный анализ морально-нравственных и биоэтических представлений пациентов с религиозным (53,0 %) и нерелигиозным (47,0 %) типом мировоззрения выявил статистически значимое расхождение по всем 15 переменным, характеризующим морально-нравственное состояние личности пациентов. Результаты анализа позволили установить различия в отношении пациентов ко всем 7 анализируемым биомедицинским технологиям: экстракорпоральному оплодотворению, суррогатному материнству, клонированию человека, трансплантации органов, терапии фетальными клетками, искусственному прерыванию беременности и эвтаназии. Отношение к биомедицинским технологиям религиозных пациентов является биоэтически ответственным и строится на моральных основаниях, имеет моральное значение и наполнено моральным смыслом. Религиозность способствует более глубокому пониманию пациентами смысла биоэтических дилемм и морально ответственному отношению к медицинским вмешательствам в жизнь и смерть человека. Полученные результаты позволяют утверждать о том, что религиозность, являясь фактором формирования биоэтического мировоззрения пациентов, выступает этическим регулятором практики применения биомедицинских технологий.

Ключевые слова: религиозность, биоэтическое мировоззрение, биомедицинские технологии, пациенты.

Introduction. As a result of the widespread introduction of advanced biomedical technologies into medical practice, the values of religious interpretation of fundamental philosophical problems increases significantly [3, 18], and bioethical content becomes a modern trend in sociological research in the field of health and public health [4]. This is due to the appearance of truly revolutionary consequences for the new opportunities arising from medical manipulations in the border areas of life and death of a person. In such conditions, the religious and philosophical understanding of the bounds of medical interventions in the life and death of people is necessary «not only for researchers engaged in the development of new technologies, but also for those who use these technologies, that is, ordinary citizens» [18, p. 9]. In the circumstances, «one of the ways to protect against disasters, which is fraught with science as an act of man, is the development and acceptance of Christian ethical knowledge» [12, p. 72].

At present, an increasing number of scientific studies of Russian scientists are devoted to the problem of the formation and development of a bioethical ideology. All of them have a certain scientific and practical significance. In particular, the researchers revealed the peculiarities of the religiosity of the Russian population in general [7, 8] and student in particular [2]. Andreeva L.A., et al [2, p. 98] found that the type of religiosity of young people matches with the type of religiosity of Russians and is defined as «a type with an unstable religious orientation that reveals doubts about the truth of even the basic and essential provisions of the dogma». Of particular scientific interest are theoretical studies devoted to predictive interpretation of the consequences of the application of new biomedical technologies [11] and explication of the ideology bases of law by the norms of Christian morality [14]. An important practical perspective belongs to studies of the problems of the formation of ethical regulators of professional activity of medical workers [4, 9] under the new model of moral relations in medicine [1] and the study of health and disease phenomena in the context of the Christian doctrine of personality [17]. However, despite the successes achieved in the study of this problem, its relevance remains nowadays. In the previous studies obviously insufficient attention is paid to the study of the influence of religious ideas on the formation of the bioethical ideology of patients. At the same time, in the study of this problem, one cannot ignore the fact that the Russian society maintains a high trust in the church as a social institution while at the same time increasing its social significance compared to other social structures.

The aim of the study was to explore religiosity as a factor of the bioethical ideology formation among patients.

Methods. A cross-sectional study was applied. Questionnaire for studying the bioethical representations of patients was used. Prototype of the latter was a questionnaire proposed by the employees of the Department of Biomedical Ethics of the Russian State Medical University (Moscow) LB. Liaus, V.I. Saburova, I.V. Siluyanova, N.A. Sushko in 2002 and presented by a 20-point questionnaire [9]. The modified questionnaire was validated during the pilot study. The questionnaire consisted of three main parts and the final (passport) part characterizing the status of the respondents (5 questions). The first part of the questionnaire is devoted to determining the religious and confessional identity of patients (2 questions), the second-moral characteristics of patients (15 questions), and the third – attitude of the patients to biomedical technologies (18 questions).

Study participants were patients 18 and older years old, who went to outpatient clinics in Arkhangelsk and the Arkhangelsk region in March 2015 and gave their informed consent to participate in the study (N = 513).

According to the classical concept of religiosity, the terms «believer» and «unbeliever», «atheist» are synonymous with «religious» and «irreligious» types of a person [8, p. 97]. The distribution of patients with a religious and non-religious ideology was a difficult methodological task. Its complexity consisted, on the one hand, in the absence of unambiguous religious criteria, and on the other, in the presence of different methodologies for measuring the level and degree of religiosity. According

to the first methodology, the religiosity is defined due to the question: «To which people do you belong?».

The most complex method for determining the level and degree of religiosity was developed by DM Ugrinovich [15]. It contains 49 empirical signs, the ratio of which allows us to refer the individual to this or that type of religiosity. F.N. Ilyasov [5] proposed an inexpensive and reliable technique, including two direct questions: with the help of the first one is measured the sign «belief», the second – «attitude toward religious (atheistic) activity». Typology of religiosity by F.N. Ilyasova is built on a combination of these two signs. According to the results of the study F.N. Ilyasova [5], the share of true believers in modern society is very small (3 %). The share of those who believe in the supernatural beginning of the world and doubting (43 %) is much larger in comparison with the latter. They, as a rule, are not familiar with the subject of belief and do not pray, that is, «they believe, not fully understanding what they are doing».

Typology of religiosity done by E.A. Kublitskaya includes 3 groups: believers; those who are wavering between believer and non-believer; and non-believers (including atheists). This typology is sufficient for carrying out an analysis of the influence of ideology positions on the social orientations of the individual [7, p. 98].

Practical application of the Kublitskaya typology assumes a dichotomous division of the population into religious and non-religious. However, a methodological problem arises. It is unclear those who doubt should be believers or non-believers. In this regard, scientists have no common opinion. So, for example, Soviet sociologists ranked the group of those who doubted toward the religious population [5, 6, 15], while the American ones did not do it [16]. Currently E.A. Kublitskaya [7, p. 98] believes that the replenishment of the religious population at the expense of this group is not entirely justified, since sociological studies conducted in our country have found that 35-45 % of those who doubt do not believe in God or in other supernatural powers.

In our division we used the typology of EA. Kublitskaya religiosity. To the believers we referred the religious patients, and to the non-believers - the non-religious, including doubted patients and atheists.

Chi-squared tests were used for statistical analysis. Data are presented as a percentages (%) and 95 % confidence interval (95 % CI). The critical level of significance is assumed to be 0.05. The processing of statistical data was carried out using the SPSS ver. 21 and WinPEPI.

Results

A little more than half (53,0 %, 95 %CI 47,7-57,3) of patients were classified as religious people. At the same time, one third (31,2 %, 95 %CI 27,3-35,3) considered themselves a non-believer person, including an atheist (5,7 %, 95 %CI 4,0-8,0). The group of those who doubted, that is, those who could not clearly define their ideology positions, was 15,8 % (95 %CI 12,9-19,2). Moreover, the basis of the ideology of the majority (71,7 %, 95 %CI 67,7-75,5) was Orthodox Christianity and only 6,8 % (95 %CI 4,9-9,3) – other religious denominations.

To explicate the moral state of the believers and non-believers we used 15 variables, combined into 2 blocks. The first block of variables reflected the ethical characteristics and representations of patients about the relationship between religion, morality and medicine (Table 1), the second block defined judgments about the state of Russian society and health care (Table 2).

Table 1

Ethical characteristics of believers and non-believers and their perceptions of religion, morality and medicine, % (95 % CI)

Variables	Type of ideology		χ^2 p-level
	believers	non-believers	
1. Moral problems are a constant subject of reflection in the process of life activity			
Yes	89,3 (85,1-92,5)	83,4 (78,2-87,6)	**χ^2 = 9,815**
No*	2,9 (1,5-5,7)	9,5 (6,44-13,9)	***p* = 0,007**
I do not know	7,8 (5,1-11,5)	7,1 (4,4-11,0)	
2. Pre-chastity is evidence of human dignity			
Yes*	75,0 (69,5-79,8)	38,2 (32,3-44,5)	**χ^2 =72,932**
No	14,0 (10,4-18,6)	41,1 (35,1-47,4)	***p* < 0,001**
I do not know	11,0 (7,8-15,3)	20,7 (16,1-26,3)	
3. A person's life begins with conception			
Yes	78,7 (73,4-83,1)	48,5 (42,3-54,8)	**χ^2 = 51,425**
No	19,1 (14,9-24,2)	43,6 (37,5-49,9)	***p* < 0,001**
I do not know	2,2 (1,0-4,7)	7,9 (5,1-11,9)	
4. The origin of morality has a divine (metaphysical) nature			
Yes*	35,7 (30,2-41,5)	5,0 (2,8-8,5)	**χ^2 = 79,240**
No	39,3 (33,7-45,3)	55,2 (48,9-61,3)	***p* < 0,001**
I do not know	25,0 (20,2-30,5)	39,8 (33,9-46,1)	
5. Morality and religion are closely interrelated and interdependent			
Yes*	64,3 (58,5-69,8)	29,0 (23,7-35,1)	**χ^2 = 62,009**
No	20,6 (16,2-25,8)	39,8 (33,9-46,1)	***p* < 0,001**
I do not know	15,1 (11,3-19,8)	31,1 (25,6-37,2)	

The end of the table 1

Variables	Type of ideology		χ^2 p-level
	believers	non-believers	
6. Medicine is associated with morality and depends on the moral attitudes of society			
Yes*	56,6 (50,7-62,4)	25,7 (20,6-31,6)	**χ^2 = 50,023**
No	28,3 (23,9-33,9)	42,7 (36,7-49,1)	***p* < 0,001**
I do not know	15,1 (11,3-19,8)	31,6 (26,0-37,7)	
7. Religion should intervene in the practice of medicine			
Yes*	30,8 (25,7-36,6)	6,6 (4,1-10,5)	**χ^2 = 48,335**
No	59,6 (53,6-65,2)	82,6 (77,3-86,8)	***p* < 0,001**
I do not know	9,6 (6,6-13,6)	10,8 (7,5-15,3)	
8. Use (consumption) of medical services is carried out taking into account of religious views			
Yes*	39,0 (33,4-44,9)	8,7 (5,8-13,0)	**χ^2 = 63,804**
No	54,8 (48,8-60,6)	78,8 (73,3-83,5)	***p* < 0,001**
I do not know	6,2 (3,9-9,8)	12,5 (8,9-17,2)	
Total	53,0	47,0	100,0

*Statistical significance $p \leq 0,05$.

Table 2

Evaluations about Russian society and health care among believers and non-believers, % (95 % CI)

Variables	Type of ideology		χ^2 *p*-level
	believers	non-believers	
1. The state and development of Russian society is closely linked with the preservation of traditional religious values			
Yes*	90,8 (86,8-93,7)	51,3 (45,0-57,5)	**χ^2 = 99,765,**
No	6,3 (3,9-9,8)	30,0 (24,5-35,9)	***p* < 0,001**
I do not know	2,9 (1,5-5,7)	18,7 (14,3-24,1)	
2. Russian mass media actively introduce ideas of consumption and hedonistic values into the public consciousness			
Yes*	59,6 (53,6-65,2)	32,8 (27,2-38,9)	**χ^2 = 15,183**
No	13,2 (9,7-17,8)	23,2 (18,4-28,9)	***p* = 0,001**
I do not know	27,2 (22,3-32,8)	44,0 (37,9-50,3)	
3. The main reason for the unfavorable state of affairs in the domestic health care is the spiritual and moral crisis of society			
Yes*	47,4 (41,6-53,4)	20,3 (15,7-25,9)	**χ^2 = 41,400**
No	52,6 (46,6-58,4)	68,5 (62,4-74,0)	***p* < 0,001**
I do not know	0	11,2 (7,8-15,8)	
4. Medical professionalism assumes that the doctor has moral qualities and knowledge of ethical knowledge			
Yes*	75,4 (69,9-80,1)	56,8 (50,5-62,9)	**χ^2 = 22,110**
No	8,8 (6,0-12,8)	20,7 (16,1-26,3)	***p* < 0,001**
I do not know	15,8 (11,9-20,6)	22,4 (17,6-28,1)	
5. Following of the principles of professional ethics and deontology in medicine requires that a future doctors gave a doctor's swear			
Yes*	84,2 (79,4-88,1)	72,2 (66,2-77,5)	**χ^2 = 11,525**
No	9,9 (6,9-14,1)	19,5 (15,0-25,0)	***p* = 0,003**
I do not know	5,9 (3,7-9,3)	8,3 (5,4-12,5)	
6. The topics of biomedical ethics (death, life as a value) have to be teached by clergymen			
Yes*	30,1 (15,0-35,9)	18,3 (13,9-23,6)	**χ^2 = 10,517**
No	37,5 (32,0-43,4)	40,2 (34,3-46,6)	***p* = 0,005**
I do not know	32,4 (27,1-38,1)	41,5 (35,5-47,8)	
7. When giving the opportunity to choose a place of work in Russia or abroad, you should be a patriot and stay working in your country			
Yes*	66,5 (60,7-71,9)	52,7 (46,4-58,9)	**χ^2 = 11,087**
No	21,0 (16,6-26,2)	26,6 (21,4-32,5)	***p* = 0,004**
I do not know	12,5 (9,1-17,0)	20,7 (16,1-26,3)	
Total	53,0	47,0	100,0

*Statistical significance $p \leq 0,05$.

Moral state of the believers in comparison with non-believers is distinguished by a higher interest in moral issues (89,3 % vs. 83,4 %) (χ^2 = 9,815, p = 0,007). They often consider that a person's life begins with conception (78,7 % vs 48,5 %) (χ^2 = 51,425, $p < 0,001$), and pre-chastity is a human dignity (75,0 % vs 38,2 %) (χ^2 = 72,932, p = 0,001). Thinking about the nature of the origin of morality, believers more often consider that it was given by God (35,7 % vs 5,0 %) (χ^2 = 79,240, $p < 0,001$). Therefore, for them, morality and religion are closely related (47,1 % vs 14,9 %) (χ^2 = 62,009, $p < 0,001$). They also more often mentioned that medicine depends on the moral attitudes of society (56,6 % vs 25,7 %) (χ^2 = 50,023, $p < 0,001$). The majority of believers (59,6 %, 95 % CI 53,6-65,2) and non-believers (82,6 %, 95 % CI 77,3-86,8) consider that religion should not interfere in medicine. However, every third believer admits the latter (30,8 %, 95 % CI 25,7-366 vs 6,6 %, 95 % CI 4,1-10,5) (χ^2 = 48,335, $p < 0,001$), focusing on their religious representations when using (consuming) medical services (39,0 % vs 8,7 %) (χ^2 = 63,804, $p < 0,001$).

Believers and non-believers perceive the need to preserve traditional religious values in Russia differently (χ^2 = 9,815, p = 0,007). If almost all believers (90,8 %, 95 % CI 86,8-93,7) think that it is necessary to save a religious tradition, then among the non-believers, this is 1.8 times less (51,2 %, 95 % CI 45,0-57,5). Believers are more likely to consider that the mass media carry out active propaganda of hedonism and consumption in the society (59,6 %, 95 % CI 53,6-65,2 vs 32,8 %, 95 % CI 27,2-38,9) χ^2 = 15,183, p = 0,001). Moreover, the unfavorable state of affairs in Russian medicine is associated with the spiritual degeneration of Russian society (47,4 % vs 20,43 %) χ^2 = 41,400, $p < 0,001$).

Believers in compared to non-believers are more aware of the need for moral and ethical knowledge among medical professionals to achieve professionalism in medicine (75,4 % vs 56,8 %) χ^2 = 22,110, $p < 0,001$). The taking of a doctor's swear, the content of which reflects the basic provisions of the code of professional ethics in medicine, is undeniable among the majority of believers and non-believers (84,2 % and 72,2 % respectively). However, believers more rarely consider the doctor's swear unnecessary (9,9 % vs 195 %) χ^2 = 11,525, p = 0,003). Moreover, they more often consider that topics of biomedical ethics (life as value, death) have to be teacher by clergymen (30,1 % vs 183 %) χ^2 = 10,517, p = 0,005). Given the choice of a place to work in Russia or abroad, the majority of the interviewed patients will not leave the country (believers – 66,5 %, non-believers – 52,7 %), but believers will less often prefer to travel abroad (21,0 % vs 26,6 %) χ^2 = 11,087, p = 0,004).

To determine the influence of the type of the ideology on the content of bioethical representations of the interviewed patients, we studied the attitude of believers and non-believers to biomedical technologies associated with different period of life: the onset (in vitro fertilization, surrogate motherhood, cloning), maintenance (organ transplantation, fetal cell therapy), and the termination (artificial termination of pregnancy, euthanasia).

The attitude of the believers and non-believers to methods of artificial reproduction of human beings is presented in Table 3.

Table 3

The attitude of the believers and non-believers to methods of artificial reproduction of human beings, % (95 % CI)

Variables	Type of ideology		χ^2
	believers	non-believers	p-level
In Vitro Fertilization			
Positive	39,7 (34,1-45,6)	40,7 (34,7-47,0)	χ^2 = 0,049, p = 0,825
Neutral	20,2 (15,9-25,4)	24,1 (19,1-29,8)	χ^2 = 1,100, p = 0,294
Negative*	23,9 (19,2-29,3)	5,4 (3,2-9,0)	**χ^2 = 33,931, $p < 0,001$**
Missing*	16,2 (12,3-21,0)	29,8 (24,5-35,9)	**χ^2 = 13,704, $p < 0,001$**
Surrogacy			
Positive	23,2 (18,5-28,5)	21,6 (16,9-27,2)	χ^2 = 0,185, p = 0,667
Neutral*	30,5 (26,4-36,2)	39,4 (33,5-45,7)	**χ^2 = 4, 471, p = 0,034**
Negative*	35,3 (30,0-41,1)	21,2 (16,5-26,8)	**χ^2 = 12,483, $p < 0,001$**
Missing*	11,0 (7,8-15,3)	17,8 (13,5-23,2)	**χ^2 = 4, 860, p = 0,027**
Human cloning			
Positive *	2,6 (1,3-5,2)	8,7 (5,8-12,9)	**χ^2 = 9,336, p = 0,002**
Neutral	14,3 (10,7-19,0)	15,8 (11,7-20,9)	χ^2 = 0,205, p = 0,651
Negative*	68,0 (62,3-73,3)	53,9 (47,6-60,1)	**χ^2 = 10,678, p = 0,001**
Missing	15,1 (11,3-19,8)	21,6 (16,9-27,2)	χ^2 = 3,641, p = 0,056
Total	53,0	47,0	100,0

*Statistical significance $p \leq 0,05$.

The majority of believers and non-believers have a positive (39,7 % and 40,7 %, respectively) (χ^2 = 0,049, p = 0,825) or neutral (20,2 % and 24,1 %, respectively) (χ^2 = 1,100, p = 0,294) attitude to in Vitro fertilization (IVF). The rationale is the assertion that IVF «enables to get a child for childless families and single women» (believers – 50,7 %, 95 % CI 44,8-56,6, non-believers – 50,2 %, 95 % CI 43,9-56,5) (χ^2 = 0,014, p = 0,905). In this case, every second respondent considers children born due to IVF are «the same as the rest» (believers – 50,4 %, 95 %CI 44,5-56,3, non-believers – 52,7 %, 95 %CI 46,4- 58,9) (χ^2 = 0,278, p = 0,598), and only 4,4 % (95 %CI 2,5-7,6) of believers and 5,8 % (95 %CI 3,5-9,5) of non-believers consider that such children are less healthy (χ^2 = 0,519, p = 0,471). At the same time, believers are more likely to have a negative attitude to IVF than non-believers (23,9 % vs 5,4 %) (χ^2 = 33,931, p < 0,001). They also often do not allow its use, considering it «an unnatural way of pregnancy» (19,5 %, 95 % CI 15,2-24,6 vs 5,0 %, 95 % CI 2,9-8,5) (χ^2 = 24,300, p < 0,001) and twice less likely to be admitted only in extreme cases (6,6 %, 95 %CI 4,2-10,2 vs 13,7 %, 95 % CI 9,9-18,6) (χ^2 = 7,145, p = 0,008). Children who were born due to IVF, are more often considered to be «born unnatural» (17,3 %, 95 % CI 13,3-22,2 vs 10,4 %, 95 % CI 7,1-14,9) (χ^2 = 5,051, p = 0,025).

Every fourth or fifth patient has a positive attitude to surrogate motherhood (believers – 23,3 %, non-believers – 21,6 %) (χ^2 = 0,185, p = 0,667). Believers less often substantiate their attitude to surrogate motherhood by «the opportunity for childless families and single women to get a child» (believers – 36,8 %, 95 % CI 31,3-42,6, non-believers – 46,9 %, 95 % CI 40,7-53, 2) (χ^2 = 5,393, p = 0,020), and they are twice as likely to prevent its use (28,3 %, 95 % CI 23,4-33,9 vs 13,7 %, 95 % CI 9,9-18,6) (χ^2 = 16,205, p < 0,001).

Believers (68,0 %) are more likely to have a negative attitude to cloning than non-believers (53,9 %) (χ^2 = 10,678, p = 0,001). They more often consider «it unacceptable under any circumstances» (69,9 %, 95 % CI 64,2-75,0 vs 53,5 %, 95 % CI 47,2-59,7) (χ^2 = 14,668, p = 0,001).

Attitude to biomedical life extension technologies among believers and non-believers is presented in Table 4.

Believers have more often a negative attitude to organs and tissues transplantation than non-believers (48,9 % vs 133 %) (χ^2 = 74,303, $p \leq$ 0,001). They call it as «unnatural» (22,4 %, 95 % CI 17,9-27,8 vs 5,0 %, 95 % CI 2,9-8,5) (χ^2 = 31,870, $p \leq$ 0,001) and do not agree that it is «A step forward in medicine» (18,0 %, 95 % CI 13,9-23,0 vs 32,8 %, 95 % CI 27,2-38,9) (χ^2 = 14,877, p < 0,001). One third considers organ transplantation has to be only in extreme situation (believers – 27,2 %, 95 %CI 22,3-32,8, non-believers – 31,1 %, 95 % CI 25,6-37,2) (χ^2 = 0,950, p = 0,330).

Every second believer (50,0 %) and non-believer (55,2 %) has a difficulty in assessing of the possibility of the therapeutic techniques usage based on the fetal tissues. At the same time, believers are more likely to be negative about the therapy with fetal cells (37,1 % versus 24,5 %).

Attitude to abortion and euthanasia among believers and non-believers is presented in Table 5.

Believers are against abortion (45,6 % vs 19,1 %) (χ^2 = 40,503, p < 0,001) than for the latter (6,3 % vs 11,6 %) (χ^2 = 4,602, p = 0,032). They less often try to justify their neutral attitude with various life circumstances (43,0 % vs 58,5 %) (χ^2 = 12,267, p < 0,001). There are no differences between believers and non-believers on the following statements: «abortion is permitted when the health

Table 4

Attitude to biomedical life extension technologies among believers and non-believers, % (95 % CI)

Variable	Type of ideology		χ^2 p-level
	believers	non-believers	
Transplantation of organs and tissues			
Positive*	23,9 (19,2-29,3)	37,8 (31,9-44,0)	**χ^2 = 11,603, p = 0,001**
Neutral*	16,5 (12,6-21,4)	29,5 (24,1-35,5)	**χ^2 = 12,183, p < 0,001**
Negative*	48,9 (43,0-54,8)	13,3 (9,6-18,1)	**χ^2 = 74,303, p < 0,001**
Missing*	10,7 (7,5-14,9)	19,4 (15,0-25,0)	**χ^2 = 7,913, p = 0,005**
Fetal cell therapy			
Positive*	12,9 (9,4-17,4)	20,3 (15,7-25,9)	**χ^2 = 11,561, p = 0,003**
Negative*	37,1 (31,6-43,0)	24,5 (19,5-30,3)	**χ^2 = 9,529, p = 0,002**
Missing	50,0 (44,1-55,9)	55,2 (48,9-61,3)	χ^2 = 1,378, p = 0,240
Total	53,0	47,0	100,0

*Statistical significance $p \leq 0,05$.

Table 5

Attitude to abortion and euthanasia among believers and non-believers, % (95 % CI)

Variable	Type of ideology		χ^2 *p*-level
	Believers	non-believers	
Abortion			
Positive*	6,3 (3,9-9,8)	11,6 (8,2-16,3)	**χ^2 = 4,602, *p* = 0,032**
Neutral*	43,0 (37,3-49,0)	58,5 (52,2-64,6)	**χ^2 = 12,267, *p* < 0,001**
Negative*	45,6 (40,0-51,5)	19,1 (14,6-24,5)	**χ^2 = 40,503, *p* < 0,001**
Missing*	5,1 (3,1-8,5)	10,8 (7,6-15,3)	**χ^2 = 5,656, *p* = 0,017**
Euthanasia			
Positive*	14,3 (10,7-19,0)	28,2 (22,9-34,2)	**χ^2 = 14,908, *p* < 0,001**
Neutral*	14,3 (10,7-19,0)	24,1 (19,1-29,8)	**χ^2 = 7,887, *p* = 0,005**
Negative*	51,8 (46,0-57,7)	22,0 (17,2-27,6)	**χ^2 = 48,406, *p* < 0,001**
Missing	19,6 (15,2-24,6)	25,7 (20,6-31,6)	χ^2 = 2,862, *p* = 0,091
Total	53,0	47,0	100,0

*Statistical significance $p \leq 0,05$.

or life of mother under threat» (believers – 49,6 %, 95 % CI 43,7-55,5, non-believers – 41,1 %, 95 % CI 35,1-47,4) (χ^2 = 3,769, p = 0,052), and «abortion is permitted due to incorrect development of the fetus» (believers – 42,3 %, 95 % CI 36,6-48,2, unbelievers – 37,8 %, 95 % CI 31,9-44,0) (χ^2 = 1,086, *p* = 0,297).

The divergence of views is established in respect of:

- «abortion is a sin» (believers – 22,4 %, 95 % CI 17,9-27,8, non-believers – 10,4 %, 95 % CI 7,1-14,9) (χ^2 = 13,304, *p* < 0,001);

- «woman has to decide herself about abortion» (believers – 17,6 %, 95 % CI 13,6-22,6, non-believers – 35,7 %, 95 % CI 29,9-41,9) (χ^2 = 21,543, *p* < 0,001);

- «abortion is permissible only in the early stages of pregnancy» (believers – 10,7 %, 95 % CI 7,5-14,9, non-believers – 22,0 %, 95 % CI 17,2-27,6) (χ^2 = 12,214, $p \leq 0,001$).

Believers more often consider that «a doctor has a right to refuse to conduct an abortion due to ideology» (32,7 %, 95 % CI 27,4-38,5) than non-believers (13,7 %, 95 % CI 9,9-18,6) (χ^2 = 27,658, $p \leq 0,001$). Moreover, the attitude of believers to euthanasia is mostly negative (51,8 % vs 22,0 %) (χ^2 = 48,406, *p* < 0,001), rather then positive (14,3 % vs 28,2 %) (χ^2 = 14,908, *p* < 0,001) or neutral (14,3 % vs 24,1 %) (χ^2 = 7,887, *p* = 0,005).

Discussion

The term «ideology» means «a system of generalized views on the world and the place of man in it, attitude of people to the surrounding reality and themselves, as well as the beliefs, ideals, principles of cognition and activity» [10]. The carrier of ideology is a person and a social group who perceive the existing reality due to a certain system of views. Ideology influences all spheres of human activity and cognition. Formation of the ideology is due to the process of socialization, education, cultural and historical experience, and the choice of a life position and strategy for its implementation. It is directly related to the growth of consciousness, the enrichment of the inner world of man and the assimilation of spiritual values. In the structure of the ideology there are two main types: religious and non-religious (secular).

The current period of development of modern society occurs under the conditions of humanization of secular and religious life. The main characteristic of the latter is process of convergence of secular and theological ideas, leading to contradictions between knowledge and faith, science and religion, believers and non-believers. Due to the gradual erosion of boundaries between social groups of believers and non-believers, as well as lack of classification criteria in order to determine ideology, in the modern secular society the understanding of the phenomenon of religiosity is greatly expanded. At present, it includes a wide range of relations to religion: from fanatical and truly devotional to superficial and even aesthetic [5]. This creates the prerequisites for the formation of a qualitatively new type of ideology – bioethical, based at the same time on modern scientific concepts and religious beliefs [1, 13]. Bioethical ideology allows connecting the latest achievements of medical science with moral laws and traditional spiritual values.

Differences in the content of religious and non-religious types of ideology are evidenced by the results of our comparative analysis. The obtained results show that the bioethical representations of believers, reflecting the moral state of the individual and explaining the attitude to biomedical technologies, are meaningful, critical and responsible. This is greatly facilitated by moral representations of believers, such as: awareness of the dependence of morality on religion, understanding of the need

to apply religious morals in medicine, and the perception of the inevitability of the interaction between medicine, religion and morality in the modern secular world.

Moral state of the patients mainly, depends on the materialistic or idealistic perception of existing reality, as well as adoption of natural or synergistic, including theological, explanations of the world. Undoubtedly, individuals with difference religious denominations, have a different degree of development of religious consciousness. However, common to them is a commitment to traditional spiritual values and the adoption of norms of religious morality. Ethical knowledge of morality, religion and medicine, causing the essential transformation of the bioethical views of patients, lay the foundations for the formation of a bioethical ideology and, as a consequence, contribute to the establishment of limits of medical interventions in the natural processes of birth, life and death. Religiousness contributes to the successful development of the bioethical ideology, which today becomes an important condition for the moral development of man and an ethical regulator of the practice of applying medical services.

Conclusion. Thus, our findings allow us to state that the attitude to biomedical technologies of patients with a bioethical ideology is based on moral grounds, and has a moral meaning. It promotes a deeper understanding of the content of bioethical dilemmas and a more responsible attitude to medical interventions in the life and death of a person. The latter allows us to hope that the bioethical ideology of patients, acting as an ethical regulator of the use of medical services, will also serve as an ethic regulator of introducing new biomedical technologies into medical practice, the application of which is associated with the uncertainty of the consequences and the danger to human life and health.

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ACQUISITION OF DEONTOLOGICAL PRINCIPLES THROUGH GAME TECHNOLOGIES

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The actual task of professional education of students is the development of independent evaluation and selection of information received. In pedagogical practice, active and interactive teaching methods are used. The influence of the role play on the formation and assimilation of deontological principles among the students of a medical college was studied. The initial level of knowledge on the principles of deontology revealed 48 % of correct answers. After the role play and discussion of the basic deontological principles of the relationship between the doctor – patient, the doctor – the nurse, the degree of mastering the material was estimated at 79 % of the correct answers. It is established that the use of role games consolidates professional skills, reveals the creative abilities of students and the ability to find solutions in various clinical situations. Mastering students with deontological principles of behavior makes it possible to avoid conflict situations in further independent work. The results of the conducted research showed high efficiency of the use of gaming technologies in the educational process.

Key words*:* deontology, role-playing game, education in a medical higher school, students.

ОВЛАДЕНИЕ ПРИНЦИПАМИ ДЕОНТОЛОГИИ ЧЕРЕЗ ИГРОВЫЕ ТЕХНОЛОГИИ

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Актуальной задачей профессионального обучения студентов является развитие самостоятельной оценки и отбора получаемой информации. В педагогической практике используются активные и интерактивные методы обучения. Изучено влияние ролевой игры на формирование и усвоение деонтологических принципов среди студентов медицинского вуза. Исходный уровень знаний по принципам деонтологии выявил 48 % правильных ответов. После ролевой игры и обсуждения основных деонтологических принципов взаимоотношения врач – пациент, врач – медицинская сестра, степень усвоения материала оценивалась в 79 % правильных ответов. Установлено, что

применение ролевых игр закрепляет профессиональные навыки, раскрывает творческие способности студентов и умение находить решения в различных клинических ситуациях. Овладение студентами деонтологическими принципами поведения позволяет не допускать конфликтных ситуаций в дальнейшей самостоятельной работе. Результаты проведенного исследования показали высокую эффективность использования игровых технологий в учебном процессе.

Ключевые слова: деонтология, ролевая игра, обучение в медицинском вузе, студенты.

Professional thinking of the physicians of any specialty including dentists incorporates an extremely important notion of duty (duteous), and the basic principle of deontology is the conscious subordination of private interests to the interests of society. The object of medical ethics is medical morality, which is a system of norms and rules of behavior of the doctor, his rational and high-human behavior in achieving the most effective results in preventing diseases, in healing and recovery of the patient.

The essence of medical morality is determined not only by the personal individual qualities of the doctor, the level of his professionalism, responsibility to the case, but also by the totality of social conditions, status, position in society, the conditions of his work, the development of science. Internal rules include the relationship of health workers to work, based on mutual respect, discipline, subordination, friendliness, a sense of collegiality, clear performance of their professional duties. Most physicians are guided in their daily activities by delivering disinterested medical assistance to the people who need it. However, some medical professionals see the patient as a direct or indirect source of their earnings; in this case some non-standard moral and ethical relationships based on the so-called human factor may arise between a doctor and a patient in the dental office.

Currently, the effective development of dentistry is possible only if the experts adhere to ethical and deontological principles and rules. The basic ethical principles of professional activity of a dentist are fixed in the ethical code, developed by the Stomatological Association of Russia. They reflect the specifics of the interaction of the dentist and patient, as well as the society as a whole, regulate the relations between colleagues, maintain the professional level of interpersonal interaction, which undoubtedly contributes to the strengthening of trust in therapeutic and preventive measures.

For the physicians of all specialties including dentists it is general medical training, modern methods of prevention, diagnosis, treatment, knowledge of deontological principles that are directly related to the fulfilment of their professional duty. The nature of the physician-patient relationship that is established during their first contacts is extremely important for the treatment outcome which involves taking into account the patient's personality characteristics. A physician should analyze all his actions and conduct, be self-critical, bear responsibility for his actions, and have professional medical observation. The physician when in contact with a patient must pay attention to his appearance, facial expression, notice and detect changes in his condition. To make an accurate diagnosis a doctor should use all the achievements of medical science and technology assessing their effectiveness but treating them as addition to and not instead of direct communication with a patient [1, p. 16-18].

The physician-patient relationship is now becoming increasingly important. However, the introduction of bioethics principles into practical dentistry is difficult. The emerging competition among dentists as well as patient's increasing role in the treatment process show the need for the dentists' professional growth not only as highly skilled specialists. An ever greater number of patients want to participate in the decision making process concerning their health, in choosing a treatment method. This involves the physicians' increased competence in the tactics of building a dialogue with a patient. Most often, the physician-patient relationship is built on the basis of the doctor's personal qualities. Scientific approach is now being developed to build a dialogue between a physician, a patient and his relatives. The most acceptable model of physician-patient communication is based on the equality of all parties. The patient can synthesize information and identify priorities for himself and the physician should help him in that. This model of relationships is being further developed in the patient's informed consent for the diagnostic procedures and therapeutic manipulations to be carried out.

What are the reasons for the modern doctors' low competence in establishing a proper physician-patient dialogue? Among them, one can note the detachment from the practice of medical ethics and deontology.

A physician should know the deontological principles of his behavior, be able to resolve and prevent conflict situations. However, the physicians' knowledge in this area is superficial; therefore there is a need for the medical students' education to include extended courses of medical psychology and bioethics which are necessary in conditions of fee-for-service medical care. The most important condition for a physician to enter professional activities is to train him as a harmonious, comprehensively developed personality [2, c. 161].

The urgent task of students' professional education is the development of independent evaluation and selection of information received. Active and interactive teaching methods in the form of role-playing games are used in the educational process. The application of active teaching methods is one of the important means of training a competitive person. The purpose of role-playing games is to develop skills and capacities to play diverse formal and informal social roles in real life by modeling the real conditions of professional activities [3, p. 200]. When playing the game, the basic principles should be the compliance with ethics and deontology, the doctor's and patient's legal provisions. All educational games fall into three categories: direct didactic impact when the teacher himself is in the game; mediated didactic impact when the teacher acts as an observer; mixed didactic impact when the teacher acts as a facilitator, expert or consultant. Regardless of the type, all role-playing games have common rules: developing a game goal, game rules, defining a subject material, method guidelines, preparing a game plan and roles distribution [2, p. 23-24].

The purpose of the research: to study the impact of s role-playing game on the development and assimilation of deontological principles.

Materials and methods. To accomplish this goal, a study was conducted which involved the students from the dentistry department of Volgograd State Medical University who studied the discipline of Therapeutic Dentistry. Before the start of role-playing games to assimilate the principles of bioethics and deontology, the test was conducted to identify the knowledge baseline in this area. After the game, the teacher determined the level of the material learned and professional skills acquired on this subject, and a control test was also conducted.

Research results o and their discussion. During a role-playing game the students show their knowledge in the discipline of Therapeutic Dentistry. Particular attention is paid to the students' ability to conduct a dialogue with a patient, to draw a diagnostic hypothesis through information search, the students' capacity fir teamwork. Incoming testing revealed the knowledge baseline on deontological principles (correct responses 48 %). After the role-playing game and discussion of the basic deontological principles of physician-patient and physician-nurse relationships, the level of knowledge was much higher. The degree of the material mastered was estimated at 79 % of correct responses. If one pays attention to the bioethical education of students during classes the process of student-patient relationship changes at the end of the cycle. The students conduct a dialogue with a patient, pay due attention to the medical history, explain the need for specific procedures and manipulations, discuss the financial issue of providing fee-based services, explain what services can be provided in the framework of Compulsory Health Insurance. The factors that affect the quality of patient treatment were specified in the course of a role-playing game. This was necessary in order to have a clearer vision of a dentist-patient relationship in outpatient settings.

Conclusion. During a role-playing game, the students' knowledge of specific problems is exhibited, professional skills are consolidated, their creative abilities and capacities are revealed to find solutions in various situations. The research results showed the effectiveness of the use of gaming technology in the teaching process.

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ABOUT THE IMPORTANCE OF MONITORING NON-MEDICAL EXPECTATIONS OF SURGICAL PATIENTS

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The artile presents the results of a questionnaire survey of 197 patients who received inpatient treatment at the Vladikavkaz Junction Station Hospital of Russian Railways JSC. The questionnaire included 26 questions structured according to the levels of work and reflecting the parameters of non-medical expectations of patients. 85 patients of the surgical profile were included in the group I, and 112 patients of the therapeutic profile were included in the group II.

The result: the group I demonstrated significantly lower rates of patient satisfaction with the level of social and living conditions when receiving medical care and regarding the compliance with the patients' rights. The average satisfaction rates of patients in the groups were 0.92 ± 0.02 and 0.98 ± 0.02, which generally characterizes the level of social efficiency of the hospital as high.

The measures of an educational, economic, disciplinary and scientific-public nature were introduced at the hospital to improve the level of responsiveness of the health system. A structured approach to the organization of population studies among individual groups of patients allows identifying hidden defects in the system of ensuring non-medical expectations of the population and organizing their targeted elimination.

Key words: healthcare, social effectiveness, questionnaire survey, satisfaction rate.

О ЗНАЧЕНИИ МОНИТОРИНГА НЕМЕДИЦИНСКИХ ОЖИДАНИЙ ХИРУРГИЧЕСКИХ ПАЦИЕНТОВ

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В статье представлены результаты анкетирования 197 пациентов, получивших стационарное лечение в «Узловой больнице на станции Владикавказ ОАО «РЖД». В анкету вошли 26 вопросов, структурированных по уровням работы и отражающих параметры немедицинских ожиданий паци-

ентов. В I группу были включены 85 пациентов хирургического профиля, а во II группу – 112 терапевтических пациентов.

В результате: в I группе были получены достоверно худшие показатели удовлетворенности пациентов уровнем социально-бытовых условий при получении медицинской помощи и соблюдением их прав. Средние коэффициенты удовлетворенности пациентов в группах составили 0,92 ± 0,02 и 0,98 ± 0,02, что в целом характеризует уровень социальной эффективности больницы как высокий.

Для повышения уровня отзывчивости системы здравоохранения в больнице были внедрены меры образовательного, экономического, дисциплинарного и научно-публицистического характера. Структурированный подход к организации популяционных исследований среди отдельных групп пациентов позволяет выявить скрытые дефекты в системе обеспечения немедицинских ожиданий населения и организовать их целевое устранение.

Ключевые слова: здравоохранение, социальная эффективность, анкетирование, коэффициент удовлетворенности.

The health system (HS), as defined by the World Health Organization (WHO), refers to the totality of different organizations, institutions and resources intended for action in the interests of public health [1]. The WHO proposed four main areas for evaluating any health system and model: the development of the resource base necessary for the functioning of the system, the distribution of finance, ensuring the rational use of resources and the implementation of expectations of the patients and the preservation of their trust in the system [3].

In modern conditions, it should be recognized that it is impossible to ensure the consistency of the quality of surgical care with an ever-increasing level of expectations of the population without improving the material and technical base, the introduction of modern surgical treatment technologies, the development of the principles of biomedical ethics, and also without the introduction of a scientific and methodical approach to monitoring non-medical needs of patients and the introduction of innovative forms of professional development of young surgeons [2, 5–7, 11, 12].

It is gratifying to note that the national medical community has actively joined the development and implementation of the concept of health system responsiveness (HSR), which is an important non-clinical indicator of the effectiveness of its functioning, reflecting the response of the health system to non-medical expectations of the population [8, 12].

The proper level of the HSR, in its application significance, reflects the 15 bioethics principles declared in *the UNESCO Universal Declaration on Bioethics and Human Rights* [9] and provides each patient with:

– freedom of choosing healthcare providers;

– accessibility and provision of decent living conditions when obtaining medical care;

– respect for human dignity;

– respect for the principles of confidentiality and autonomy;

– participation of patients in the decision-making process;

– satisfaction with the quality of communication with the medical staff;

– transport accessibility and the ability to communicate with the outside world;

– consideration of vulnerability and special needs of all population groups.

The patient satisfaction structured by components of the medical service provided is an indicator of the HSR, which monitoring involves the population studies of different levels and designs [10, 13]. The social effectiveness (SE) of such studies is to identify hidden problems in the system and the possibility of their targeted elimination with minimal losses for other components.

The nontriviality of the conceptualization of the SE problem of modern health system becomes more evident if one draws attention to the fact that, despite the joint efforts of state structures and professional associations of medical workers, there is currently no common understanding of the mechanisms for shaping the opinion of consumers of medical services on the quality of medical care, as well unified methodological approaches to the assessment of the HSR to the needs of different social groups of the population [8].

In the European countries, in 2010, the Committee of Ministers of the European Union approved the recommendations R(2010)6 «On Good Governance in the Health Care System», regulating the conduct of sociological surveys among patients on satisfaction with the level of compliance with their rights, with the need to bring the results of these studies to the public. Considering that the Russian federal, departmental and regional health authorities have recently adopted the practice of questioning patients about the satisfaction with compliance for their rights, the availability of the results of these studies to the public is not yet being discussed. Moreover, one of the main factors determining the reliability of research results of this kind is the quality of design and the level of qualifications of researchers [11].

The formalized approach to the performance of the duties of all medical personnel, enshrined in regulatory regulations to ensure a high level of quality and safety of medical activities, is the basis for ensuring the proper level of the HSR. The

daily clinical practice imposes demands on doctors that go beyond their official powers that are regulated by the medical law [4, 8, 10]. This can be seen by the examples of the wide variability in the implementation of the patient's right to voluntary informed consent to medical intervention [7, 13], and to other terms that determine the meaning of the concept of «social effectiveness».

With the purpose of revealing the hidden defects of the SE at the level of individual structural units and determining ways to increase the work of the hospital, a program was developed and implemented at the Non-state Healthcare Institution Vladikavkaz Junction Station Hospital of Russian Railways JSC to receive feedback through a population-based study among patients in 2014–2015.

Material and methods

The design of the study was planned in such a way that the employees of the profile department were not involved in the questioning procedure. According to the organizers of the study, the employees directly involved in the treatment of interviewed patients were not informed about the nature of the study. At the same time, the organizers deliberately predicted, to some degree, the inferiority of patients' answers to a number of questions that could not be understood unequivocally by everyone, but thus we achieved greater objectivity of results and «purity» of conclusions.

The questionnaire included 26 questions structured according to the areas of activity of various departments of the Junction Station Hospital and the parameters of socially significant, non-medical expectations of patients. The initiators believed that the questions reflected the patients' opinion on all the structural units of the hospital and were designed to characterize the activities of personnel at all levels of the Junction Station Hospital and contained, in particular, integrally expressed characteristics.

This work is based on the results of the statistical analysis of the results of the survey of 197 respondents who received inpatient treatment. The analysis was carried out taking into account grouping of patients on the main medical component. The group I (primary) included 85 patients after elective surgeries from the surgical departments. The group II (comparison) included 112 patients from the department of internal medicine.

In the group I, the share of the urban population was 70.5 %, women were 87 %, and 83.5 % were working-age population. In the group II, the urban population accounted for 73.2 %, 79.5 % were women, and 80.3 % were working-age population.

Statistical analysis was performed on a PC using Microsoft Access 7.0 and Microsoft Excel 7.0. The data are presented in the form M ± m, where M is the mean, m is the standard error of the mean. The Student's test was used when comparing the average values in different groups. The difference in the indices was considered statistically significant at $p < 0.05$.

Results and discussion

72 respondents from the group I (84.7 ± 3.9 %) and 100 patients from the group II (89.3 ± 2.9 %) did not experience difficulties in hospitalization in the Junction Station Hospital ($p > 0.05$). 11 patients (12.9 ± 3.6 %) of the surgical profile evaluated the difficulties they experienced in hospitalization as unimportant, and two (2.4 ± 1.6 %) evaluated them as very significant. As for the therapeutic patients, only 11 of them (9.8 ± 2.8 %) attributed the difficulties with hospitalization to the category of nonessential ones, and only one patient (0.9 %) experienced significant difficulties at the pre-hospital stage.

Despite the high overall availability of hospitalization, we believe that one of the ways to improve the organization of work with surgical patients is the provision of conditions for eliminating formal and technical barriers to fast hospitalization. The study made it possible to establish that the total proportion of those dissatisfied with this component of our work among surgical patients was 15.3 ± 3.9 %. This should be considered as a serious reserve of increasing the efficiency of work, taking into account the current high competition in the market for medical services. The Junction Station Hospital was guided by these goals when initiating the development and approbation of a local protocol within the framework of the concept «*Fast Track Surgery*» that was potentially designed to reduce the duration of hospital treatment.

The legal block of questions was an area of our special interest. When assessing the completeness and quality of patient awareness of their rights and responsibilities, statistically significant differences were found in the groups. Thus, 7 respondents (8.2 ± 3.0 %) from the group I indicated that they were not informed about their rights and duties properly, while in the comparison group II, a significantly smaller number of such cases was detected-only two (1.8 ± 1.2 %) ($p < 0.05$)

When answering the question about the fact of written registration of informed consent, the same 8.2 ± 3.0 % of respondents ($n = 7$) from the group I did not confirm it, and this response was received from only one patient (0.9 %) in the group II ($p < 0.05$).

A separate question was focused on the opinion of patients about the opportunities to ask their attending doctors any questions related to their health condition. Among the surgical patients, 79 (92.9 ± 2.8 %) considered that they had every opportunity to adequately secure this right, two patients (2.3±1.6 %) did not have such opportunity at all, and the remaining four (4.8 ± 2.3 %) believed

that this right was partially satisfied. For comparison, nobody among the therapeutic patients felt deprived of this legal right ($p < 0.05$).

The result of the survey revealed that this section of work at the Junction Station Hospital for the surgical patients should be recognized as that of an unacceptably low level of effectiveness, which requires a targeted elimination of shortcomings. One cannot help but point out that these conclusions became possible only as a result of the sociological study of patients. When conducting an expert evaluation of each completed case as part of the quality control and safety of medical activities, all 100 % of the inserts about the patient's informed consent forms were filled out and signed by the patient and the doctor.

Overall at the Junction Station Hospital, 89.3 ± 2.2 % of respondents were satisfied with the provision of medicines at the expense of insurance companies. However, when analyzing this indicator, variable results were found in the comparison groups. Thus, in the group I, 66 patients (77.6 ± 4.5 %) confirmed full satisfaction with the provision of medicines at the expense of insurance companies, which is significantly lower than in the group II where 110 respondents (98.2 ± 1.2 %) were fully satisfied with the provision of medicines ($p < 0.001$). 13 respondents among patients in the surgical department (15.3 ± 3.9 %) were partially satisfied, two (2.4 ± 1.6 %) were unsatisfied, and four (4.7 ± 2.3 %) found it difficult to answer. In the II group, 98.2±1.2 % consider themselves fully satisfied with insurance coverage and only 1.8 % found it difficult to answer this question.

If 22.8 ± 3.0 % of patients ($n = 45$) acquired additional medications during their treatment at the hospital, then there were no statistically significant differences in this important indicator at the profile departments: 23 patients (27.1 ± 4.8 %) in the group I and 22 patients (19.6 ± 3.7 %) in the group II ($p > 0.05$). 17.6 ± 4.1 % of surgical patients (n = 15) and 15.2 ± 3.4 % ($n = 17$) of therapeutic patients had to pay for additional examinations ($p > 0.05$). Other patients confirmed the satisfaction with the availability of the diagnostic complex at the Junction Station Hospital.

According to our data, the need for additional material costs for their treatment is not a criterion of an extremely low quality of medical services for patients. Thus, according to an integral assessment of the quality of care in the laboratories of the hospital by patients, the average score on a 5-point scale was 4.22 ± 0.11 in the group I, and 4.54 ± 0.06 ($p < 0.05$) in the group II. However, the achieved reliability in the lower evaluation of this section of medical care by surgical patients should alarm the organizers of the healthcare system and shows the greater importance of an integrated approach to BP in surgery, at least in the context of observing the legal rights of surgical patients.

The quality of nutrition was on average estimated by respondents from the group I to be 4.26 ± 0.1 points, and 4.55 ± 0.2 points by the group II ($p > 0.05$), confirming the unacceptably high dissatisfaction of surgical patients with this important component of ensuring the level of their non-medical expectations. Although in absolute terms, patients of both groups appreciated the quality of nutrition at the Junction Station Hospital.

One of the final questions was as follows: «*How would you define your attitude towards the hospital (in points) as a whole?*» Although the opinion of respondents was high on the whole, there were still significant differences between the compared groups, with a greater degree of negativity in surgical patients, expressed in the average of 4.61 ± 0.06 points in the group I and 4.81 ± 0.04 points in the group II ($p < 0.01$).

All 100 % of the therapeutic patients answered in the affirmative to the final question of the questionnaire: «*Would you like to receive medical assistance in our hospital in the future?*», which cannot be said about surgical patients, of which 9 patients (10.6 %) do not intend to be treated at the Hospital in future ($p < 0.01$).

The HSR assessment report form adopted by the public health institutions of Russian Railways provides for the calculation of the integral patient satisfaction rate (PSR) for individual components of the work. Calculation of PSR = (number of patients satisfied/total number of respondents). When taking into account the parameters with a score, the satisfaction criterion corresponded only to values of 4 and 5 points.

The final rates of patient satisfaction for 2015 are reflected in the Table.

Patient satisfaction rates in comparison groups

Group	Rates					
	PSR 1	*PSR 2*	*PSR 3*	*PSR 4*	*PSR 5*	*AvPSR*
Group I	0.92 ± 0.02	0.94 ± 0.04	1.0	0.91 ± 0.02*	0.85 ± 0.03*	0.92 ± 0.02*
Group II	0.96 ± 0.04	1.0	1.0	0.99 ± 0.03*	0.96 ± 0.04*	0.98 ± 0.02*

*$p < 0.05$ when comparing the groups.

When assessing the individual components reflecting the state of measures to ensure the patient satisfaction at the Junction Station Hospital, it was found that the satisfaction rates of the activity of the polyclinic and diagnostic departments of the Hospital (PSR 1), the work of the attending doctor (PSR 2) and nursing staff (PSR 3), were high in both groups of comparison, without demonstrating reliable intergroup differences.

At the same time, such important results as satisfaction of patients with the level of social and living conditions when obtaining medical care (PSR 5), and most importantly, the patient satisfaction with compliance with the patient's rights (PSR 4), were significantly lower in the surgical departments ($p < 0.05$) than in the comparison group. Formation of the patient satisfaction rate (PSR 4) was carried out based on the summarizing the results of the questionnaire on patient awareness of internal regulations at the Junction Station Hospital and about their rights, the opportunity to ask a doctor any questions, confirmation of the fact of written informed consent to all treatment components, satisfaction with the provision of medicines at the expense of insurance companies.

The average rate of satisfaction of patients with all components (AvPSR) confirmed the revealed tendencies.

The study did not reveal specific features of the increased social demanding that are typical for surgical patients; rather, we are inclined to attribute the difference in the results obtained due to the different quality of ensuring the level of non-medical expectations in different profile departments. The subsequent work was organized precisely in this direction.

In general, the results of the study aimed at determining the ways to increase the SE of the activity of our institution can be considered satisfactory, since the goal was achieved and the main areas for improving this work were identified.

Taking into account the preliminary results of the assessment of the level of organization of the work on raising the HSR at the Junction Station Hospital, a set of measures was developed and implemented to improve the organizational technologies for providing medical assistance, including educational, economic and disciplinary measures. For surgical patients, the practice of obtaining an informed consent for certain types of medical care has been introduced. In addition to optimizing the work of the medical commission on the control of the quality and safety of medical activities, scientific and journalistic measures were introduced to increase the individual professional responsibility of medical workers.

A serious reserve in raising the level of professional development of medical workers, including in the field of implementation of non-medical expectations of patients, is the involvement of doctors from the non-academic environment in scientific activity. The Junction Station Hospital, in addition to many years of cooperation with the North Ossetian State Medical Academy, developed measures to stimulate the participation of employees in scientific forums, the publication of scientific papers in high-level publications. Thus, more than 20 employees of the Hospital became co-authors of scientific reports in 2014–2015, they published over 15 articles in peer-reviewed journals on the results of research on topical areas of medicine.

To ensure a high level of information support for the treatment process at the Hospital, manuals for physicians were published during the past two years: «*Fundamentals of Patient Rights Protection*» and «*Legal Foundations for Patient Safety*», as well as an informational guide for patients: «*What Should a Patient Know? Legal Foundations of Medical Care*» that is available in all structural units and on all information stands of the Hospital.

Conclusion

Thus, a social assessment of the functioning of a medical institution, along with the improvement of measures of a curative and economic nature, is an indispensable condition for the development of a modern health system.

The high level of planning and implementation of anonymous patient questionnaires is an effective tool for monitoring the social effectiveness of the medical institution, which allows implementing adequate measures to target the deficiencies in the management of a modern medical institution.

A structured approach to the organization of population studies among individual patient groups allows identifying hidden defects in the system of ensuring the non-medical expectations of the population and organizing their targeted elimination with minimal losses for the system as a whole.

Involvement of employees of the medical organization to scientific and journalistic activity is one of the forms of continuous professional education. Such measures, along with regulated measures and improvement of various forms of information support for the treatment process are a non-standard way of increasing the social efficiency of a medical organization.

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РЕДАКЦИОННАЯ ЭТИКА ЖУРНАЛА PUBLICATION ETHICS OF THE JOURNAL

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ТРЕБОВАНИЯ И УСЛОВИЯ ДЛЯ ПУБЛИКАЦИИ В ЖУРНАЛЕ PAPER SUBMISSION GUIDELINES

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