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Владимир Иванович Петров

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Editorial note

JOURNAL "MEDICAL LAW" TURNS 25

Vladimir I. Petrov

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It is 25 years since the first issue of the journal "Medical Law" was published and its 100th issue is being published! This is a unique event in the intellectual life of modern Russia which has a special significance due to the special situation in modern medicine and health care.

The sacred task of protecting human rights to life and health is the main goal of this publication. We still do not have a scientific specialty "Medical Law", although specialists in the field are especially in demand. Therefore, the journal, celebrating anniversary, carries out an important mission of developing the scientific base of legal relations in medicine and health care. The materials published in the journal are always timely, highly professional and effective for medical professionals, lawyers and patients. It is very pleasant to note that our colleagues pay great attention to bioethics issues as authors of studies on the interrelation between ethics and law in medicine.

We would like to express special gratitude to the founder and permanent Editor-in-Chief of the Medical Law journal, Corresponding Member of the Russian Academy of Sciences Yuri Dmitrievich Sergeev. His efforts to create the National Association of Medical Law in our country, to found several journals on medicine and law, his unquestionable authority in the international arena as a scientist and organizer of medical legal researches, a member of the Board of Directors of WAML (World Association for Medical Law) – all this certainly helps the development of the legal system in Russia for the benefit of medical professionals and patients.

Chief of the Medical Law journal, Corresponding Member of the Russian Academy of Sciences Yuri D. Sergeev

It is possible to say a lot of good things about Yuri Dmitrievich and the team of like-minded people he created, but it is better to just open the journal "Medical Law" and get acquainted with its materials.

And we sincerely congratulate the founders, the editorial board, all authors and readers of the magazine with a wonderful event and look forward to new issues!

В.И. Петров

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Научная статья

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КОНТЕНТ-АНАЛИЗ ТИПОВ РАЦИОНАЛЬНОСТИ В ПРЕДСТАВЛЕНИЯХ О МЕДИЦИНЕ БУДУЩЕГО

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Аннотация. В статье методом контент-анализа рассмотрены представления учащихся медицинского вуза об эталонах рациональности в медицине прошлого, настоящего и будущего. В исследовании приняли участие 229 ординаторов 32 специальностей. Количественный анализ ключевых слов в представлениях о будущем медицины обнаружил маркеры всех типов рациональности. Постмодернистские идеалы суперздоровья и бессмертия стали трендами в медицинской футурологии, несмотря на то, что десятая часть опрошенных считает их иллюзией. Молодые доктора вернули основной постулат Клятвы Гиппократа – «Исцеление» – в топ ключевых слов медицины будущего. Вера, авторитет, диалог, согласие, самолечение во многом утратили привлекательность.

Ключевые слова: права человека, биоэтика, социология медицины, типы рациональности, объективизм, субъективизм, релятивизм

Original article

CONTENT ANALYSIS OF TYPES OF RATIONALITY IN THE CONCEPTS OF MEDICINE OF THE FUTURE

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Abstract. In this article content analysis is used to examine medical students' views on the standards of rationality in medicine of the past, present, and future. The study involved 229 residents of 32 specialties. A quantitative analysis of keywords in views of the future of medicine revealed indicators of all types of rationality. Postmodern ideals of superhealth and immortality became trends in medical futurology even though a tenth of respondents considered them illusory. Young doctors placed the basic tenet of the Hippocratic Oath, "Healing," back among the top keywords for medicine of the future. Faith, authority, dialogue, consent, and self-treatment have lost much of their appeal.

Keywords: human rights, bioethics, sociology of medicine, types of rationality, objectivism, subjectivism, relativism

Introduction. The Cartesians of Modernity rejected tradition, authority, and custom as ineffective points of reference for human activity and called for trust in reason alone. Since then, the French have answered the question, "What body part should I use to ride a horse?", – by saying "The head!".

If one lacks intelligence, one has to beat the animal – that is not rational. Rationality, according to Weber, is a precise calculation of the means to an end; according to Wittgenstein, it is the best adaptation to the circumstances of life; according to Toulmin, it is logical consistency. The historical change of the types of rationality

is described in every textbook on the philosophy of science [1]:

– classical understanding of rationality is closely related to the ideal of scientific objectivity;

– nonclassical rationality follows the principle of relativism, which takes into account a person's dynamic attitude to the world, their activity, subjectivity, armed with technical and linguistic means and methods of studying the interaction of objective and subjective realities;

– post-nonclassical rationality that allows one to construct a world in which one is both an observer and an activator, because today it is rational not to think, but to observe, take note, perceive, construct in the imagination and make one' fantasies come true if not in the objective, then at least in the virtual reality.

A historical shift in the types of rationality accompanies the development of medical science and practice. The prescription of classical rational thinking according to Descartes (dividing the complex into simple components, then arranging them in a strict sequence, making complete lists of the elements available for consideration) induced the emergence of medicine of suffering organs, excluding for a time the personality of the affected person, for whom illness is an unambiguous evil, from doctors' field of vision. Classical rationalism focuses on healing, understanding disease as a malfunction to be repaired.

Nonclassical rationality sees illness not only as evil, but also as good, since an ill person has a number of advantages, for example, some patients react to intolerable suffering by losing consciousness, illness gives grounds to avoid the need to search for a way out of their hopeless situation, deviation from the norm gives the right to create a new "norm", for example, the adaptation of patients with a psychiatric diagnosis in modern society is higher than that of people with a psychiatric norm. The doctor faces a tangled web of intricacies of unique individual human life, in which a decreed monologue of the doctor is inappropriate. Unlimited possibilities in the exploration of the difference of human existence in the situation of illness open up alternative medical technologies, a dialogue between doctor and patient, in which there is no definite clarity. Illness as a way of life induces the medicalization of culture as a phenomenon.

Rationalism in the postmodern era is designed to revitalize thought. Post-nonclassical rationality is oriented toward overcoming the obstacles that accompany illness, and is partial to variants of instability, contradiction, randomness. Subjectivism dictates the rules of social life through forceful methods, which, oddly enough, in medicine activates not the treating doctor, but the patient and the healthcare system. The patient, in a harsh form, relying on human rights and personal resources, despite the restrictions of an objective nature, demands healing there and then, increased longevity and quality of life, prolongation of youth, free medication and medical care. Chimeras of salvation, up to and including victory over death, paradise on earth, panacea for all diseases the patient seeks for themselves, falling into the trap set up for the young and immature by those promoting a unique experience of incredible existence: "If you spend money, then spend it on this" [2], exclaims the hero of Victor Pelevin's latest novel. Refusal of dialogue with the doctor is fraught with a patient monologue, which is intended to pave the way to the goal by means of post-nonclassical rationality. Manipulation of doctors by patients is becoming the norm of life.

Despite the fact that we live in the postmodern age, it is irrational to abandon classical and nonclassical rationality. «And is it not with this perspective that M. Weber associated "the risk of the final disenchantment of the world" (when everything will finally be enclosed in the frame of one dimension – a thoroughly rationalized! – everyday life, ordinariness and routine)?» [3].

Our study is devoted to the young doctors' search for an effective mix of the available prescriptions for rational behavior in a situation of ill-health. The aim of the paper is to identify residents' views on trends in the development of rationalism by using content analysis, based on the selection of keywords reflecting the doctor-patient relationship in medicine past, present and future, and to analyze, based on the chosen concepts, meaningful statements about the future of rationalism in healthcare. In our opinion, the key words of classical rationality in medicine are: authority, faith, compliance, responsibility, healing; of nonclassical rationality: trust, awareness, dialogue, cooperation, consent; of post-nonclassical rationality: superhealth, immortality, self-treatment, third opinion, illusion.

A total of 229 residents from 32 specialties participated in the survey. A quantitative analysis of keywords in views on the future of medicine found markers of all types of rationality in the following percentages: superhealth (64 %), immortality (60 %), healing (34 %), cooperation (32.3 %), compliance (31 %), awareness (25.3 %), responsibility (22.7 %), trust (15.7 %), third opinion (13 %), illusion (10 %), faith (8.7 %), authority (7.4 %), dialogue (6.5 %), consent (6.1 %), self-treatment (4.8 %).

Clearly, postmodern ideals of superhealth and immortality have become trends in medical futurology despite the fact that a tenth of respondents consider them to be illusory. Classical (healing, compliance, responsibility) and nonclassical (cooperation, awareness) reference points, apparently, are meant to pave the path to achieving the goal set in a familiar manner. Among the vague reference points are trust and third opinion. Young doctors have a hard time with the loss of trust in doctors, they understand the importance of this condition, but they are afraid to define it as a key word. Third opinion is another matter. Google may help, though it may destroy the massiveness of the medical profession. Outliers include faith, authority, dialogue, consent, self-treatment – a mix of key words from all types of rationality. The first four are undermined by modern healthcare; the last is the bogeyman of medical education. A qualitative analysis of statements about future medicine actualizes old and

new meanings of key words that are relevant to the future in one way or another.

Superhealth means high health indicators, adherence to a healthy lifestyle, social well-being, compliance with doctor's recommendations, and control of aging. By 2100 scientists predict an increase in life expectancy by 50–70 years, and in another 100 years – achievement of practical immortality.

The medicine of the future is a superhealthy nation. Understanding the human genome will give superhealth, will make it possible to exceed human biological capabilities. Children born in the new world will be superhealthy, and it is important not only to be born superhealthy, but also to maintain this quality throughout life and subsequently leave behind a healthy generation. Health will be evaluated not as practically healthy, but as superhealthy. Smart pills, smart lenses, nanorobots, artificial bones, artificial cells, multiple organ transplants await us. Superhealth will improve performance, endurance and quality of life. The pursuit of superhealth will solve the problem of longevity. Superhealth is immunization against all diseases – an interdisciplinary, comprehensive approach to evaluating the body's resources. It is necessary to learn to be healthy, to be creative with your health, to be able to do it with your own hands. The ability to be superhealthy ensures awareness, cooperation, and compliance. Finally, with superhealth we can take on America.

Perhaps superhealth is not necessary for everyone, for some people it is of no interest. Superhealth is possible for a fraction of the population who will cooperate with their doctors, who are informed and skilled in every field. In the pursuit of superhealth, patients will realize and correct their mistakes – this will be the first step toward immortality.

Immortality is the industry of the new revolution. Resisting the natural course of life, curing ailments, slowing down the aging process, replacing its structures on all levels from genetic to organ, humanity will obtain immortality. Nanorobots will check every cell of the body and replace aging cells with new ones. Immortality will reduce the human population, as children will be born not from the womb, but from an incubator, a supercomputer will maintain an optimal population size.

Everyone strives toward immortality, but only a chosen few will reach it. To quote Plato: "None of us has yet been born immortal, and, if it happened to anyone, he would not be happy as it seems to many" [4]. Whether immortality is necessary is a philosophical question. For half of the respondents, immortality is an illusion, concealing the real problems of overpopulation and pollution. One thing is certain – medicine is immortal.

Healing of all humanity is possible through investment in medicine and the support of drug testers, volunteers who are willing to risk their health to save humanity. Healing as the purpose of medicine is actualized both by market mechanisms (if you pay, then pay for healing) and by a new paradigm (if healing is possible, then so is superhealth). Traditional tools of self-treatment will remain relevant: willpower, resolve, wisdom, determination, composure. There will be new opportunities: healing of incurable diseases through genetic editing, through subconscious deception of feelings, through illusions. Mental healing is a trend of the future. Personalization is emphasized, stressing that everyone's healing is unique, so everyone makes their own sense of it.

Cooperation is understood as mutually beneficial, with oneself, on an equal footing with one's environment, with telemedicine, with pharmaceutical companies, with foreign luminaries, with domestic scientists. Cooperation is ensured by unlimited time to see the patient. The ability to understand the patient is the agreement to accept everyone and everything, having understood the intentions. Patients must be taught to stop arguing with the doctor. Cooperation is destroyed by the rigid bureaucratization of medical practice. Collaboration with the devil for superhealth and a cure for all diseases is an illusion.

Compliance in the future grows through the convenience of following doctor's recommendations, through finding one's own doctor. It is becoming clear to all that the greater the commitment to the doctor's recommendations, the higher the quality of life. Patient education, improvement of dosage regimens, focus on results, and reduction of negative treatment effects are all contributing to compliance. Respondents were divided in their interpretation of the effectiveness of compliance methods. Some believe that a change in mindset will lead to 100 % compliance, namely, the old cultural pattern of following all prescriptions without exception. Others rely on simple human relationships between doctor and patient, on goodwill.

Patient **awareness** grows through a third opinion, through a phone app about the course of treatment, the research being conducted, the ability to tell the truth about the consequences for themselves and for others.

Patients' responsibility for their health is understood as a conscious choice that will lead not to immortality, but to longevity. The doctor becomes not just an episodic person in the patient's life, but a person who shapes their health and lifestyle. Doctors fear the responsibility of introducing new drugs. Computer modeling will make experiments on humans a thing of the past.

Trust is the psychological compatibility of doctor and patient, a dialogue with a highly qualified specialist along with a third opinion from specialists in different fields. To gain trust, one must take responsibility, hence doctors must become more responsible than they are now.

The **third opinion** will be given by artificial intelligence – a system of medical image recognition, a neural network based on the appearance of the disease is able to reduce the time of diagnosis by 40 %. The future of medicine is a unified digital space, based on the cooperation of doctor, patient and artificial intelligence. Who will be the beneficiary of digital clinical thinking: the largest transnational research laboratories or regional medical centers, or maybe just a person from the outside, reasoning in terms of common sense? While it is unclear, what is clear is that artificial intelligence is already making the doctor's job both easier and more difficult. The third

opinion has yet to be incorporated into the doctor's professional competencies, elevating his status.

The **illusions** of immortality, the cure of all diseases, the feeling of having complete information are given not by doctors, but by engineers and cyberneticists. Superhealth is an illusion generated by the philistine "third mind," which reduces everything to self-treatment. The more a person lives, the more often they become ill. The more advanced medicine is, the more sick and weak society becomes, because sick people produce sick offspring. Developed medicine, like fire, can warm or burn. Society as a whole abuse the benefits of medicine – uncontrolled antibiotics, genome editing… The big question is, what is the alternative? The illusion of a beautiful and carefree life blinds people: this self-deception is the belief in a brighter future.

Belief in God, in immortality, in healing, in superhealth unites doctors and patients. Residents believe in a bright future, reliable high-quality medicine, decent wages, and grateful patients. Belief in medicine is not going anywhere, because a person's belief in the omnipotence of medicine, in themselves, in the best, in the good is the secret of superhealth.

Authority is the ability to influence the patient, to explain, to teach, to share knowledge, to be able to show power, authority in the professional sphere. To become an authority for the patient the doctor must improve. Authority is a capital that accumulates over the years of work. By reducing the routine workload of healthcare workers, they will learn more and therefore teach their patients.

Dialogue is the art that leads to healing.

Consent is based on an understanding of the benefits to the patient.

Self-treatment: In 100 years, everyone will be capable of self-treatment without the aid of doctors and medical institutions through artificial intelligence and religious sects. Robotic doctors will replace the patient's examination with a digitized dialogue with the patient. Self-treatment with genetically engineered bacteria is promising – symbiotes that live in the human body and can produce and inject the necessary hormones, painkillers, and antibiotics into their host's bloodstream as needed.

In conclusion we note the residents' solidarity with A. Camus, who believed that the real generosity toward the future lies in giving everything to the present. Until we have this, we live with illusions of superhealth and immortality, which does not inspire confidence in patients. The qualitative component of the content analysis captures the understanding of the main aspects of medicine of the future – personalized treatment, doctor-patient cooperation, patient responsibility for their own health, creation of new drugs with artificial intelligence, robotization of surgery and therapy. The attractiveness of artificial intelligence systems, which "are essentially expert services assisting the doctor," [5] is obvious to young doctors, but there is no understanding of the impact of doctor decision support systems, automatic evaluation of visual images, and telemedicine on the future of the medical profession.

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Научная статья

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ЭТИКА ПРИНЯТИЯ РЕШЕНИЙ В МЕДИЦИНЕ В ЭПОХУ ТЕХНИЧЕСКОЙ РЕВОЛЮЦИИ

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Аннотация. Каким образом мировоззрение, научные открытия и эмпирические оценки соотносятся друг с другом при принятии решений в медицине? Ответ на этот вопрос дан в научном контексте. Существует теория принятия решений, которая востребована медицинскими специалистами, хотя пока и недостаточно [1, 2]. Итак, что же такое теория принятия решений и в какой степени ее развитие может быть применено к медицине с растущими противоречиями технологической революции и биоэволюции человека? Выбор тактики ведения пациента не зависит исключительно от клинических решений. Моральная позиция врача играет важную роль в принятии решений в медицине. В статье рассматриваются некоторые факторы, влияющие на этот тренд. Обоснована роль этической экспертизы. Это особенно важно в связи с внедрением технологий «улучшения человека» в медицинскую практику. Принятие решений всегда связано с выбором вариантов. Моральные соображения являются ключевым моментом, который должен повлиять на этот выбор в условиях неопределенности прогнозов, касающихся применения новых биотехнологий.

Ключевые слова: теория принятия решений, биоэтика, медицина, биотехнологии, ожидаемая ценность, гуманитарная экспертиза

Original article

ETHICS OF DECISION MAKING IN MEDICINE IN THE ERA OF TECHNICAL REVOLUTION

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Abstract. Which way do world outlooks, scientific findings and empiric evaluations correlate with each other in decision making in medicine? The answer to this question is given in the scientific context. There is a theory of decision making which is in demand by medical professionals, though not enough yet [1, 2]. So, what is the theory of decision making and to what extent its advancement may be applied to medicine with growing contradictions of technological revolution and human bioevolution? The choice of tactics in a patient's management does not depend exclusively on clinical decisions. A doctor's moral stand plays a significant role in decision making in medicine. This article deals with some factors that have effect on this stand. The role of ethical expert examination is substantiated. It is particularly important due to implementation of «human enhancement» technologies in medical practice. Decision making is always associated with a choice of options. Moral considerations are a key point that must influence this choice under uncertain predictions concerning application of new biotechnologies.

Keywords: theory of decision making, bioethics, medicine, biotechnologies, expected value, humanitarian expert examination

Introduction. Theory of decision making – is a methodology that involves a choice of actions that results in efficient achieving a desired goal [3].

There is a *normative theory* that describes a rational process of decision-making, and a *descriptive theory* describing the practice of decision-making. In medicine a descriptive theory is more in demand, but it is difficult to understand without knowing what a normative theory is.

To make "strict" statistically true forecasts for the future, a sampling from the future data should be made. As such sampling is impossible, so we should rely on the already existing data. But in this case forecasts

become only "shadows of the past". There is previous experience and new challenges, new realities. Can we trust the forecasts based on the data of the past? In this sense practical medicine makes everything quite clear – prognosis for a disease and a treatment plan result from the past experience and clinical tests. In short it may be expressed like this:

Making a diagnosis. *If a number of symptoms in the patient occurred in Y % patients and was diagnosed as a chronic heart disease (CHD), consequently, there is a Y % probability that this patient suffers from CHD.*

Prognosis of drugs administration. *If X % patients with hypertensive crisis took N drug to recover from the crisis, there exist X-per cent probability that this very drug will help a particular patient recover from the crisis [4].*

Without sustainability of the series it is highly improbable to draw a valid conclusion. Though, it does not mean that the series ought to be absolutely sustainable. For example, it may have sustainable dispersions and absolutely non-stationary means; in this case we are able to draw conclusions only in relation to the dispersion and otherwise only to the mean. Sustainability may bear a more exotic character. The search for sustainability of the series is one of the purposes of statistics. In our case it is medical statistics. Epidemiologic explorations which correctness and completeness provide for a high probability of correct decision making in particular clinical cases may be of invaluable help.

Though, when we deal with revolutionary processes as implementation of "human enhancement" technologies, the situation is getting more complicated. It is evident that the process in this case is not stable and even if the probability functions of some expectations distribution may be calculated, these functions are "subject to unpredictable changes" and consequently the whole system is unpredictable. In modern practical medicine, such cases may be presented by rare diseases as well as rare combinations of the primary and accompanying diseases.

A typical example is doctors' behavior when the first few cases of West Nile fever occurred in Volgograd oblast of the Russian Federation. Uncertainty was associated with the cause of origin of this exotic disease. Mosquitoes were not considered as agents of the infection and now the measures taken against mosquitoes helped avoid development of the epidemics of the disease.

Uncertainty in decision making. In the theory of decision making uncertainly of the situation is associated with suspense, unpredictability of the results of the decision made.

As an example *of it is technologies of human genome editing Regularities of bonds in a genome have not been fully studied yet and it takes many years for monitoring the patients who had undergone such an operation in order to get any findings. Though, from the viewpoint of humanitarian expert examination it is impossible as it consciously violates human rights – the person's health and probably person's own life are jeopardized. At the same time development of scientific knowledge cannot be stopped and if any technology has been already developed, it is only the matter of time when it may be implemented. For this reason, a society with its control over such experiments is only able to "establish" some parameters of the experiment, to limit it, but not prevent its application.*

In such a situation, uncertainty analysis developed in decision theory is very useful. Consider its types on the material of practical medicine.

Stochastic uncertainty. There is some information on probability distribution in multiple results. ***Example:*** *lasting pain behind the sternum + arrhythmia + changes in the distal part of the ventricular complex in the ECG = CHD? No! It may be climacteric cardiopathy, coronary artery insufficiency, hyperthyroidism and a lot of conditions that require absolutely different medical treatment.*

Behavioral uncertainty. Information is available on its influence on the results of the participants' behavior. ***Example:*** the patient's incompetency minimizes efficiency of the correctly administered treatment.

Natural uncertainty. Information is available only concerning possible results but there is a lack of information about an association between decisions and their outcome. ***Example:*** *decision about pregnancy interruption may have neutral consequences but also may result in infertility.*

A priori uncertainty. No information about possible results. ***Example:*** *application of the drug that did not pass the third stage of clinical trials (CT). Application of the method for editing the genome of the embryo of HIV-infected parents.*

The task of substantiating decisions under conditions of uncertainty of all types, except a priori, is reduced to narrowing the initial set of alternatives based on the information available to the decision maker [5]. It is important to note that it is not correct to interpret such reduction in medicine only as a necessity to collect a super-detailed past history and doing numerous tests. The patient's personality who becomes an object of a medical intervention should also be taken into consideration. If a patient supports the doctor's decision, the uncertainty level decreases [6]. Practically, it is a binary subject – "doctor-patient" – which makes a decision in medicine. As soon as the binarity is violated, uncertainty increases. Hence, the optimal choice of the doctor-patient relation model enhances the chances to make a correct decision in diagnosis, treatment and rehabilitation which is a matter of ethical regulation. Still, a doctor possesses more freedom in decision making. Firstly, a doctor has a so-called "therapeutic privilege". Secondly, the freedom of the patient is limited by a certain degree of psychosomatogenesis, which prevents an adequate assessment of the situation. Consequently, the decision maker personality (DMP) in medicine usually means the personality of the doctor. So, the quality of recommendations for decision making under e.g. stochastic uncertainty increases taking into account such DMP characteristics as an attitude to gains and losses, inclination to take a risk, wish to play a leading role in relations with a patient, a rational criticism in relation to Standards and Rules of rendering medical assistance [7].

As for the application of "human enhancement" technology, we always deal with a prior uncertainty (not excluding other types of it). Decisions justification under a prior uncertainty in non-medical fields is possible by creating the algorithm of adaptive management but in medicine the situation is regulated by the "do not do any harm" principle, that is why the choice of a decision is subject more to ethical arguments than the arguments of scientific medicine. Just because the latter are absent.

The choice under uncertainty is the most important problem in the theory of decision making because each choice is aimed at a certain result. Besides, this result presents some value for us, especially when it goes about changes in the human nature. Thus, the expected value directly affects decision making.

Expected value theory. It was Blaise Pascal in the XVII century who first wrote about expected value [8, 9]. Though, he meant "mathematical expectancy" and for this reason mathematical operations were supposed. Let us imagine that we have a few (and even a set of)] possible actions and each can produce a few possible results with various probabilities. For a correct decision we should determine all possible results, show their positive and negative values and probabilities and sum up the results. This is what expected value. But the question arises – who is this expected value for? It looks so that both the doctor and the patient have the same aim – the patient's health. Consequently, they have the same expected value. But in reality we see that there is a number of intermediate values manifested as the means to achieve the value. And the doctor and patient (or the patient's relatives) may imagine the value in absolutely different ways.

Example. *A 24 yo nullipara woman. She visited the gynecologist with a complaint of bleeding. She was hospitalized with a diagnosis "hysteromyoma". She was advised to be operated and she agreed to it. At the consultation the doctor explained that the uterus might be extirpated if no other possibility to remove the myoma existed. The patient signed the form of the Informed consent for the operation, though hysterectomy was not mentioned in it, During the operation the doctor had to extirpate the uterus as the myoma was located at the vascular bundle and its nodes were of an intricate configuration. The patient left the hospital in a satisfactory condition and never came to the clinic afterwards.*

Three years later the patient's father occasionally watched a health program on TV, and the presenter did not advise women to agree to the operation for hysteromyoma as there existed efficient drugs that made a myoma decrease in size and thus often made the operation needless. The drug mentioned was gonadotrophin agonist. The next day the patient's father went to the lawyer and prosecuted the clinic with a claim to compensate moral and physical damages caused to his daughter. The claim amount was USD 20 000. The substance of the claim was that the doctor had not administered the proper drug to his daughter but advised an operation instead. The plaintiff alleged that administration of gonadotrophin agonist might have prevented hysterectomy and his daughter could have had children.

At the trial the doctor expressed the opinion that the drugs might have been of no use and the patient could have wasted the money as she needed at least 5 injections 8–10 thousand rubles each. The plaintiff's attorney objected saying that it was possible to judge about the efficiency of treatment only if it had been conducted and it was the patient who could decide about the money and not the doctor.

The legal evaluation of this case may be based on one single fact – incorrect formulation of the informed consent. In fact, the patient did not agree to hysterectomy, as there was no such a paragraph in the document that she had signed and an agreement made in the oral form was not registered anywhere. As for recommendations to use gonadotrophin agonist, it cannot be the object of legal evaluation. Law does not describe probabilities and refers only to facts. The fact that the patient was not provided with complete information about alternative methods of treatment should be established by a medical expert, but in this case it is problematic, since in the medical history this case was described as not subject to therapeutic treatment.

As for ethical evaluation, it can be made for all the issues of the case. Firstly, irrespective of the doctor ought views, experience and competency, the doctor should have informed the patient about all existing methods of treatment and explain why administration of gonadotrophin agonists was ineffective in her case. Only if the patient had refused from the treatment it would have been possible to decide on the operation.

Secondly, it was necessary to explain in details all possible complications and consequences of the operation in the informed consent, as the patient should be aware of the correlation between the risks and benefits of the operation. In this very case the doctor used the so-called "therapeutic privilege" that makes it possible, as an exception, to take decisions for the patient or take them in the doctor's opinion to the correct decision. This particular problem was easy to settle and quite clear for a competent patient, that is why "therapeutic privilege" was superfluous.

Thirdly, the doctor cannot assume the role of the "financial counselor", these are only the patient and their relatives who can decide, whether they can pay for the treatment chosen. Though, this issue may be questionable if the patient is aware of the efficient treatment but unable to pay for it. It may lead only to frustration and deteriorate quality of life which is also ethically unjustified. There are no universal recommendations for such situations so far (they are described below), each time the issue has to be resolved only by the doctor and only for each particular patient.

And fourthly, the situation that cannot but attract our attention, as it is typical of our time. The patient's father learned about the above drug from a popular health program. Can the source be reliable? Can it be considered as the doctor's consultation? Why no reservation was made in the program that administration of these drugs

should be discussed in each individual case and only with a competent specialist? We assume that "advice" of this kind that our mass media are overfull with and, in fact, present only a hidden advertisement of expensive services and drugs, are immoral. They mislead patients and provoke conflicts in medicine. It makes the question arise if censorship should be introduced for medical information in mass media.

This example makes it clear how many variables are engaged when making a decision and how the doctor's and the patient relatives' viewpoints differ in relation to the expected value. That is why arguments of those experts who insist on decision making in medicine as only information-logical activity look unconvincing. Only efficient computer programs are thought to help a doctor in the situation of limited time of decision making or limited opportunities of its implementation. New algorithms for such decisions are being developed for various fields of medicine and even for various nosologies. Though it is impossible **to make an algorithm for patients' attitude towards the expected value and making a decision;** an ethical and emotional component is too strong and the level of competency in clinical issues is low. As the doctor has no right to implement his/her decision without the patient's consent, all programs used turn out to be useless.

"Losses are more sensitive than gains". Besides, the probability of the correct choice using such programs is not high enough. Though, even it could reach 99 %, the risk of their use could be too high because 1 % would mean at least one unjustified death. All this makes us be cautious about the possibility to use the theory of expected value in medicine. Still, there are other variants to optimize the process of decision making.

Example. *In 1738, Daniel Bernoulli published an article called "Exposition of a New Theory on the Measurement of Risk" [10], where he proves that the theory of expected value is normatively incorrect. He gives an example in which a Dutch merchant tried to insure the cargo shipped from Amsterdam to Saint Petersburg in winter, though there was 5% risk that the ship and the cargo would be lost. In his decision he determines the function of usefulness and calculates the expected usefulness and not expected financial value.*

In the last century, Abraham Wald (1939) expressed the opinion that all subproblems of decision making are united in one single theory [3]. He developed a categorical construct of this theory introducing such notions as "loss function", "risk function", "acceptable decision rule", "bayesian decision rules", "a priori distributions", etc. Now it is evident that consideration of *subjective* components of decision making refers directly to medical decisions, especially when Wald's followers – Frank Ramsey [11], Bruno de Finetti [12] and Leonard J. Savage [13] developed a concept of subjective probability, application of which made it possible to describe the situations, using the expected utility theory when only subjective probabilities are possible. It is particularly significant for modern medicine, as it allows to describe decision making under different risks (clinical, ethical, social, financial, administrative, etc.).

In general, we can suggest that expected value theory is mostly applied to scientific researches and the expected utility theory – in the development and implementation of new biotechnologies. At present, in spite of the attempt to describe the interaction of science and engineering as "technoscience" [14], it is evident that scientific and technological issues in medicine possess a very modest share of complementarity. Pessimists also say that technologies displace science and technological decisions become more preferable than theoretical ones. Of course it goes about fundamental sciences,

Both for practical, "technological" and fundamental medicine the most important is the proof of D. Kahneman and A. Tversky's theses that for personal decision making "losses are more sensitive than gains" [5]. Besides, people are focused more on "alterations" of their own utility condition than utility conditions themselves and evaluation of the corresponding subjective probabilities is shifted in relation to the specific "reference point". This theory is principal for the decision making process in medicine. In fact, it was Hippocrates who by saying "do not do any harm" established a moral maxima of a correlation between losses and gains. He did not call for to cure but called for not to do worse, not to lose the human life.

But in the medical community the principle "do not do any harm" was always accepted without any relation to a possible gain. Hence, the strive for hyper-diagnostics and excessive administration of drugs in modern medicine. Most important is not to make a mistake. Most important is not to lose what already exists. But, if in a pure theory minimization of losses leads to inaction, then in medicine inaction is also harm. For this reason decisions are always made, but they are always preceded by a fear to make a wrong decision.

Errors in decision making. In the theory of decision making special attention is focused on possible errors. Usually, they are divided into two types. They are usually divided into errors of the first and second kinds. The cause of such classification lies in the consequences of erroneous decisions which differ in that the missed gain has less effect on the situation than the real loss. For example, for an exchange broker the consequence of failure to buy shares when they should have been bought differs from that when the shares were bought and he should not have done it. The first situation means the missed profit and the second – direct losses including the broker's ruin. The same is for a politician: the consequences of refusal to take the power in a revolutionary situation differ from the failed attempt to take the power. For a general to start a military operation that will be lost is much worse than to miss the situation for a successful operation [15]. For a medical doctor the goal set "at all costs" may cost much higher than following the natural course of events with a minimal correcting intervention.

Example. *Primigravida and primipara K., 23yo, was referred to the maternity home by her attending*

gynecologist a few days before the supposed date of delivery with a diagnosis "39 weeks of pregnancy. EDEMA but no hydrops gravidarum, Rh-negative without antibodies" was not diagnosed. The analysis of the pregnant woman's case history showed that the indication for hospital admission was an abnormal weight gain of 15 kg and edematous shins.

Examination at the pathologic pregnancy department showed traces of albumin in the urine and cardiotocography (CTG) of the fetus showed a questionable CTG type IUGR (intrauterine growth retardation). Diagnosis: Pregnancy 39–40 weeks. Moderate preeclampsia. Chronic fetoplacental insufficiency(CFPI). Rh-negative without antibodies".

It was decided to prepare the woman for delivery at full-term pregnancy, preeclampsia, and lack of readiness for delivery. During her stay at the pathologic pregnancy department repeated CTG, and ultrasonography were normal, blood and urine tests were without pathology, though the shins were still edematous. The woman was offered induction of labour induction with amniotomy – artificial rupture of the fetal bladder] as the gestational age was 40 weeks with moderate preeclampsia?

Induced labour was complicated by the abnormal labour forces and required a medical correction. At labour assistance the fetus's condition got worse (acute progressing intrauterine hypoxia). Labour ended in caesarian section and the baby was born with 4–5 Apgar score (neonatal asphyxia).

From the attending gynecologist's point of view the reason to hospitalize the woman was her weight gained during pregnancy and edema of the shins, so she interpreted these signs as a pregnancy complication – preeclampsia. At this stage the attending gynecologist evidently wanted to be on the safe side and avoid responsibility shifting it to the doctors of the maternity home even with minimal changes (within the individual norm) in the pregnant woman. Besides, the woman experienced psychological pressure (non-conformity with medical standards of weight, tests and blood pressure) and was intimidated that complication might happen both to the woman and her baby. This way, the woman admitted to the pathological pregnancy department at the end of pregnancy without any convincing reasons had only to be placed in the delivery room. Labour induction with immature birth canals provoked abnormal labour and required stimulation which was useless in this situation and finally led to caesarian section. In V.E. Radzinsky's opinion [16] this tactics bears the name "crocodile phenomenon" – "not a single step backwards", not because it is as aggressive as this nice animal but because the crocodile cannot move backwards and besides it attacks the first thing that comes to hand, or better to say, to tooth.

At the same time, classification of errors into the first and second types is justified when the record and analysis of risks is done accurately. So, in economics raising profit is not as important as minimizing risks. The main difference lies here.

In many cases we can see a paradoxical situation when a wide choice can result in a poor decision and even in the refusal to take any decision. Sometimes it may be theoretically explained by the so-called "analytical paralysis", real or imaginary and by a "rational ignorance" that is also quite possible. As the medical doctor cannot afford "analytical paralysis", sooner or later he/she is doomed to make an error being aimed at the successful treatment and not minimizing losses. As Barry Schwarz suggests, the choice did not give us more freedom but limited us, did not make us happier but always causes dissatisfaction. It fully refers to healthcare professionals. For this reason it is so important to know the logics how to solve clinical problems to avoid errors of both the first and second type.

The process of problem solving in practical medicine. In practical medicine the process of problem solving consists of such main subprocesses as:

1. Detection of a problem situation – making a diagnosis.

2. Problem statement (detection and definition of its source elements and relations between them) – forecast of the treatment results (taking into account accompanying conditions, the patient's personality and facilities of the clinic).

3. Search for the problem solving – choosing the tactics of the treatment process (treatment and rehabilitation plans, choosing the drugs, techniques, method of control).

The stages of problem solving were described with some modifications by many authors. The most popular among them are the following:

Stages of problem solving in theories by O. Selz [17], K. Duncker [18], Greeno [19]

O. Zelz	K. Duncker	Greeno
1. Forming a complex that includes: a) characteristics of the known and b) known-unknown relation determining c) the place of the unknown in the complex. Incompleteness of this complex is the essence of the problem	1. Going deeply into the problem situation – understanding its internal relations, perceiving it as a whole containing some conflict	1. Constructing a cognitive network made of the elements of the known (datum) and unknown (relation between the elements of the known and unknown has not been established yet)
2. Launch of intellectual operations: recollection or making a decision	2. Finding a *functional value* of the decision. 3. Implementation of the functional value in a concrete decision	2. Constructing connections (relations) between the elements, modifying the network with additional information from the memory

The most acceptable for **clinical** problems is K. Duncker's theory, as it corresponds to the structure of a medical "triad": knowledge – assessment – activity. Though application of these theories in their pure form is hardly possible maybe because it is a particular person with his/her own emotions, ideals, experience, everyday problems, who learns, assesses and acts in the clinic. Hence, personality in decision making is one of the most important conditions of their success/failure. In fact, the process of problem solving (in science in particular) and successful solving of it is affected by the following factors:

1. **Attitude.** Attempt to repeat what was successful in the past. The level of attitude is proportional to the level of difficulty of the problem. A previously applied method is difficult to use in a different way.

2. **Characteristics of an emotional (motivational) state.** Efficiency of a decision is proportionally affected by a previous success/failure. The higher or weaker is the motivation, the worse is the outcome of problem solving – the most efficient is a medium intensity of motivation.

3. **Knowledge.** It may influence problem solving both positively and negatively depending on its depth.

4. **Intellect.** Low intellect intensifies dependence on attitude, high intellect makes the dependence lower.

5. **Personality.** At the personal level the success of problem solving depends on a] flexibility, b] initiative, c] confidence, d] nonconformity, e] ability to restrain activity.

Conclusion. Thus, subjective probabilities are so important in medicine that they give special characteristics to decision making. Expected value and expected utility should be integrated in the process. But it is not just a man who makes a decision - it is a medical doctor who is limited by the requirements of his/her social role. Consequently, parameters of this role will also be parameters of decision making. What are they determined by? By a normative regulation of the medical profession, in other words – by the norms of bioethics. For this reason, a bioethical regulation determines both the process and outcome of decision making in medicine.

Hence, in respect of development and application of "human enhancement" technologies in medicine decision making will be successful only if decisions are based on a] data of fundamental sciences and b] data of humanitarian expert examination, a bioethical one in the first line.

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КОРОНАВИРУС И ВАКЦИНАЦИЯ: МЕДИЦИНСКОЕ, БИОЭТИЧЕСКОЕ И КОНФЕССИОНАЛЬНОЕ ИЗМЕРЕНИЯ

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Аннотация. В данной статье обсуждаются некоторые дискуссионные вопросы, находящиеся на стыке медицины, биологии, философии, теологии, религиоведения и биоэтики, возникшие в связи с коронавирусом и вакцинацией населения, которые по-разному решаются с позиций различных мировоззрений и конфессий. Показываются некоторые издержки в адаптации религиозных конфессий к регламентации жизнедеятельности во всех сферах в период коронавируса. Обосновывается, что одной из причин быстрого распространения вируса являются некоторые действия церквей, мечетей и синагог в направлении обеспечения эффективной самоизоляции и социального дистанцирования. Доказывается нежелательность и вредность некоторых публичных дискуссий по поводу стратегии и тактики жизнедеятельности в ситуации пандемии: об инфекционной безопасности обрядов причащения, крещения и др.; о халяльности антивирусных препаратов; о правомерности использования препаратов, воздействующих на ДНК индивида; о допустимости препаратов, изготовленных из абортивных и иных человеческих материалов.

Ключевые слова: коронавирус, религия, христианство, ислам, вакцинация, биоэтика, антивирусные препараты

Original article

CORONAVIRUS AND VACCINATION: MEDICAL, BIOETHICAL AND CONFESSIONAL DIMENSIONS

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Abstract. This article discusses some controversial issues at the intersection of medicine, biology, philosophy, theology, religious studies and bioethics, which have arisen in connection with the coronavirus and vaccination of the population, which are resolved in different ways from the standpoint of different worldviews and confessions. Some costs are shown in the adaptation of religious confessions to the regulation of life in all spheres during the period of coronavirus. It is substantiated that one of the reasons for the rapid spread of the virus is some actions of churches, mosques and synagogues in the direction of ensuring effective self-isolation and social distancing. It proves the undesirability and harmfulness of some public discussions about the strategy and tactics of life in a pandemic situation: about the infectious safety of the rituals of communion, baptism, etc.; the halal nature of antiviral drugs; on the legality of the use of drugs that affect the individual's DNA; on the admissibility of drugs made from abortive and other human materials.

Keywords: coronavirus, religion, Christianity, Islam, vaccination, bioethics, antiviral drugs

Introduction. The natural sciences, medical sciences, humanities, and social sciences are just beginning to formulate some of the patterns associated with the coronavirus. Religious studies, Islamic studies, and theology have also been involved in the study of the confessional experience of countering the pandemic. But some preliminary generalizations can already be made here. Confirmation is the international scientific and practical conference "Interfaith harmony is the key to post-COVID rehabilitation and spiritual revival of Russia", "which was held on January 26–27, 2021 in Makhachkala on the basis of the scientific and health complex "Zhuravli", where methods of restoring health for those who have suffered severe forms of coronavirus infection, based not only on a medical approach, but also on the restoration of the spiritual state of a person, were discussed. There, authoritative scientists and alims spoke about increasing the role of all religious communities in organizing counteraction to the spread of the virus. It was emphasized that in a stressful state, the human immune system weakens, which facilitates the introduction of the virus into cells and its spread throughout the body. Therefore, it is important that a person is psychologically stable and calm. Turning to the Almighty often helps in this [1].

The purpose of this research article is to analyze some significant changes in the strategy and tactics of religious activity in the context of the pandemic. The positive aspects and some shortcomings of the work of religious communities to counteract the epidemic are revealed.

The scientific novelty of the study lies in the justification of the undesirability and harmfulness of public discussions around various aspects of coronavirus and antiviral vaccination, namely: the extent of the impact of drugs on the human genome; on the permissibility of their use from the point of view of Christianity, Islam and Judaism due to the use of prohibited ingredients, including abortion materials; on the infectious safety of communion and other religious rites, etc.

The theoretical and methodological basis of the research is the main state and confessional documents that define the strategy and tactics of society in the situation of coronavirus, as well as the philosophical methodology that requires a concrete historical approach to the analysis of social phenomena, carried out taking into account the real conditions of life and activity of people, the basic principles of bioethics.

Research results and their discussion

The majority of the population, believers and clergy were sympathetic to the significant changes in the regulation of all life activities during the pandemic. Although it must be said that these changes in the metric of religious life did not always go smoothly. For example, the actions of all faiths without exception, especially during the initial period of the pandemic, were not very prompt, and they joined the state policy of self-isolation and refusal of public events rather late. So, for example, in Dagestan at the end of March last year, when the epidemic was already raging in full, more than a thousand people still gathered for Friday prayers in the Juma Mosque of Makhachkala, and in Kizilyurt-about 3,000 people. This shows that the leadership of the muftiate joined the state policy of self-isolation and refusal of public events rather late.

Many signs of boycotting the state policy of countering the pandemic, considering it as an attempt by the state to interfere in religious life, took place in the initial period in all faiths. For example, as the Polish newspaper Rzeczpospolita notes, from the point of view of faith, there is nothing more important on earth than the service of Mass, and for the eternal life of a person – nothing more important than receiving Holy Communion. Just as hospitals treat diseases of the body, so churches treat spiritual diseases, so it is inconceivable that people would not pray in our temples. And the Austrian pastor Christian Sieberer, in an open appeal to the state authorities, asks: can it be true that for the first time in the history of Austria, people will not be allowed to come to mass to celebrate the death and resurrection of our Lord? After all, even during the plague epidemic and during the war, under the rule of the Nazis and the Stalinist occupation, such a ban never existed [2].

Now it has become clear that one of the main reasons for the rapid spread of the virus was mass worship services in churches, mosques, synagogues and other events of a religious nature. For example, the South Korean authorities have officially confirmed that as of March 2020, out of 8,200 cases of COVID-19, more than half are attributed to followers of various churches. And in Malaysia, out of 238 cases of infection, 77 were associated with the holding of an Islamic religious festival in Kuala Lumpur from February 27 to March 1, 2020 [3]. An even more obvious picture was observed in Israel, where many Jewish communities, especially those who lived in Palestine long before the emergence of Israel, and recognize their relative autonomy from the state, as well as some representatives of Muslim minorities, boycotted and continue to boycott official anti-epidemic policies and ideology.

We also consider it important to state that some discussions involving many believers and clergymen of all religious denominations without exception were imposed on the community artificially, and most importantly-untimely, and they did not and do not contribute to increasing the effectiveness of countering the pandemic. We will point out some undesirable vectors of these discussions.

For example, we consider untimely the theological discussion about the infectious safety of the rite of communion, which was raised in the media by some representatives of the Christian clergy. So, the archpriest of the church of St. Nicholas in Galutvin and the rector of the Chinese patriarchal metochion in Moscow, Igor Zuev, directly stated: "There is no danger of infection from communion from one cup. It cannot be, because in the cup there is not just bread and wine, but Christ himself" [4].

Confirmation that such statements in the period of mass epidemics are fraught with serious consequences is the well-known in Russian history "plague riot" in the XVIII century, when as a result of the ban on mass prayers at the Bogolyubskaya Icon of the Mother of God, located at the barbarian gates of Kitay-gorod (China-town), excited by some initiators, the crowd of rioters who did not want to obey the ban, killed the Moscow Archbishop Ambrose and organized pogroms.

We also consider it inappropriate, untimely and harmful to discuss the issue of halal antiviral drugs, especially the discussion in the media on this topic in the context of the pandemic itself. This includes appeals from authoritative Islamic bodies and individuals, such as the Council of Theologians of the Muslim spiritual board of Russia, the Muftiate of Tatarstan, and others to the Gamalei and Vector centers with a request to disclose the composition of vaccines in order to make a theological decision on its permissibility [5].

We assume that under normal conditions, theological arguments about the halal or non-halal nature of medical drugs have a right to exist. And the theological prohibition to be vaccinated can be connected with the use in the production of drugs of components recognized as non-halal: alcohol, pork, dead meat, blood and everything that is not killed with the name of Allah, as well as with the lack of chemical processing in the technology of their manufacture, in which the substances lose their natural properties. But in the current situation of the pandemic, we believe that

such discussions and appeals only bring harm and do not contribute to the unity of the Ummah in the fight against danger.

In conditions when a significant part of the population is not yet sure of the effectiveness of the drugs, many people doubt whether to be vaccinated, such statements and appeals of authoritative Islamic leaders, especially through the media, can be decisive in refusing to vaccinate.

Moreover, the Koran and Sunnah clearly allow the use of non-halal food and medicines in extreme conditions that threaten life itself. "If someone is forced to eat the forbidden *without disobedience* and without transgressing the limits of what is necessary, then there is no sin on him. Indeed, Allah is Forgiving, Merciful" [6] (italics are highlighted by the authors, because of the importance of this point). According to the letter and spirit of the Koran, a person, his physical and spiritual health are the highest value, and he is obliged, first of all, to take care of saving his own life – a priceless gift of Allah.

It is also impossible to recognize the useful tone of the statements of some believers and religious ministers, where the epidemic is considered as "God's punishment", a lesson, punishment, and that it is another proof of Divine omnipotence. To prove his power, God does not need to resort to such extreme measures, condemning people to suffering and the loss of loved ones. After all, He has other, more effective means of influencing people and educating them to worship God, high morals and spirituality. This is on the one hand. On the other hand, we consider it unacceptable and methodologically incorrect to transfer postulates that have symbolic and spiritual significance to real life, including medicine, biology, etc. The consequences of such attitudes, condemning people to inaction and waiting for a miracle, are not difficult to imagine.

Indeed, as it is written in the Quran, "and no misfortune will befall you except by the Lord's permission; and the heart of everyone who believes in the Lord will be guided by Him to the right path. Allah is All-knowing of all things" [6]. That is, any virus, disease, epidemic, natural disaster does not arise and occur by itself, but is created only by Allah and by His will. In the light of this interpretation of divine omnipotence, it turns out, as Abu Hureira said, "there is no transmissible disease and there is no bad omen... " [7]. When, objecting to this, the Bedouin asks: haven't you seen how a camel with scabies, coming to us, infects everyone? To which the Prophet asks an answer question: "Who infected the first camel?" [7].

In this dialogue, we are interested in the ideological and theological meaning of the above polemic, which means that the omnipotence of God also extends to acts that have serious hardships, sufferings and trials as a result. Of course, in the modern medical and biological sense, such statements are not correct and even absurd, since they focus only on the divine hope and rejection of modern science (including medicine) and practice.

Representatives of religious denominations have very different views on vaccination. Some, perhaps the majority of them, support the official state anti-covid policy and make calls for clergymen and laypeople to be actively vaccinated. Others, on the contrary, based on bioethical and canonical considerations, call for abstaining from vaccinations against coronavirus. At the same time, some arguments are given, including that it is believed that such vaccination involves interference with human DNA, which is unacceptable according to religious and moral canons. This is confirmed by the popular in virtual reality interview with Protopresbyter Andrey Aleshin, to which he encloses a translation from the Greek language and comments on the famous article by the English researcher Anthony Patch, which proves that anticovid vaccination is a direct intervention in the human genome for the purpose of its further programming that can never be approved by religion at all [8].

It should be noted that such a wide range of opinions among ministers of worship and believers in general reflects the presence of different approaches among domestic and foreign geneticists, virologists and microbiologists. The official Russian position on this issue was expressed by the director of the Gamalei Research Center for Epidemiology and Microbiology, Academician of the Russian Academy of Sciences Alexander Gintsburg, that "the Russian Sputnik V vaccine does not affect the human genome. It has no effect on the nucleic acid, nor on heredity, nor on any other things related to the change in our hereditary material". And that the drug does not multiply in the human body, so it cannot integrate and interact with DNA. In his opinion, the human genome can only be affected by what can be integrated into it or in some way affect the structure of DNA. This vaccine is produced on the basis of a non-dangerous human adenovirus with an embedded section of the SARS-CoV-2 coronavirus genome, which provokes an immune response [9].

The opposite position, which is quite widespread, including among believers, is based on the fact that anti-covid protection is fundamentally impossible without direct intervention in the human genome. So, according to the Nobel Prize winner Luc Montagnier (by the way, who received for the discovery of the immunodeficiency virus), the total genomic sequence of the SARS-Cov-2 virus contains 16 genetic fragments of HIV-1, HIV-2 and MIV (monkey immunodeficiency virus), which are present in all preparations without exception [10].

This is also due to a certain modification of stem cells (which are known to be able to transform into many types of cells of organs and tissues of the body). As a result, most of our somatic (non-reproductive) cells can be replaced by these genetically modified stem cells. This process leads to the transfer of genetic information to the germ cells, leading to mutations in all subsequent generations. Since this is a modification of sexual cells, not somatic cells, the new genetic material will be present in each individual cell of the offspring. Thus, there is a so – called insertion-a genetic mutation in which another DNA sequence is inserted into the DNA sequence, which will be detected in all generations of a particular person [11].

And another aspect of this problem, which opponents of vaccination pay attention to, has not only biological,

but also social and spiritual consequences. It consists in the fact that the vaccine contains marking components that indicate changes in the DNA. The vaccine contains an enzyme called luciferase, a fluorescent material that is invisible to the ordinary eye but visible to instruments, as well as so – called nanobots-molecules that can be programmed to perform a specific task. They function as biological sensors, communicating information from inside the body to outside, to the corresponding structures [10]. This leads to the well-known conclusions about total programming, "chipping" of a person, "the formation of a society of total control", which many people have recently been talking about.

We have highlighted only one side of the vaccination problem, which has biological, social, spiritual, bioethical and religious aspects. The other side, which is quite actively discussed by all faiths, is related to the problem of the presence of abortive materials in modern vaccines [12]. Although all Western and domestic experts, without exception, recognize the fact of the use of abortive cultures in the production of vaccines, there are significant differences in its assessment. According to the experts of the Center for Epidemiology and Microbiology. Gamalei, indeed, in the production of vector vaccines intended for the prevention of viral diseases around the world, the NEK 293 cell culture is used. It was obtained in 1973 by the transformation of an abortive culture of human embryonic kidney cells with adenovirus. It entered our Center in 1981 from the Institute of Genetics, University of Cologne, Germany. According to the Leonard Hayflick limit, all human cells dividing in cell culture die after about 50 divisions. Therefore, by 1981 all cells taken from the source material were absent in the cell line, and it is possible to speak about the connection of this line with the abortive material only in historical terms [9].

Based on such considerations, all the arguments of opponents of vaccination for religious and bioethical reasons are not justified, because after many transfers, nothing remains of live abortive material.

The above arguments of the Center's experts are quite convincing, but they do not take into account one very important amendment, which was made in 1971 by our scientist Alexey Olovnikov, who proved that the Hayflick limit is characteristic only for cells with uncirculated DNA, while bacteria with ring DNA multiply without restrictions on the number of divisions. He proposed the marginotomy hypothesis, which suggested that the limit of cell division with linear DNA is due to incomplete copying of the end sections of the chromosome at the time of cell division (just as the second car of the train will never reach a dead end and will stop at a distance equal to the length of the locomotive). As the cell prepares to divide, the enzyme DNA polymerase runs along the chromosome to make a copy of it. If the chromosome has a ring structure, the enzyme successfully completes a full circle, and the ends of the copy stick together to form a chromosome for a new cell, which can occur with an infinite number of divisions and transfers [13].

Thus, it becomes obvious that along with vaccination, the genetic fragments of other people – the parents of aborted babies-are introduced into the body; secondly, through the matrix RNA constructor that edits the human genome, interference is carried out in the God-given nature of man; thirdly, it can be argued that a new, unprecedented, artificial species of humanity is being created. It is clear that none of these postulates fit into the canonical foundations of all world religions.

It is clear that these and some other ambiguously understood aspects related to vaccination have not only a narrow medical and biological dimension; they are also included in certain socio-ethical and spiritual-ideological meanings. It is no coincidence that recently the number of publications of opponents of vaccination and covid-dissidents has sharply increased. And the presence of the most contradictory information only scares off a part of the population, especially some priests, whose opinion people listen to, have a negative attitude to vaccination for the above and other reasons. For example, in February of this year, a round table meeting "All-Russian vaccination or a threat to national security" was held in Moscow, organized by the famous actress, covid-dissident, as she identifies herself, Maria Shukshina. It should be noted that although there were constructive ideas in the speeches, especially in terms of the popular explanation of the biological mechanisms of vaccination, but still a negative intonation in the evaluation of vaccination was evident. This is confirmed, for example, by the speech of the molecular biologist E. G. Kalle. On the one hand, she expertly and popularly explained the principle of the vaccine: the vaccine created on the classic platform carried the killed virus, and when it entered the body, our immune system recognized it completely. Since 2000, the virus platform has changed. Now the new vaccine is really a genetically engineered product based on a completely new principle – vector. Only one "detail" is taken from the virus, and our immune system must recognize the pathogen from it. And to do this, an instruction is written, which in the form of DNA is refueled in a vehicle, which is an adenovirus vaccine, and transferred to the cells. Moreover, this vehicle itself is equipped with a powerful mechanism for suppressing immune cells, which are our human defense system [14].

A person who is unfamiliar with genetics and molecular biology, and there are 99 % of people in our country, the deep mechanisms of vaccination will be incomprehensible, but the final part of the discourse, where we are talking about the destruction of the human immune system, will create a certain psychological dominant in the reader, which will finally form his attitude to vaccination (remember Stirlitz also drew attention to the fact that the last words and phrases are remembered). And until a person is explained in an accessible language the mechanisms and extent of the impact of vaccination on the immune system, he will not seek to make the coveted vaccination.

In our opinion, one of the reasons why a significant part of the population is rather inert about vaccination is the lack of clear information about such biological, bioethical and other aspects of this problem. In the modern information age, when everyone has access to the Internet, where there is a lot of the most contradictory information

about the coronavirus, a lot of publications of opponents of vaccination, only complete and reliable information from competent specialists can generate trust in a person. At the same time, such information should be voiced not only in specialized scientific journals, but also in the media and in the virtual space. Moreover, in genetics and microbiology, much is formulated only at a hypothetical level, it is not fully known, for example, how long a foreign gene acts, how many particles of coronavirus it produces in the body, it is not entirely clear whether the cells die or are embedded in the human genome. Instead of increasing awareness of the population about vaccination, about the mechanisms of its action, on the contrary, we have "restrictions on scientific discussions on vaccination issues" [11].

Conclusion

Thus, based on the results of the study, the following **conclusions** can be formulated:

- along with the important contribution of all faiths to the fight against the pandemic, it is necessary to note the untimeness and harmfulness of some theological discussions that do not contribute to the overall success in countering the coronavirus and do not stimulate the desire for mass vaccination of the population;

- the pandemic should be seen not only as a medical and biological dimension, but also as a social, humanitarian, spiritual and moral dimension. Therefore, all theoretical and practical issues should be solved taking into account the domestic and foreign confessional experience, in compliance with the principles of modern bioethics.

In this article, we have tried to raise some well-known ideological, philosophical and confessional issues and rethink them in connection with the functioning of religion in the context of the pandemic. Many of them are quite scrupulous for the believer and the clergy. And the state authorities at all levels, ensuring the epidemiological safety of citizens, should show tact, remaining in the legal field, and the denominations should treat the measures implemented by the state with understanding. After all, both for the state and for religion, human life and health are the highest values.

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НОВАЯ МОДЕЛЬ ЦЕННОСТНОГО ОТНОШЕНИЯ К ЖИЗНИ. ХОСПИСЫ И ПАЛЛИАТИВНАЯ МЕДИЦИНА

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Аннотация. В данной статье анализируются некоторые философские вопросы, касающиеся здоровья и жизни человека, связанные с паллиативной медициной и хосписами. Биоэтика помогает формированию новых ценностей в обществе, в национальном самосознании. Она значительно способствует гуманизации естественных и социальных наук, новых технологий, медицины и здравоохранения за счет перехода от естественных, медицинских, социальных и гуманитарных знаний к установлению баланса между наукой и моралью. Биоэтика как особая форма практической философии жизни учит, что взаимосвязь человека со своей собственной жизнью, со всей биосферой не только дискреционная, теоретическая и эмоциональная, но, будучи практическими отношениями, она всегда предполагает определенную оценку. Философский анализ проблемы эвтаназии показал, что философская мысль XX и XXI вв. рассматривает смерть не как нечто чуждое человеческому существованию, а как экзистенциальный компонент самой жизни. Причем философски трактуются не только граничащие вопросы жизни и смерти, но и экзистенциальные основы человеческой жизни, то есть свободы и ответственности. Идея достойного права человека на смерть сегодня активно обсуждается в двух направлениях: как проблема эвтаназии и проблема хосписов. В статье предпринята попытка дать философскую интерпретацию паллиативной медицине, корни которой уходят в средневековую культуру. В статье на основе исследования становления и развития биоэтики обосновывается положение о том, что императив современного человеческого существования требует качественно нового подхода к сложным, глобальным, разнообразным проблемам современности.

Ключевые слова: здоровье, здоровье как ценность, смерть, эвтаназия, хоспис, паллиативная медицина

Original article

THE NEW MODEL OF VALUE ATTITUDE TOWARDS LIFE. HOSPICES AND RELAXING MEDICINE

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Abstract. This article discusses some of the philosophical issues of life and health related to hospice movement and palliative, palliative medicine. Bioethics promotes the formation of new values in social and national consciousness, it stimulates significantly the humanization of natural and social sciences, new technologies, medicine and health care, make a transition between the natural, medical, social and humanitarian knowledge, as well as to establish balance between science and morality. Bioethics as a special form of practical philosophy of life teaches that human inter-relation with his own life, the whole biosphere is not only contemplative, theoretical and emotionless, but, being a practical relation, it constantly involves a certain assessment. The philosophical analysis of the problem of euthanasia has shown that the philosophical mind of the 20–21st centuries doesn't view death as an alien to human existence, but as an existential component of life itself. Not only the problems of life-death bordering situations are implemented philosophically, but also the existential bases of human life i.e. freedom and responsibility. Today the idea of a human's dignified death is discussed in two directions: as an euthanasia issue and the problem of hospices. In the article an attempt was to give the palliative medicine a philosophical interpretation, the roots of which can be found the Medieval culture. On the base of the formation

and development of bioethics in article is substantiated the position according to which the imperative of the contemporary human existence demands a qualitatively new approach to current complicated, global and various issues.

Keywords: health, health as value, death, euthanasia, hospice, palliative (palliative medicine)

Introduction. In modern society, the right to a dignified death is discussed in two directions: as a problem of euthanasia and as a problem of hospices providing palliative social-medical care to the dying. We find the roots of the ideology of palliative medicine in medieval culture, Christian worldview and ideology. At present, the modern human rights ideology has been added to them, which has confirmed the moral principle of respect for a person with respect for autonomy. Hospice's philosophy's practice has established new ethical approaches to caring for dying patients. Its essence is today concentrated in the bio-moral principle of the "right to a dignified death". There is a lot of talk today not only about the right to life, but also about the right to a dignified death [1, 2].

In the twentieth century, a special direction was developed within medicine – palliative medicine. The term "palliative" comes from the Latin word pallium (mask, blanket, cloak) [3, 4]. In other words, it assumes that the doctor must be able to take care of the patient, take him under his auspices. Palliative medicine practically confirms the value of human life until the last moment of life.

The main goal of palliative medicine is to seek to alleviate patients' pain, not only to provide medical but also moral assistance to patients and their caregivers [5]. Palliative medicine has developed a special attitude towards death as the last resort of human life, which should be lived with dignity. Undoubtedly, palliative care is the result of the humanization of traditional medicine, where the patient's suffering ends only in death. The main humanitarian idea here is to accompany life to death, to give a person the opportunity to leave life with dignity, and relatives to fulfill their last human duty to the dying.

"Good (dignified) death" is not only a humanitarian idea of palliative medicine, but also a philosophy of death. By providing the highest possible quality of life for the deceased (relieving pain, improving mental and emotional state, providing maximum comfort, the ability to communicate with loved ones, etc.), palliative medicine practically confirms the value of human life until the last moment of life. From the philosophical point of view of death, palliative medicine embodies the idea of light death, but not in the sense of euthanasia, but in the sense of supporting the deceased's efforts to endure suffering and pain.

The principles of palliative care have been fully realized in the establishment of hospices [6, 7]. The term originated from the English hospice (nursing home, divine home, shelter). The tradition of setting up a nursing home where dying people could be housed dates back to medieval Europe. Such houses operated near monasteries. The first shelter for medical and psychological care for the dead was established in London in 1969. It is named after a Christian saint, Christopher, whose name literally translates as "Christ-bearer". This meant that these institutions were called to carry out the messages of Christian mercy in daily life. 1969 opened St. The Christopher Hospice was also the first educational and charitable institution.

Hospice does not mean just a hospital. Hospice is based on the idea of anti-hospitalism. Being sick in a hospice, one should not feel isolated from the world, cut off from social reality. In palliative medicine, the bio-ethical and philosophical foundations are no less important than the medical one. The basic idea is to help people get out of life with dignity. By the way, the "human right to a dignified death" was nominated and based on the works of the classics of British philosophy Francis Bacon and John Locke. They introduced the principle of "accompanying life to death". The hospice movement currently solves not only medical and social rehabilitation problems, but also has a serious moral and psychological impact on public life. One of the key elements of the philosophy of death is the idea of humanity. "Compassion for the dying is reflected in the growth of humanity in various spheres of society" [5].

The activities of hospices are fraught with many challenges that are common to all post-Soviet health care. One of the main ones is the outflow of staff, very insufficient funding, etc. And although there are many people in this field who work at the behest of the soul and not for the sake of salary, nevertheless, the issue of staff shortage has not been resolved. Or they add to the state budget allocations benevolently.

However, in addition to the lack of staff, insufficient funding has created many new problems. The choice of palliative care horse largely depends on the capabilities of the country, city or region. Creating a palliative care unit next to a hospital is not as costly as setting up your own hospice. The further development of this promising branch of palliative care directly depends on the solution of a number of economic problems.

In the West, palliative care is often provided at the patient's home. The possibility of that is conditioned by the high standard of living of the population – good living conditions, the opportunity to hire a nanny, etc. The situation in Armenia is completely different. Two-thirds of patients die not in the home but in the hospital. This indicates the low social standard of living of the population. Unfortunate living conditions, difficult relationships with relatives force such unfortunates to find their last refuge in hospitals and hospices [8].

Problems related to the organization of palliative care in modern Armenia can not be solved without the involvement of state non-budgetary funds. This is the only way to improve the quality of medical care and provide social assistance to the dying. The sponsorship of commercial, non-governmental organizations, foundations and other organizations can serve as a basis for

the material and social support to be provided to this group of patients. This field is not very developed in our country. Educational programs dedicated to palliative medicine have been developed and introduced in Armenian medical educational institutions [9].

The hospice movement has developed a number of principles that aim to create the conditions for dignified sick people to die with dignity. "You do not have to pay to die", "Hospice is the house of life, not death", "Hospice is another option of euthanasia", "Hospice is not the walls, but people who are compassionate, loving and caring".

This right was enshrined at the international level at the minimum standard of patients' rights back in 1981. (World Medical Association Lisbon Declaration of Patient Rights). Point "e" of that document says: "The patient has the right to die with dignity". "Palliative care can be provided to patients, both inpatient and outpatient, and medical staff are completing training in providing such care". The law of Armenia on the protection of citizens' health does not now enshrine the human right to "die with dignity" [2].

Palliative care is a relatively new phenomenon in Armenia. The Armenian Association for Pain and Palliative Care (ACE) was founded in 2003 and currently has 146 members, including mainly specialists from the National Oncology Center and various clinics in Armenia. HPAA joined the European Palliative Care Association in 2004. He is also a member of the Global Relief Alliance. APA is a member of the Council of Europe Working Group on Palliative Aid Organizations and is considered by the Council of Europe to be the main partner responsible for palliative care in Armenia.

From time immemorial, death has been regarded by civilized humanity as a crucial problem for the existence of the human individual. The fact of death has always had a special place in the philosophy of national culture. Concern about death has always been one of the values that strengthens the psyche of Armenians. Meditations on the inevitability of death are inseparable from the Armenian philosophical discourse on biomastics. Attitudes toward death have changed in modern society. It seems that modern culture tries to hide death from man, distracting him from thinking about it.

Conclusion. In the 21st century, biology has turned its face to the issue of death, which was previously blocked for in-depth research. At present, death is not an alien, external phenomenon of human existence, but a primary component of life itself. The existential basis of the philosophy of life – freedom and responsibility – is actively interpreted in the West. And this is fundamentally necessary for the discussion of such an urgent issue as euthanasia. In our opinion, euthanasia is not a choice between death and "life". The problem is that, in essence, euthanasia is a choice between 'death', that is, a torturous death, 'death without undue suffering'. This is the fundamental difference between euthanasia and suicide. But since it is about ending life in an unnatural way, the issue of euthanasia remains a hotly debated topic. In all cases, when it comes to euthanasia, it is always a matter of human voluntary choice. In modern society, special social-medical services have been created to help the dying patient. At the same time modern number of societal values have begun to be reinterpreted: now more often they speak not only about the right to life, but also about the human right to a dignified death. The importance of the right to a dignified death in hospice goes beyond the medical reality and reflects the characteristic features of the caring life of modern civilization.

The limits of human individual existence are characterized by the existential values of life and death. Active entry into life has always been the subject of special care of the society, and the painless, easy departure from life remains a serious problem.

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УПРАВЛЕНИЕ УЧЕБНЫМИ БОЛЬНИЦАМИ В МАЛАЙЗИИ: ПРАВОВЫЕ ВОПРОСЫ И ЗАДАЧИ

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Аннотация. Больница – это учреждение, которое построено, располагает персоналом и оборудованием для диагностики заболеваний, для оказания медицинской и хирургической помощи больным и пострадавшим, а также для их временного проживания во время лечения. В целом, больницы в Малайзии делятся на две категории: государственные и частные. Другой тип больниц, которые служат центром исследований и обучения, называется учебной больницей. Помимо предоставления медицинской помощи пациентам, здесь проводятся клиническое обучение и подготовка будущих и текущих врачей, медсестер и других медицинских работников. Некоторые учебные больницы также занимаются исследованиями и являются центрами экспериментальных, инновационных и технически усовершенствованных услуг. Тем не менее в Малайзии не существует специального законодательства, регулирующего деятельность учебной больницы. Такая ситуация приводит к неопределенности в некоторых важнейших областях управления. Поэтому целью данного исследования является изучение правовых вопросов и проблем, связанных с управлением учебной больницей в Малайзии. Проводится тщательный доктринальный анализ для изучения пробелов в текущей правовой практике. Полученные результаты будут использованы для выработки рекомендаций по улучшению управления учебными больницами в Малайзии.

***Ключевые слова*:** учебная больница, управление больницей, Малайзия

Original article

GOVERNING THE TEACHING HOSPITALS IN MALAYSIA: LEGAL ISSUES AND CHALLENGES

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Abstract. Hospital, is an institution that is built, staffed, and equipped for the diagnosis of diseases; for the treatment, both medical and surgical, of the sick and the injured; and for their housing during this process. Generally, hospitals in Malaysia are being categorized into two categories which are: public and private. Another type of hospital that serves as a centre for investigation and teaching is known as a teaching hospital. It provides clinical education and training for future and current doctors, nurses, and other health professionals, in addition to delivering medical care to patients. Some teaching hospitals also have a commitment to research and are centres for experimental, innovative and technically sophisticated services. Despite its important roles, there is no specific legislation to govern the teaching hospital in Malaysia. This situation leads to uncertainties in some crucial areas of the governance.

Therefore, this study aims to explore the legal issues and challenges with regard to the teaching hospital's governance in Malaysia. A thorough doctrinal analysis is being conducted to examine the loopholes of the current legal position. The findings will be used to propose some recommendations for the improvement of the governance of the teaching hospitals in Malaysia.

Keywords: teaching hospital, hospital governance, Malaysia

1. Introduction

Throughout the years, many types of healthcare facilities were established to facilitate different functions and objectives of medical services. The most common types of hospitals are: public hospital, private hospital and teaching hospital. Public hospitals generally are owned and fully funded by the government. Thus it is expected to provide free medical care to their patients and if not fully free, certain subsidies and discounts are to be given.

In contrast, a private hospital is normally owned by a profit company or a non-profit organisation and funded by various sources such as the patients themselves, the government, and the insurers. They are generally known with exorbitant fees charged to their patients to enable them to cover the high medical costs incurred while at the same time ensuring the flow of profit to their stakeholders. Despite the expensive charge, it is still a preferred choice by many people who believe that the private hospitals are better in terms of services and facilities. Whereas, a teaching hospital is a place where two main functions are conducted: providing services to the general public in terms of healthcare treatment and at the same time facilitating the educations and training for future health practitioners.

Malaysia is one of the countries that established teaching hospitals that provide healthcare services to the public. In the year 2019, the number of beds in the teaching hospital in Malaysia has increased by 400 which resulted in the total number of beds in Malaysia's teaching hospitals amounting to 4,264. The additional 400 beds in the year 2019 had shown not less than a 10 % increase from the total number of beds Malaysia's teaching hospitals had prior to the year 2019 [1]. The total number of beds in the teaching hospitals is equivalent to 10 % of the total number of beds that public hospital in Malaysia has and is also equivalent to 27 % of the total number of beds in Malaysia's private hospitals. These percentages show that teaching hospitals are also playing a key role in providing healthcare facilities and services in Malaysia and at the same time are responsible for training the future healthcare professionals of the country. This percentage will keep on increasing in the near future since there are another three (3) teaching hospitals that are currently under development and are expected to begin their operation in the year 2021 to 2022.

With the statistics mentioned in the above paragraph, it is to be expected that a specific law should be in place to govern the teaching hospitals Malaysia. However, there is no specific legislation regulating the teaching hospitals. In general, the available laws only regulating public and private hospitals in Malaysia. The related legislations are listed in Table 1 below:

Table 1

Acts Relevant to Public Hospitals and Private Hospitals in Malaysia

Public Hospitals	Private Hospitals
Fees Act 1951 (Act 209) An act that stipulates the fees implemented in all public offices in Malaysia	Private Healthcare Facilities and Services Act 1998 (Act 586) An act that stipulates the rules that need to be complied in operating as a private healthcare provider in Malaysia as well as the relevant fees implemented in all private hospitals in Malaysia
Medical Act 1971 (Act 50) An act that regulates medical practitioners and the practice of medicine	

The newly developed teaching hospitals in Malaysia need to follow Act 586 for their structural plan as well as pre-operation development before the teaching hospitals are authorised to operate. Nevertheless, the said compliance stops there since once the teaching hospitals had gone into operation, most of their governing laws and legislations are constructed internally with the approval from its board of directors or any relevant authorities. This has led to some confusion in the general public especially with regard to the bills imposed on them as patients. Therefore, it is believed that all these problems can only be addressed if there is a proper legislation to govern the teaching hospitals in Malaysia.

2. Literature Review

Teaching hospitals are institutions that provide clinical education and training to doctors, nurses, and other health professionals in addition to delivering medical care to patients [2]. Some teaching hospitals also have a commitment to research and are centres for experimental, innovative and technically sophisticated services [3]. Accordingly, teaching hospitals have greater roles and responsibilities to be carried out considering the threefold functions that it carries out. This also means that various issues and challenges are faced by these hospitals. Some of the educational challenges include: decline of educational mission attendance, lack of educational facilities,

and non-compliance with educational standards. In addition, the therapeutic role of teaching hospitals by providing medical care and services to the general public have also its own sets of challenges. Concerns have been raised over the issues of quality of health services provision, lack of resources and facilities. On top of that, the role of teaching hospitals as research centres also poses certain challenges such as research structure, research quality in the hospitals, and low research facilities. On the other hand, there are also opportunities which should not be missed by teaching hospitals. Teaching hospitals provide bright prospects and potentials for research opportunities, medical specialist training, up-to-date medical facilities and the benefits of teaching hospitals to patients [4].

The growing number of teaching hospitals in Malaysia is obvious. Apparently, in Malaysia, there are currently six public teaching hospitals that are affiliated with their respective universities. Before the year 2019, Malaysia has only five teaching hospitals, which are UMMC, National University of Malaysia Medical Centre (HUKM), University of Science Malaysia Hospital (HUSM), International Islamic University of Malaysia Medical Centre (IIUMMC) and MARA University of Technology Teaching Hospital [5]. In 2019, a new teaching hospital was opened and known as University Putra Malaysia Teaching Hospital with another two universities that are still in development phases for the teaching hospital. From the first teaching hospital in Malaysia, which is UMMC in the year 1968, there is an increasing trend in Malaysia to develop its own teaching hospital for each public university that has a medical school or medical faculty in their courses offered. By taking this trend into consideration, there will be at least 11 teaching hospitals in Malaysia in the coming future. This has yet to include private universities that also offered medical studies.

Against these challenges, opportunities and growth faced by teaching hospitals, legislations are viewed as requisites for maximizing the benefits of teaching hospitals and simultaneously, minimizing any unwelcoming effect of such establishment. Any legislation in a form of an Act will become some form of guidance as well as a framework to the design and implementation of profound healthcare services [6]. The emphasis on the roles of legislations was found in a study carried out by Huang Biliu on the topic of hospital reform in China. The same study came up with six criteria that should be enhanced by the hospitals in China so as to be in line with the new healthcare reform [7]. One of these aspects is to improve the rules and regulations applicable in the hospital so as to ensure that the hospital is appropriately controlled. By doing so, it will then be able to enhance the management of the hospital. The same study, therefore, give emphasis on the roles of rules and regulations as a significant means to ensure better control and management of hospitals.

In view of the significant roles posed by the laws, Ghana sets out a specific legislation relating to teaching hospitals known as Ghana Health Services and Teaching Hospitals Act 1996 (Act 525). In fact, some amendments were made in recent times in order to improve the governance and management systems of the hospital [8]. It was believed that the same amendment would give the teaching hospitals in Ghana a new facelift as well as ensuring the mistakes done in previous teaching hospitals will not be repeated. It can also be seen on how the government of Ghana place much importance in the governance of teaching hospital in that country which led them to amend the current statutes to govern the hospitals.

The statutory requirement of teaching hospitals in Taiwan conforming to accreditation is another method of effective governance [9]. One of the rules that needs to be passed for any hospital in Taiwan to be accredited as a teaching hospital is by looking at its operation of the administrative system, operation of the medical education committee, budgeting and spending, and assessing teaching and research performance. From this, it can be said that the governing of the hospital by following a set of laws is essential in Taiwan to enable the hospital to be accredited as a teaching hospital. Accreditation to be a teaching hospital was also discussed in an article written by Ahmed Al-Kuwaiti and Fahd Al Muhanna [10]. The article has mentioned the legal and governance structure or support as one of the challenges that hospitals face to receive teaching hospital accreditation. From there, it can be concluded that for a hospital to be accredited as a teaching hospital, it needs to comply with the legality as well as to have support from the government and without it, the accreditation will become a failure. One article from Indonesia that is closely related to this topic has made the analysis about the concept of governance and corporate governance in Indonesian hospitals [11]. The article has compared the legality which is the law stated under Indonesia Hospital Law 2009 with the concept as well as on how the law contradicts each other in ensuring good governance in Indonesia Hospital. The article has later concluded that there is no clear definition of the term of corporate governance and governance in the hospital law.

3. Methodology

This study used doctrinal research to identify and determine the sources of law to analyse the legal doctrine and how it has been developed and applied (Singhal and Malik, 2012). References were made to journals, online journals, articles, and books to gain relevant, essential information and a deep understanding on the issue of governance of the teaching hospital in Malaysia. The study also utilised online databases such as Scopus, ProQuest, Lexis Nexis and the Current Law Journal (CLJ) using keywords 'teaching hospital', 'public hospital', 'private hospital' and 'hospital governance'. A thorough doctrinal analysis is being conducted to examine the loopholes of the current legal position. The findings will be used to propose some recommendations for the improvement of the governance of the teaching hospitals in Malaysia.

4. The Legal Aspects of Hospital Governance in Malaysia

4.1. Public Hospitals

Public hospitals in Malaysia are directly under the Ministry of Health. The operation of this type of hospital is totally funded by the federal government. Thus, they are subjected to rules and regulations set by the government or policies by the recognised government bodies. The following are some of the laws governing the public hospitals in Malaysia:

1. Fees Act 1951(Act 209).
2. Poisons Act 1952 (Act 366).
3. Sales of Drugs Act 1952 (Act 368).
4. Medical Act 1971 (Act 50).
5. Dental Act 1971 (Act 51).
6. Nurse Act 1950 (Act 14).

These above Acts will form the backbone in ensuring uniformity of policies and regulations among the public hospitals in Malaysia. Some of these Acts will also govern other types of hospitals in this country. One of the most common issues in the public hospitals is the fees charged to the patients. Since this is a prevalent public interest, a specific Act was established to ensure the synchronization between all public hospitals in Malaysia. The Fees Act 1951 (Act 209) was the first Act ever introduced to regulate hospitals in Malaysia.

Throughout the years, Act 209 has been amended and evolved to cater to the current social and economic situation in Malaysia. As of the year 2021, Act 209 has been amended for atleast five times. The orders are as follows:

1. P.U. (A) 47/2017: Fees (Medical) (Amendment) Order 2017.
2. P.U. (A) 304/2016: Fees (Medical) (Amendment) Order 2016.
3. P.U. (A) 87/2015: P.U. (A) 22/2014: Fees (Medical) (Full Paying Patient) (Amendment) Order 2015.
4. P.U. (A) 22/2014: Fees (Medical) (Full Paying Patient) (Amendment) Order 2014.
5. P.U. (A) 363/2014: Fees (Medical) (Cost of Services) Order 2014.

4.2. Private Hospitals

Private hospitals can be further explained in accordance with the types of ownership they were established. This is important as it will determine which laws and regulations a private hospital is subjected to before it can be established. In general, there are three types of ownerships and their related legislations can be seen in the following table:

Table 2

Types of ownerships and related legislations

Type of Private Hospitals Ownerships	Legislations
Sole Proprietorship	Registration of Business Act 1956
Partnership	Limited Liability Partnership Act 2012 (Act 743) Limited Liability Partnership (Amendment) Act 2015 (Act A1477)
Body Corporate	Companies Act 2016

Once the ownership of a private hospital is established, the second phase will need to be carried out: which is the development of building for the private hospital. All three (3) types of ownerships for private hospital will need to adhere to one (1) similar Act which is the Private Healthcare Facilities and Services Act 1998 (Act 586). Act 586 deals with the rules and regulations in approving the establishment and license to operate the business as a private hospital. This particular Act has also established various subsidiary legislation in ensuring that the establishment of private hospitals in Malaysia caters to the minimum acceptable standards as well as the quality needed. Besides Act 586, other laws and legislation relating to the establishment as well as the governance of the private hospitals are listed in the following table:

Table 3

Legislations for the establishment of a private hospital [12]

Legislations	Areas of Regulations
The Atomic Energy Licensing Act 1984 (Act 304)	Radioactive material, nuclear material and prescribed substances
Factories and Machinery Act 1967 (Act 139)	Steam boiler, unfired pressure vessel and machinery equipment
Uniform Building By-Laws 1984, Street, Drainage and Building Act 1974 (Act 133)	Land, certificate of completion and compliance of buildings and equivalent and signboard approval
Fire Services Act 1988 (Act 241)	Safety for fire exit
Environmental Quality Act 1974 (Act 127)	Environment safety and clinical waste management
Workers Minimum Standards of Housing and Amenities Act 1990 (Act 446)	Healthcare facilities for estate workers
Medical Device Act 2012 (Act 737)	Medical device
Pathology Laboratory Act 2007 (Act 674)	Pathology laboratory

Besides having a proper legislation, an enforcement agency is also important in ensuring the private hospitals in Malaysia follow the standard of quality required by the government. For this purpose, the Ministry of Health has established the Private Medical Practice Control Section (CKAPS) which one of its main functions is relating to the licensing of the private hospital. Further, the subsidiary legislations were also establish to regulate the operation of the private hospital including the maximum amount of fees that can be charged for every type of service provided to their patients [13]. The related subsidiary legislations are listed below:

1. P.U. (A) 260/2016: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2016.
2. P.U. (A) 358/2013: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013.
3. P.U. (A) 138/2006: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Order 2006.

4.3. Teaching Hospitals

Teaching hospital is affiliated to a medical school that provides practical training to medical students and graduated medical doctors. At the beginning, the teaching hospitals were always affiliated to public universities in Malaysia. Thus the earlier teaching hospitals were established under the Universities and College Universities Act 1971 (Act 30), similar to the public universities. They were being directly monitored and supervised by the Ministry of Higher Education (MOHE). The law has defined government healthcare facilities as any facilities used or intended to be used for the provision of healthcare services established, maintained, operated or provided by the Government but exclude privatized or corporatized government healthcare facilities [14]. Therefore, this definition excludes teaching hospital since it was established as a corporate entity under the public university. Recently, the teaching hospitals need to follow the legislations set out for a private hospital instead of a government hospital in its establishment phase. The related legislations are listed in the following table:

Table 4

Legislations for the Establishment of Teaching Hospitals

Legislation	Areas of regulation
Private Healthcare Facilities and Services Act 1998 (Act 586)	Approval and licensing of the hospitals
The Atomic Energy Licensing Act 1984 (Act 304)	Radioactive material, nuclear material and prescribed substances
Factories and Machinery Act 1967 (Act 139)	Steam boiler, unfired pressure vessel and machinery equipment
Uniform Building By-Laws 1984, Street, Drainage and Building Act 1974 (Act 133)	Land, certificate of completion and compliance of buildings and equivalent and signboard approval
Fire Services Act 1988 (Act 241)	Safety for fire exit
Environmental Quality Act 1974 (Act 127)	Environment safety and clinical waste management
Workers Minimum Standards of Housing and Amenities Act 1990 (Act 446)	Healthcare facilities for estate workers
Medical Device Act 2012 (Act 737)	Medical device
Pathology Laboratory Act 2007 (Act 674)	Pathology laboratory

Besides the legislation listed in the above Table, teaching hospitals in Malaysia have the autonomy to charge any amount of fees for their services. The teaching hospitals are not bound by either Act 209 (Chargeable fees for the public hospital in Malaysia) or P.U. (A) 138/2006 (Maximum chargeable fees for private healthcare facilities). Instead, a teaching hospital has the power to decide the fees amount own its own. The approval for the fees only needs to be tabled and approved by the teaching hospitals/ university's board of directors.

5. Legal issues and challenges

5.1. The Ambiguity in the Classification of Teaching Hospital

As previously mentioned, the category of teaching hospital itself is a confusion. At the beginning it was regarded as a public hospital, but later as a private hospital. At the end, it depends on individuals' interpretation in accordance to the purpose they wish to achieve. Due to this, there are times where teaching hospital was said to be a public hospital and should then be treated like one where it will enjoy all the privileges and exemptions as a government institution, but there are times where teaching hospital was regarded as a private hospital. Example of such situation was during the implementation of Goods and Services Tax (GST) in the year 2015, where Royal Customs Department of Malaysia had classified teaching hospital as a private hospital for the treatment of Government Services Tax (GST) [15]. This ambiguity will cause difficulty for teaching hospital as it is the very basic concept that needs certainty for proper governance of this institution.

5.2. The Necessity to Follow Private Medical Practice Division of the MOH Malaysia (CKAPS) in the Development of Teaching Hospital

The initial development phase of teaching hospitals involves a few stages in accordance with the guidelines stipulated under Act 586 [14]. Under the development phase, teaching hospitals need to follow the relevant standard of building requirements as set out in Act 586.

The development of teaching hospitals needs to follow the standard of hospital buildings and facilities as set out by the Private Medical Practice Division of the MOH Malaysia (CKAPS). This in accordance with Section 16 (1) of Act 586 whereby, the premises for the hospital need to comply with the building layout plan, design, construction and specification to which the approval to establish or maintain relates. All relevant equipment, apparatus, instrument, material, article, sample or substance or any other things found in the premises or any matter connected therewith shall also be in compliance with the standard set out by CKAPS. The floor plan requirements for the building as well as the design have been detailed out by CKAPS in a very detailed requirement that includes its size and length.

One of the issues with regards to this is that the standard that has been set out by CKAPS is relatively higher compared to the public hospitals. Since it involves higher standards, it has resulted in a higher cost in developing the teaching hospitals. This will automatically force the government to fund more money to complete the project. It has to be noted also that the higher the cost means the longer the time for the development of a teaching hospital.

5.3. Problems relating to Maintenance of Teaching Hospital at the operational stage

All teaching hospitals need to follow the standards set out by the Private Medical Practice Division of the MOH Malaysia (CKAPS) for the construction of the hospital premises as well as the purchasing of its equipment and apparatus. Complying with this standard will make the teaching hospitals in a better condition and quality as compared to the public hospitals. This will contribute to the higher cost of maintenance just like the private hospital which definitely has more money from the expensive fees they charge to the patients. However, in reality most of the teaching hospitals in Malaysia are actually a public hospital.

5.4. Problems relating to Licensing of Teaching Hospital for Operational Purpose

In ensuring that the teaching hospitals are always following the same standard as required by CKAPS, they should get the hospital registered and licensed under Private Healthcare Facilities and Services Act 1998 (Act 586). Even though they are constructed in accordance with CKAPS and licensed under Act 586, however this body does not have the enforcement power towards them as in reality they are not a private hospital. Due to this reason, the continuity of high-quality hospital premises is very difficult to achieve.

5.5. The Variation of Fees Charged in Teaching Hospital

As mentioned earlier, teaching hospitals have autonomy in deciding the fees that will be charged to their patients. This has resulted in each teaching hospital having its own set of fees to be used in charging its patients. Two teaching hospitals situated in the same state will not necessarily have the same fees charged for the patients of the same condition. This will cause confusion and difficulties to the public. For them, since most teaching hospitals are under public universities, they should be regarded as public hospitals.

Apart from the above problems, the difference in fees charged will also make it difficult for the relevant quality assurance body to monitor the teaching hospitals and to produce a ranking or rating between all teaching hospitals. Since the fees of these hospitals are not comparable to each other, it is not appropriate to relate the fees charged with the quality of services provided to their patients. Thus, a teaching hospital that charged their patients at higher fees could not be said to have provided better services as compared to a teaching hospital that charged lower fees.

6. Conclusion

The previous discussion highlights the milestones of healthcare law in Malaysia. Some important concerns over governing teaching hospitals were highlighted; ranging from classifying teaching hospitals, autonomy of teaching hospitals, financial sustainability, licensing to fees prescriptions. Accordingly, there is a dire need for legislations aiming to enforce legal conduct of teaching hospitals either by creating specific legislations on teaching hospitals or by incorporating relevant provisions into the current and existing laws. Developing such legislations can be settled by identifying and recognizing the stakeholders involved including enforcement agencies. The proposed legislations should also prescribe the right conduct and standards operating a teaching hospital considering the three-fold roles of teaching hospitals as centres for education, service provider and research. On top of that, in order to ensure the legislative effectiveness, the legislations should be able to facilitate proportionate penalties and sanctions.

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ЭТИЧЕСКАЯ ЭКСПЕРТИЗА НАУЧНЫХ ПУБЛИКАЦИЙ В МЕДИЦИНЕ: ЗАРУБЕЖНЫЙ ОПЫТ И РОССИЙСКАЯ ПРАКТИКА

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Аннотация. В настоящее время большое внимание уделяется корректному представлению результатов клинических и доклинических исследований в научных публикациях. Это не удивительно, поскольку международные стандарты оценки эффективности научной деятельности базируются на показателях цитируемости и количестве публикаций в рецензируемых изданиях. Данная традиция зародилась в Великобритании и явилась результатом борьбы за гранты в научном сообществе. Вариант оценки по индексу Хирша (индивидуальные авторы) и импакт-фактору (журналы) давал возможность количественного сравнения работ без обращения к их содержанию. Оценка последнего оставалась за редакциями журналов, и предполагалось, что она объективна. Данный метод соответствовал процессу цифровизации, но он до сих пор не получил этической оценки. Не только потому, что в научном сообществе существует достаточно большой разброс мнений по данному вопросу [1], но и потому, что моральные сюжеты вообще не комплементарны цифровым процессам.

Ключевые слова: наукометрия, медицинская наука, рецензируемый журнал, этическая экспертиза, статья, монография

Original article

ETHICAL EXAMINATION OF SCIENTIFIC PUBLICATIONS IN MEDICINE: FOREIGN EXPERIENCE AND RUSSIAN PRACTICE

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Abstract. Currently, much attention is paid to the correct presentation of the results of. This is not surprising, since international standards used for assessing the effectiveness of scientific clinical and pre-clinical studies in scientific publications activities are based on citation rates and the number of publications in peer-reviewed journals. This tradition originated in the UK and is the result of a struggle for grants in the scientific community. The Hirsch index (individual authors) type of assessment and the impact factor (journals) made it possible to quantitatively compare papers without referring to their content. The assessment of the latter was accomplished by editors of the journals, and it was assumed that it was objective. This method was consistent with the digitalization process, but it has not yet received an ethical assessment. This is happening not only because there is a fairly wide range of opinions on this issue in the scientific community [1], but also because moral plots are generally not referred to digital processes.

Keywords: science metrics, medical science, peer-reviewed journal, ethical expertise, article, study

Introduction. Publication activity is very high in the field of medical sciences. At the same time, there are several features associated not so much with the subject of research (the living organism of a Human!), but with the nature of research activities. As a rule, in the modern world, lone scientists are not found in medicine research,

but rather research teams, therefore, the publications are authored by the teams.

Example. For example, the article "The prevalence of wide qrs complex (≥110 ms) among the population, depending on sex, age and place of residence" in the Russian Journal of Cardiology (2020. V. 25. No. 6. P. 15-23) has 22 authors. (*Muromtseva G.A., Vilkov V.G., Shalnova S.A., Konstantinov V.V., Deev A.D., Evstifeeva S.E., Balanova Yu.A., Imaeva A.E., Kapustina A.V., Karamnova N.S., Shlyakhto E.V., Boytsov S.A., Nedogoda S.V., Shabunova A.A., Chernykh T.M., Belova O.A., Indukaeva E.V., Grinshtein Yu.I., Trubacheva I.A., Efanov A.Yu., Astakhova Z.T., Kulakova N.V.)* There are 0.3 pages per author.

This immediately raises a purely ethical question about the personal contribution of each author. In some journals, as we *results. Either patients develop resistance to a certain group of drugs, or there appear new microorganisms not targeted by the usual drugs. The (most famous) chronology of the emergence of new antibiotics can be cited: 1942 – penicillin G, 1950 – oxytetracycline, 1956 – penicillin, 1961 – ampicillin, 1988 – azithromycin, 2015 – teixobactin. Scientific research in this area is carried out simply: there is no response to therapy with a certain antibiotic, a new one is being developed. There are already six generations of advanced antimicrobial drugs. For example, penicillin was the first natural remedy, while the third or sixth generation is already an improved version, which includes the strongest inhibitors. The dependence is direct: the more recent generations of drugs are more effective on the pathogenic microflora. But this effect, as it turned out, is temporary.*

Recently, scientists started to talk of the end of the era of antibiotics – COVID19 has made significant changes in our understanding of what is active and what is not. For example, initially, a large role was given to azithromycin. Then, the Recommendations of the Ministry of Health of Russia (No. 10) adviced on limiting its use, and the latest Recommendations generally state its ineffectiveness in the treatment of COVID19. The question arises: perhaps it is not necessary to change individual drugs, but the concept? But this requires fundamental, not applied, research.

Usually, the results of fundamental research is presented in the study report form. But only articles in peer-reviewed journals are taken into account while assessing the effectiveness in modern science metrics. And in order to fulfill the "Hirsch plan" a scientist is forced not to develop a new concept, but to feverishly publish insignificant articles. If in other sciences this simply slows down new fundamental developments, in medicine it hinders a successful treatment of patients. This effect can be regarded as a violation of professional ethics, because a doctor does not use any new concept of therapy, but is constrained by the Standards and Procedures of medical care provision, which are very far from fundamental science.

It is not ethically justified that the science metric indicators are taken only from journals. Now it is mainly a database of publications in English. There are two key words – "journals" and "English". A database, which would include all publications, books and other publications for the scientific citations references, does not exist and, most likely, no one will create it in a foreseeable future. The books are published on GoogleScholar, the Web of Science, the main citation index, has also announced that it is going to integrate publications, but these are only early attempts. As a result, the subjects in which communications mainly takes place through research reports, have, so far, been excluded from the calculations (for example, medical humanities).

Many specialists, in particular in the studies of science, which is being displaced from the expert field by science metrics, believe that the journal system is outdated, since communication through social networks is faster and more efficient. That is, a situation may arise when scientists will exchange information through social networks, but publish reports in journals only in order to quote someone. Then Facebook will become the main means of communication, and journals – an attachment to it, where you can place "likes" (see about scientific journals at https://postnauka.ru/faq/12936). There are already studies showing that "likes" on social networks in natural sciences can predict subsequent citations in scientific journals with high accuracy, so that the information status of the Web of Science database can seriously deteriorate. Or it won't be needed at all.

And, finally, the third distinction of publication policy in medicine is the need for ethical examination of a scientific research before it is published. Here it is necessary to single out two areas of such expertise:

1. Ethical content of the publication itself (conflict of interest, compliance with the rules for the authors of this journal, the presence of borrowings)

2. Compliance with ethical standards in the study.

We will not dwell on the first item, as the methodology for analyzing published materials has been established and is approximately similar in all publications. As for the second item, there are a number of differences in different editions. Let's look at it closer.

First, we can refer to the specialized bioethics journal "The American Journal of Bioethics" [2], which rules can be considered as a model of ethical requirements in the area discussed. The journal differs from others as it does not send an author to the ethics committee for the compliance confirmation, but conducts an examination (in a reduced form) in the process of submitting the material and reviewing:

*"**Complying With Ethics of Experimentation***

Please ensure that all research reported in submitted papers has been conducted in an ethical and responsible manner, and is in full compliance with all relevant codes of experimentation and legislation. All papers which report in vivo experiments or clinical trials on humans or animals must include a written statement in the Methods section. This should explain that all work was conducted

with the formal approval of the local human subject or animal care committees (institutional and national), and that clinical trials have been registered as legislation requires. Authors who do not have formal ethics review committees should include a statement that their study follows the principles of the Declaration of Helsinki".

The reference to the Helsinki Declaration is typical here. The reference to the Convention on Human Rights and Biomedicine (Oviedo) might be more convincing, but the journal is American and the Convention is European. In addition, an extremely general requirement to refer to the Declaration is alarming. It is obvious that in each specific study it is necessary to provide a justification for the use of specific provisions of the Declaration. Experience reveals that young researchers, when submitting documents to the ethics committee, simply copy the list of documents necessary to ensure the ethical correctness of the research. In any case, the experience of LECs (local ethics committees) shows an amazing uniformity in this part of the documents presented.

A distinctive feature of this journal is a separate provision on ethical guarantees for subjects:

*"**Consent***

All authors are required to follow the ICMJE requirements on privacy and informed consent from patients and study participants. Please confirm that any patient, service user, or participant (or that person's parent or legal guardian) in any research, experiment, or clinical trial described in your paper has given written consent to the inclusion of material pertaining to themselves, that they acknowledge that they cannot be identified via the paper; and that you have fully anonymized them. Where someone is deceased, please ensure you have written consent from the family or estate. Authors may use this Patient Consent Form, which should be completed, saved, and sent to the journal if requested".

It is important here that the journal emphasizes adherence to the principle of patient autonomy as the basis for the publication of the relevant research. Moreover, an IC (informed consent) form considered appropriate by the editorial board is attached. It should be noted that in Russia, for example, there is no universal accepted form of IC. The order of the Ministry of Health of the Russian Federation approved such forms a) for IVF and b) for the provision of primary health care.

Example. *When asked where the form of IP used in research came from, graduate students usually answer: "It was given by a scientific advisor (or a colleague)". Doctors often answer to the same question as: "I have downloaded it from the Internet".*

In clinical trials, IP is approximately the same, but there are fundamental differences depending on the purpose of the study and the methods used.

Example. *CR (clinical research) involves invasive intervention with the removal of biological material or the removal of biological material in the process of routine medical care and the generation of organic waste (abortive material). The patient signs a consent for the intervention, but it does not contain information about whether the patient's biomaterial will be kept by the researchers or it can be transferred to other researchers or a bio-data bank. Ethics committees, as a rule, do not pay attention to such an addition, and the editors may require a special form from authors for such consent.*

Now let's look at how ethical requirements are presented in a specialized journal **"Pharmaceuticals"** [3]

*"**Institutional Review Board Statement***

In this section, please add the Institutional Review Board Statement and approval number for studies involving humans or animals. Please note that the Editorial Office might ask you for further information. Please add "The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Institutional Review Board (or Ethics Committee) of NAME OF INSTITUTE (protocol code XXX and date of approval)". OR "Ethical review and approval were waived for this study, due to REASON (please provide a detailed justification)". OR "Not applicable" for studies not involving humans or animals. You might also choose to exclude this statement if the study did not involve humans or animals".

Here, in essence, the requirements are the same, but they are addressed not so much to the authors as to the ethics committee, where the certificate of the examination must be submitted by the authors. The advantage of the paragraph provided is that the types of research are clearly identified and differences in the content of the expert opinion are noted in accordance with them. At the same time, the editorial office requires detailed justification for compliance with ethical requirements! But – again, a reference to the Helsinki Declaration is very general. The profile of the journal suggests referring to other documents such as the ICH GCP (Guideline for Good Clinical Practice), Doc. E6 (R1) v. 4 (International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use; ICH) etc. A stereotyped reference to the Declaration of Helsinki indirectly shows the journal's indifference to the issues of pharmacological ethics. And there are a lot of questions.

Example. *Russian researchers often cannot answer the question of where the animals for the experiments were taken from, that have not heard about the Five*

Rules of the Thumb, find it difficult to name the methods of euthanasia used in the study and are poorly informed that the reuse of animals in the experiment is strictly prohibited. This data contains in the analytical report of the chairman of LEK VolgGMU (Archive LEC VolgGMU, Analytics-3. 24.12.2020).

There is one more fact that editors of peer-reviewed medical journals might draw attention to. In medical loci, where CTs are rarely carried out, there is a practice of "pocket" ethics committees, which are created "for the research", and then "self-dismantles" [4]. In Russia, this is due to the lack of formalization of the documentation in education and LEC activities. In other countries, this is a consequence of simple pragmatism – why be distracted by working in an ethics committee, if it is not in high demand. But in fact, LEC is a permanently operating structure with a complete rotation of members every 3 years.

LEC always has an area to work on, not only for the examination of clinical and preclinical studies. Patients can apply to the committee with a complaint about the ethical attitude of the staff, medical staff can claim violation of professional ethics, obstacles or difficulties in organizing scientific work, etc. Only the continuity in the committee work can ensure the adequacy of the ethical review in accordance of the requirements of health care. Of course, it is not the task of the editorial office to check the work of the ethics committee, where the author's article was examined. But it has become a common practice in foreign peer-reviewed journals to request additional information about the expertise completed. These requests are random but it helps to improve the quality of published studies.

The situation with ethical review of publications varies in Russian medical journals. We have identified three groups in the reviewed journals. The first group has detailed ethical requirements for articles. They are not original; they are exact copies of the similar requirements in those foreign journals where the requirements are formulated. Still, in the Russian-language version, a correction is necessary, as there is a discrepancy in the interpretation of terms and stylistic errors as a result of direct translation. But this is not a drawback, a consensus in determining the ethical standards of medical publications is necessary, and this borrowing just contributes to the creation of a consensus in the scientific medical community on a wide range of issues. Let's give an example of requirements provided in the journal **"Pharmacy & Pharmacology"** [5]:

*"**Editorial Policies***

... 4.7.2. If the work involves the use of animal or human subjects, the author should ensure that the manuscript contains a statement that all procedures were performed in compliance with relevant laws and institutional guidelines and that the appropriate institutional committee(s) have approved them. When reporting experiments on human subjects, authors should indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. If doubt exists whether the research was conducted in accordance with the Helsinki Declaration, the authors must explain the rationale for their approach, and demonstrate that the institutional review body explicitly approved the doubtful aspects of the study. When reporting experiments on animals, authors should be asked to indicate whether the institutional and national guide for the care and use of laboratory animals was followed.

4.7.3. Authors should include a statement in the manuscript that informed consent was obtained for experimentation with human subjects, and it should be indicated in the published article. The privacy rights of human subjects must always e observed. Patients have a right to privacy that should not be infringed without informed consent. Identifying information, including patients' names, initials, or hospital numbers, should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that a patient who is identifiable be shown the manuscript to be published. Authors should identify Individuals who provide writing assistance and disclose the funding source for this assistance. Identifying details should be omitted if they are not essential. Complete anonymity is difficult to achieve, however, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of patients is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic pedigrees, authors should provide assurance that alterations do not distort scientific meaning and editors should so note".

Practically all aspects of ethical examination are taken into account here, and the requirements of the journal are confirmed by clear explanations. Special attention is paid to various aspects of the implementation of the principle of respect for patient autonomy, especially – the formulation of IP. It would be interesting to see how these requirements are implemented, since many researchers, lacking appropriate bioethical training, may regard them as excessive. In general, if there is a large number of editorial requirements, it is advisable to check their feasibility. So, in the given example, it is not obvious whether the expert of the ethics committee will check the work in such detail or will limit themselves to signing a positive conclusion. This remark is not a rebuke. Just that the training of ethics committees' members has not been established in Russia, so they act, at times, lacking necessary qualification.

The second variant of ethical requirements comes down to the obligatory mentioning and even listing them, but no specification as such. There is an informational minimalism. Here is an example from the journal ***"Experimental and Clinical Pharmacology"*** [6].

It is the main pharmacological journal of Russian Academy of Medical Sciences and Russian National Formulary society.

*"**Author responsibilities***

Credibility and study standards

If the manuscript is based on an original study, the authors must submit the reliable results of their work and an objective discussion of significance of the study. The manuscript should contain all the key data, accurate description of the study details and references in order to ensure reproducibility of the results. Data falsification or the intentionally invalid statements in the manuscript are regarded as unethical and are inappropriate.

Data availability

The Editorial Board can request the authors to submit raw data in addition to the manuscript. The author must be ready to provide public access to these data, provided that public access to the data violates neither confidentiality of the research participants nor rights of an individual or a company owning these data.

Originality, plagiarism, and citing the sources

Authors must submit only original studies. Authors must properly and accurately acknowledge the work of others. Publications that had significantly contributed

to preparing the study or underlied its design should also be acknowledged".

These are not re is no medicine here. These are requirements that apply to any specialized journal – technical, historical, chemical, etc. There are rules set for how an author should behave in relation to the journal, but no rules on the behavior with the subjects of a research. The requirements strictly correspond to the headings of the sections, only the coverage a medical article specifics as a separate section is not provided.

And, finally, the third group. These are journals where ethics, medical ethics, bioethics were not mentioned at all. So, for example, there is no corresponding section in the Rules for authors in the journal "Bulletin of the Volgograd State Medical University" [7], but it is included in the List of VAK journals, where articles of academic degrees applicants are published. Moreover, over the past 5 years (earlier issues have not been analyzed), not a single article in this journal has passed the examination of the LEK, while articles submitted to foreign journals undergo such an examination. The situation is similar with many local journals. But even in prestigious federal publications, the ethical examination of the submitted materials is either not mentioned, or, if mentioned, is not singled out as a separate block of requirements. For example, in the journal "Sechenovsky Bulletin" [8].

"... I confirm that I have received a written consent for using any personal data (of patients, other persons) in the study and I am ready to provide it at the request of the editors (only for describing clinical cases).

I confirm that the approval of the local ethics committee for the research development has been obtained...".

Everything seems to be correct. The editorial board fully trusts the ethics committee, as it has been working at Sechenov University for a long time and very successfully. But the journal also receives articles from other organizations, where the situation with ethical review may not be so professional. In addition, there are organizations where LEC does not exist or has a "pocket" nature, mentioned above. All this suggests the need for a unified approach to the ethical examination of scientific publications in medicine.

Conclusions:

1. Modern science metric criteria for the scientific and pedagogical staff member publication activity have its cons and prons. The positive sides include common grounds for quantitative analysis and the methods of such analysis implementation. To the negative – the probability of applying the same criteria in different fields of study (for example, in medicine and political science) and the lack of methods of qualitative analysis. A high citation index does not correlate with a high quality of what is cited. On the contrary, the scientific community can actively criticize the author for unreliability, lack of novelty and scientific approach, etc., thus increasing the Hirsch index of the criticised scientist. *This seems like a clear violation of scientific ethics.*

2. It is assumed that journals should be accountable for the quality of publications, since articles are peer-reviewed and, if published, the editorial board considers its quality to be high. But the science metric indicators of the journal, having nothing to do with the quality of the published materials, can be so high that a few frankly weak articles will not harm the prestige of the publication. *But what about the moral assessment of such a situation?*

3. The peculiarities of medical journal publications are their applied nature, team authorship and the availability of information that the research described in the article was not harmful for the subjects, whether animals or humans. Why is the share of basic research in medicine declining? Partly because they require a study publication form, and science metric indicators of current platforms such as Scopus, WoS, PubMed do not take this option into account. *The platforms do not display ethical attitude towards the authors.*

4. As for the ethical examination of the publication material, the editorial colleagues are content with information about its paragraph in the LEK. This information may be inaccurate, therefore medical journal editors should periodically check this information. *A block of information on ethical review should be required for the "Rules for Authors" section of any journal.*

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РЕГИОНАЛЬНЫЕ ВОЗМОЖНОСТИ И ЭТИЧЕСКИЕ РИСКИ МЕДИЦИНСКОГО ТУРИЗМА (НА ПРИМЕРЕ ВОЛГОГРАДСКОГО РЕГИОНА)

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Аннотация. В статье рассматривается медицинский туризм как перспективное направление современного здравоохранения в рамках реализации федерального проекта «Развитие экспорта медицинских услуг», части национального проекта «Здоровье». Автор изучает возможности регионального здравоохранения в рамках реализации проекта «Развитие экспорта медицинских услуг Волгоградской области». Приведены данные о численности и географии приезжих, финансовых поступлениях в региональный бюджет за оказание платных медицинских услуг. Описаны риски регионального здравоохранения, тормозящие развитие медицинского туризма, и указаны способы их избежания. На современном этапе развития российского здравоохранения оказание услуг медицинского туризма законодательно не оформлено, поэтому больше внимания следует уделять этическому регулированию в данной сфере.

Ключевые слова: здоровье, пациент, лечащий врач, медицинская организация, медицинский туризм, региональная модель медицинского туризма, этические риски

Original article

REGIONAL OPPORTUNITIES AND ETHICAL RISKS OF MEDICAL TOURISM (ON THE EXAMPLE OF THE VOLGOGRAD REGION)

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Abstract. The article examines medical tourism as a promising area of modern health care within the framework of the federal project "Development of the export of medical services", part of the national project "Health". The authors examine the possibilities of regional health care within the framework of the project "Development of medical services export in the Volgograd region". The data on the number and geography of visitors, financial revenues to the regional budget for the ensuring, paid medical services are presented. The risks of regional health care that hinder the development of medical tourism are described and the ways to avoid them are indicated. At the present stage of the development of Russian healthcare, the provision of medical tourism services is not legally formalized, so more attention should be paid to ethical regulation in this area.

Keywords: health, patient, attending physician, medical organization, medical tourism, regional model of medical tourism, ethical risks

Medical tourism, one of the most profitable types of modern tourism, which not only has a high growth rate, but is also a determining factor in the economic development of a huge number of countries around the world. It is no coincidence that fifty countries of the world consider medical tourism as one of the goals

of national policy, contributing to a new concept of health care, according to which any person can turn to another country for high-quality and timely medical care, if he cannot receive it in places of permanent residence [1]. Moreover, for residents of those countries where medicine is less effective than in developed countries, medical tours abroad are a necessary measure. At the moment, a global market for medical services has already been formed with its own infrastructure (medical management, accrediting bodies, and medical tourism and tour operators). These actions have led to the fact that today, according to the International Medical Tourism Association, about 11 million tourists travel annually for medical care, and according to the International Health Research Center Medical Tourism Index, the commercial medical services sector will reach turnover of 3 trillion US dollars; at the moment this market is estimated at 439 billion US dollars [2].

Drawing attention to the prospects for promoting medical tourism in the Russian Federation, President V.V. Putin instructed the Government to quadruple the export of medical services by 2024, bringing the volume of this market to one billion US dollars. The instruction was given within the framework of the decree of the President of the Russian Federation "On national goals and strategic objectives of the development of the Russian Federation for the period up to 2024" dated May 7, 2018 No. 204 [3]. The project "Development of the export of medical services" being implemented today is part of the national project “Health” calculated for the period from 2019 to 2024. The project involves 70 regions of the country with all medical institutions.

Since 2019, in the Volgograd region, within the framework of the national project "Healthcare", the regional project "Development of the export of medical services in the Volgograd region" (hereinafter – the regional project) is being implemented, focused on the development of extra-budgetary activities of state medical organizations, increasing their competitiveness and increasing the volume of exports of medical services , both for foreign citizens and for citizens of the Russian Federation living in other regions of the country. 20 leading state medical organizations have been identified to participate in the project. They provide dental, cosmetic services, infertility treatment, routine procedures and complex specialized operations, such as replacement of large joints, cardiac surgery, laparoscopic operations, cancer treatment, and diagnostic examinations. The selection criteria were the material and technical base of the institutions, the availability of trained personnel, the availability of highly qualified doctors, a decent level of service, the introduction of advanced medical techniques and technologies.

In order to receive the necessary medical care 1170 foreign citizens visited the Volgograd region in 2019. 1271 visiting patients were provided medical assistance in 2020; 561 foreigners – in the first half of 2021, and 1450 visitors are planned to be provided medical assistance. At the same time, the income from the provided paid services in 2019 amounted to 6.2 million rubles, in 2020 – 7.8 million rubles (data provided by the Volgograd Oblast Health Committee). Most often, our region is visited by citizens of Azerbaijan, Tajikistan, Uzbekistan, Armenia, and Ukraine for treatment.

With an obvious increase in the number of visitors, we can talk about the problems that medical organizations face today when organizing work for attracting foreign patients to regional medical organizations. And in each of these problems, one can find the ethical risks of implementing a program to attract medical tourists. These problems include:

1. Low awareness of foreign citizens about the possibilities of receiving medical services on the territory of the Volgograd region. Here it is necessary to resolve the issue of who is the subject of such information, to exclude a conflict of interest and increase the personal responsibility of informants.

2. Absence of a simplified procedure for obtaining visas for foreign citizens entering the territory of the Russian Federation in order to receive medical services. In this matter, the ethical arrangement of the process of obtaining a visa can only be auxiliary; the problem must be solved in the legal field.

3. Absence of an internationally recognized system of internal quality control of medical care in medical organizations on the territory of the Russian Federation. In this regard, the ethical requirements for the quality of medical services should be more stringent, it would be good if ethical committees of medical organizations would monitor these processes. Unfortunately, their system has not been developed in our country yet.

4. Communication barriers between potential medical tourists and healthcare professionals (for example, lack of full-time translators, lack of translation of information pages of websites of Russian medical organizations). It is obvious that this is a violation of elementary ethical standards; therefore the slogan "We speak your language" should become valid in every medical organization.

5. Lack of professional liability insurance of a medical organization. The issue of professional liability insurance for medical workers has not yet been resolved; therefore, the harm caused to the patient through no fault of the doctor is compensated in different ways, long and unsatisfactory. It is possible to introduce as a mandatory item the insurance of its employees by a medical organization in the regulation on licensing it for the provision of medical tourism services

6. Lack of a system of interaction with foreign insurance companies. There are no ethical questions here, since the interaction itself is absent.

7. Low level of development of near-medical services due to the lack of interaction between the tourism sector and the health sector, as well as government regulation

in the field of medical services (assistant company). From an ethical point of view, tour operators and clinicians should stop tug-of-war on the question of who is in the lead organizer of medical tourism, but to solve issues together. But this requires a special advisory body, although issues can be resolved with the assistance of the Medical Tourism Association.

In order to eliminate these barriers and advance medical services outside the Volgograd region, the Volgograd Region Health Committee has developed a set of measures, including:

1. Introduction of a system for monitoring statistical data of medical organizations on the volume of medical services provided to foreign citizens, including in financial terms into medical organizations of the Volgograd region. Within the framework of this event, a system of monthly monitoring of the provision of medical services to foreign and nonresident citizens by the number, cost of medical services, the territory of residence of patients, the profile of the medical service provided was introduced.

2. Conducting marketing research on the tourist market of medical services. As part of this event, the institutions assessed the main countries of consumers of services, existing and potential, taking into account the transport accessibility of the region, the presence of their own export potential for the implementation of a certain type of service.

3. Carrying out an information and advertising campaign, participation in interregional and international exhibitions.

Conclusions. Firstly, medical tourism is becoming not only in demand in the social life of modern society, but also as a competitive type of economic activity of the state. However, today there is a need to use foreign experience in the development of medical tourism to create a national flexible system, critical reflection, analysis and adaptation of the information received and their introduction into everyday practice.

Secondly, in order to achieve the intended results, it is necessary not only to create an adequate ethical and legal basis for the development of the area under consideration, but also to improve the condition of medical and preventive institutions capable of accepting foreign patients. In addition, the need arose for sociological monitoring of the professional activities of doctors in order to develop measures aimed at developing the creativity of doctors, their motivation for new forms of medical activity.

Thirdly, it is necessary to establish work with patient reviews on the Internet in order to form the image of a medical institution and expand the client base.

Fourth, in the coming years, the actions of the authorities will be aimed at strengthening support for the initiatives put forward by state and commercial medical centers, which will create the conditions for establishing the export of medical services, and therefore strengthening the prestige and competitiveness of regional healthcare in the domestic market of medical services.

Fifth, medical tourism is a significant factor in the development of healthcare, moral, ethical and professional qualities of doctors and tour operators, a factor in the development of international communication. The development of regional medical tourism is possible subject to interdepartmental interaction of all stakeholders and the creation of regional ethical committees of medical organizations providing medical tourism services.

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ЦИНИЗМ КАК ПРОЯВЛЕНИЕ ПРОФЕССИОНАЛЬНОЙ ДЕФОРМАЦИИ ЛИЧНОСТИ ВРАЧА

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Аннотация. Статья посвящена актуальной проблеме профессиональной деформации личности врача. В совокупности негативных характеристик эмоционального выгорания врачей одной из наиболее разрушительных является цинизм, проявляющийся в пренебрежительном отношении к культурным ценностям и общепринятым нормам морали и нравственности. Целью работы явилось осмысление природы социально-психологического явления «цинизм», установление факторов, способствующих его возникновению и преодолению. Материалами для исследования послужили научные статьи, опубликованные в научных базах данных: eLIBRARY.RU и cyberleninka.ru за 2003–2021 гг., а также работы русского писателя и врача В.В. Вересаева (1867–1945) и русского хирурга Н.И. Пирогова (1810–1881 гг.). В ходе исследования установлено, что цинизм, представляя собой ведущую и социально значимую проблему профессиональной деятельности врача, является приобретенной нежелательной личностной характеристикой. Авторами систематизированы факторы, влияющие на развитие цинизма, рассмотрены эффективные способы его профилактики и коррекции.

Ключевые слова: цинизм, профессиональная деформация, эмоциональное выгорание, врач

Original article

CYNICISM AS A MANIFESTATION OF PROFESSIONAL DEFORMATION OF THE DOCTOR'S PERSONALITY

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Abstract. The article is devoted to the actual problem of the professional deformation of the doctor's personality. In the aggregate of the negative characteristics of the emotional burnout of doctors, one of the most destructive is cynicism, manifested in a disdain for cultural values and generally accepted norms of morality and ethics. The aim of the work was to comprehend the nature of the socio-psychological phenomenon "cynicism", to establish the factors that contribute to its occurrence and overcoming. The materials that have been used for research were the scientific articles for 2003–2021 published in scientific databases such as eLIBRARY.RU. and cyberleninka.ru, and the scientific works of the Russian writer and doctor V.V. Veresaev (1867–1945) and the Russian surgeon N.I. Pirogov (1810–1881). The study found that cynicism, which is a leading and socially significant problem

of a doctor's professional activity, is an acquired undesirable personality characteristic. The authors systematized the factors influencing the development of cynicism, considered effective ways of its prevention and correction.

Keywords: cynicism, professional deformation, burnout syndrome, doctor

Introduction. Currently, in the context of revolutionary socio-economic transformations in the field of healthcare, fundamentally changing the basic principles of a doctor's work, and the emergence of a skeptical attitude of the population towards medicine and healthcare, an increasing number of doctors in the process of medical activity are exposed to the negative impact of professional deformation, among the manifestations of which a special place belongs to cynicism.

The situation is aggravated by the crisis of medical humanities, which is a complex of scientific and educational concepts that ensure the integration of medical theory and practice into the context of society. It is associated with the intensive development of new biotechnologies and a much slower process of developing explanatory hypotheses, regulatory regulators and social predictions of their use in medical practice. Such a lag can be regarded as natural, if not for the rapid pace of technological progress, orders of magnitude higher than all previous changes in the technological field. The resulting contradiction lies in the fact that modern society, interested in the humanitarian examination of the application of new biomedical technologies, simultaneously inhibits its development. From a philosophical point of view, it can be explained by the substitution of values, which consists in giving priority to technologies and secondary to awareness and understanding of the results of their application. A serious danger in such a situation is contained in the change in approaches to the training of medical personnel who will work with new biomedical technologies. Digital medicine requires skills, the acquisition of which is "taken away" in universities from "non-core" (mainly humanitarian) disciplines. As a result, the tendency towards dehumanization of medical education is growing every year in Russian medical universities [1].

The demands of society for specialists in the medical field are more and more emphasized on the postulate that the moral culture of a doctor is a component of his professionalism. However, only one academic discipline in a medical university is directly devoted to this problem – bioethics, which proclaimed the formation of a doctor's moral culture as the goal of bioethical education [2].

There is no doubt that professional training, general culture, breadth of interests and civil position of each medical specialist determine the level of socio-economic and spiritual development of modern society. At the same time, the reform of higher medical education clearly revealed the previously existing conditional division of the "holistic educational process" into educational (main) and educational (secondary) subprocesses. And although the main criterion in the training of medical specialists is professional knowledge, however, the determining factors for the success of medical activity are the formation, integrity of the personality and the moral character of the doctor [3].

The professional activity of medical specialists inevitably includes a moral dominant, which is realized in a deep understanding by "people in white coats" of their professional duty, in high professional and moral responsibility for the quality of the process and the results of their medical activities. Without a formed system of spiritual values, a person cannot work in medicine, since a doctor is not only a specialty, but also a vocation, the highest degree of service [4]. Society expects from a doctor not only professionalism, but also sensitivity, kindness, responsiveness, the ability to understand the feelings and experiences of patients, the ability to show concern, inspire hope, encourage people to fight the disease and come to the rescue at the moment when others need it. The development of all these qualities is a very important aspect of the formation of a doctor's personality [5].

The aim of the study was: comprehension of the nature of the socio-psychological phenomenon "cynicism", the establishment of factors contributing to its occurrence and overcoming.

Materials and methods: scientific publications of databases: eLIBRARY.RU and cyberleninka.ru. for 2003–2021, as well as the work of the Russian writer and doctor V.V. Veresaev (1867–1945) and the great Russian surgeon N.I. Pirogov (1810–1881).

The modern German philosopher Sloterdijk (born in 1947) sees the reasons for the emergence of cynicism in the failure of the Enlightenment. Its ideologists proclaimed the creation of a new enlightened society, where freedom, equality, brotherhood triumph, and a bourgeois society was created, with a cult of success, money, wealth, benefit, consumption. Therefore, Sloterdijk defines cynicism as "enlightened false consciousness" [6]. A.V. Gurov and P.I. Grigorenko emphasize the split of consciousness as the attributive properties of cynicism. "Cynicism", they write, "is a phenomenon of a split consciousness, a consciousness that has accepted the Enlightenment and humanistic ideas, but does not want to follow them, based on its own consumer considerations. Cynicism is a phenomenon of a new actual consciousness generated by a split" [7]. A.A. Goloktionova, N.K. Kuznetsov and N.A. Kudryavtsev see cynicism as a phenomenon of a glamorous civilization. "Let us take the liberty of suggesting", they write, "that the modern world is literally engulfed in cynicism. Now we are a glamorous civilization, enslaved by everyday life and busy with imitation of the present, claiming originality and novelty" [8]. In conditions of pluralism of value foundations, the individual faces the choice of one of the many life strategies and involuntarily turns into

someone who, rather, tends to reject the attitudes proposed by society, treating himself and others pessimistically, showing disinterest in any changes, otherwise in words, he turns into a cynic who evaluates everything from the point of view of its usefulness for himself. As a consequence, modern moral and ethical discourse has features of inconsistency based on emotivism and subjectivity, due to which moral judgments serve the egoistic preferences of the individual [9].

With an increase in professional experience, almost any person acquires character traits that are new for him and specific to the profession. In the process of performing labor activity, there is an accentuation of personality traits necessary in a certain profession, the profile of a professional's personality begins to distort, being exposed to stereotypical ways of professional behavior [10]. The process of mastering a specific professional activity by a person as a process of inclusion in the professional sphere, and, as a consequence, the acquisition of the necessary professional qualities is the essence of individual professionalization [11]. So, doctors over time acquire personality traits that distinguish them from people of other specialties. Obviously, the skills of a surgeon, a general practitioner, a gynecologist, or an administrative doctor must differ. But a person himself is far from always able to orient himself and make the right choice of specialty. This is often the cause of medical errors, burnout syndrome and, as a result, cynicism, which ultimately leads to patient dissatisfaction with the quality of medical care [11].

Burnout syndrome contributes to professional deformation, when defense mechanisms weaken so much that the employee cannot resist destructive professional factors and the process of personality destruction begins. Emotional burnout of doctors is characterized by common features of this syndrome, which can include emotional exhaustion (a feeling of emptiness, emotional saturation, physical and mental fatigue), depersonalization of the personality and a decrease in personal achievements (decreased self-esteem, increased self-abasement, feelings of failure and constant guilt) [12].

The phenomenon of professional deformation (from Lat. Deformatio – distortion) is defined as psychological disorientation of the personality, which is formed under the influence or pressure of external and internal factors, conditions of professional activity, leading to the formation of a specifically professional type of personality [7]. At the same time, there is a point of view that says that professional deformation is one of the forms of professional adaptation, which is a process of getting used to the performance of work duties that a person faces in the workplace. This is a dynamic process of destruction of stereotypes of activity with the accompanying formation of new beliefs, abilities and skills. As a result, there is a change not only in the level of professional competence from a specialist to a professional, but also a change in personality under the influence of this process [13].

Professional deformation is characterized by positive and negative manifestations. Positive characteristics include: responsibility, composure, organization, attentiveness, improvement personal culture, discipline.

Domestic philosopher D.G. Trunov (1965–2017) highlighted the main negative manifestations of professional deformation encountered by specialists in "helping professions" [5]:

1) projecting negative issues on yourself and your loved ones;

2) intrusive diagnostics of oneself and others ("labeling" and interpretation);

3) consulting others unnecessarily;

4) acceptance of the role of a teacher, paternalism in communication;

5) excessive self-control;

6) hyperreflexia and work on oneself;

7) loss of spontaneity;

8) rationalizing, stereotyping and reducing sensitivity to living experience;

9) satiety with communication;

10) emotional coldness;

11) cynicism.

The essence of cynicism is multidimensional, in connection with which the attention of researchers is focused on various aspects of its manifestation. In the aesthetic sphere, cynicism manifests itself as a kind of excessiveness, on the one hand, of comic artistic methods (irony, grotesque, sarcasm), especially characteristic of satire, pamphlet or caricature; on the other hand, as excessive naturalism (up to ugliness) in the depiction of social phenomena. In the ethical sphere, cynicism is a complex of stable ideas of the individual (worldview), which is characterized by the desacralization of certain spheres of human culture and of human existence in the world in general: humanity as a whole, the denial of spiritual values, morality and their use to manipulate people. In this sense, pessimism, nihilism, misanthropy, pragmatism (in its vulgar interpretation) are positioned as special cases of worldview cynicism [14].

According to the definition of the modern psychologist N.A. Vedmesha, "cynicism" is understood as behavior that manifests itself in an openly negative, contemptuous, nihilistic and dismissive attitude towards socially accepted foundations, cultural values, generally accepted norms of morality and ethics, notions of decency, official dogmas of the reigning ideology, and cynical behavior is expressed in demonstrative disregard for separate moral values. For the first time in vivid artistic images, medical cynicism was described by V.V. Veresaev in the book "Notes of a Doctor": "Before me more and more medicine was unfolding – a weak, powerless, mistaken, undertaking to treat diseases that he cannot determine, which he cannot cure in advance" [15, p. 7] and "... I more and more I began to get used to the suffering of patients ... this addiction gives me the opportunity to live and breathe, not to be constantly under the impression of the gloomy and heavy, but such an addiction of the doctor at the same

time outrages and frightens me, especially when I see him facing himself ..." [15, p. 89].

A prolonged stressful situation at work leads to professional cynicism: high workload, lack of support from colleagues and superiors, insufficient work assessment, lack of days off. When working with "severe patients": cancer patients, mental patients, elderly people, children from socially disadvantaged families, doctors may develop professional cynicism as a defense that saves life resources. This negatively affects the performance of professional duties. Getting used to the daily atmosphere of suffering, indifference to patients, skepticism towards science – these are the forms of professional cynicism.

The main manifestations of professional cynicism in medicine are:

- skepticism, critical attitude to the possibilities of medical science and their professional capabilities;
- depreciation of the value of a person on a "natural" basis;
- indifference and indifference to patients.

There are objective reasons for the formation of professional cynicism. It is the daily atmosphere of suffering and getting used to it; objective limited knowledge and skills of the doctor; forced trampling on elementary humanity (violence in psychiatry, overcoming bashfulness, experiments, autopsies); the ingratitude of patients, their injustice and even hatred in some cases. But knowing and experiencing all this on his own, it is extremely dangerous for a doctor to choose the path of "accepting" cynicism as a "way out" from this harsh reality.

Since a person is not biologically programmed for cynicism, he is morally free to choose good and "smart" suffering. And despite the fact that the activity of a doctor is full of difficult situations, it is nevertheless accompanied by satisfaction and joy. The only possible way to cope with the complexity of medical activity is to understand and accept all professional difficulties, to maintain sympathy, empathy, mercy through comprehension of the dialectic of opposition and unity of "sorrow and joy" [9].

The first attempt in the history of medicine to overcome cynicism in the work of a doctor is the Hippocratic Oath. One of the 10 principles of the oath, which says "I will conduct my life and my art purely and blamelessly" [6], is a statement underlying the high morality of a doctor. With this morality ness, according to Kant (1724–1804), cannot be due to either calculation or profit. Moral behavior, the philosopher argues, cannot have external motives at all. And the only internal motive for such behavior is only duty [1].

In the medical literature, a number of virtues are highlighted that are necessary for medical practice. All virtues are classified into four groups: virtues of character (courage, mercy, reliability, honesty, empathy); virtues of competence (complete possession and understanding of medical knowledge and methods, communication skills); virtues of conscience (self-giving, self-criticism, responsibility, self-development); general moral qualities (high moral values, respect for the patient, colleagues, modesty, benevolence). All of the above virtues are important for other professions, but in medical practice their significance is enhanced to a greater extent by the specifics of the activity itself, the highest value of which is human life and health.

The fundamental virtues of a doctor are such personal qualities, without which it is difficult to imagine medical activity, such as courage, determination, self-control, patience, discipline. Courage, as a cross between fear and courage, equates to the core that allows the doctor to make difficult decisions at crucial moments. Without this personality trait, doctors would not be able to diagnose seriously ill patients and carry out proper treatment, and drugs that are of paramount importance in medical practice would simply not be found. Along with courage in medical practice, decisiveness is also needed as the ability to mobilize strength and skills for the successful implementation of the necessary professional actions to assist the patient in critical and non-standard situations. A very important quality is self-control as the ability to control the emotional and physical state in such a way that negative emotions, thoughts and conditions do not interfere with working with patients in critical and emotional situations. Of no small importance is patience, which consists in the inner overcoming of difficulties, painful mental states that often arise in medical practice, prompting to perform their professional duties despite unfavorable events and circumstances. Discipline is a character trait or tendency of a person to follow the rules of work and norms of behavior. It is indispensable in medical practice, and is developed by the collective experience and actions of the medical community for optimal patient benefit.

The above personal qualities are most in demand when performing medical duties in especially difficult conditions: unsatisfactory material support, lack of necessary medicines and medical equipment, remuneration for work inappropriate to the costs of mental and physical forces, high loads, lack of time for rest, inability to regain strength, threat to life and health in conditions of epidemics, wars, natural and man-made disasters [16]. These are circumstances that increase the risk of cynicism, the opposite of which is altruism. This most important emotional and moral quality of a doctor is disinterested concern for the well-being of others, a willingness to help a person at the cost of giving up his own benefits and sometimes even risking his own life. Altruism is closely related to such moral qualities as heroism and mercy. Along with the above, medical practice requires exceptional tact, which consists in sociability, tact and delicacy.

Essentially important (even mandatory) for the doctor N.I. Pirogov considered a sincere solution to the main question of life – "to which of the three categories he ranks himself, what he believes and what he recognizes". Moreover, it is necessary to do this with maximum honesty, first of all in front of oneself: "You do not have to be timid in front of yourself, wag your tail and move back, and answer yourself ambiguously" [17, p. 153]. And the main thing here is to frankly answer the question of

whether he recognizes the existence of God and whether he believes in God: and physical" [17, pp. 153–154]. Spiritual and moral education of medical workers, achieving the unity of their values with patients will become the basis for the successful formation in the future of a new, partner model of moral relations in medicine, built on mutual understanding, respect and trust. And the spiritual and moral education of the population, carried out at all levels of the education system, will contribute to the development of these relations, acting as an important factor in the ethical regulation of the entire set of medical practices [18].

Spirituality comes to a person through literature, art, folk wisdom, customs, cultural traditions, especially families, science and education. A spiritually rich person always stands out even in everyday life. Striving for spiritual values helps any person to easily overcome life difficulties and obstacles, to live in harmony with society and nature. The moral and social maturity of a person is manifested in his education and culture, honesty and decency, indifference to the pain and suffering of others. These higher human qualities are extremely important for people who have chosen the profession of a doctor [12].

Spiritual and moral education of future doctors is an organizational and purposeful activity of teachers, parents and clergy in the formation of the highest moral values among students of medical universities. Spiritual and moral education is understood as the process of promoting the spiritual and moral formation of a person, the formation of: moral feelings (conscience, duty, faith, responsibility, citizenship, patriotism); moral character (patience, mercy); moral position (the ability to distinguish between good and evil, the manifestation of selfless love, readiness to overcome life's trials); moral behavior (readiness to serve people and the fatherland, manifestation of spiritual prudence) [19, 20].

Conclusions. So, in the conditions of modern society, the interests of the subject are biased towards private goals and needs. The subject, as a rule, does not want to sacrifice his own well-being for the sake of sublime goal-setting. He prefers to satisfy his own needs and his own desires, turning his interests into the sphere of material and personal.

Cynicism in the postmodern era takes on the form of a diffuse phenomenon that is significantly different from its classical prototype and therefore acquires new characteristics that require consideration and analytical description. As a type of reflective worldview, cynicism affects the deepest layers of the human psyche and the foundations of society. In this regard, there is a need for a philosophical analysis of the named type of worldview and related changes related to the social sphere, its functioning as a field of manifestation of the subject – the bearer of a cynical way of thinking.

Receiving the title of doctor and starting medical practice, doctors swear to devote all moral and physical strength, knowledge and experience to the protection of human health, to preserve and develop the traditions of domestic medicine, to be guided in their activities by moral principles. And I would like to think that for young doctors these will not be just words. The history of Russian medicine knows many examples of selfless service to their cause and the interests of society. Life is changing, new technologies and methods of examination and treatment come to medicine, but humanism and high moral and moral qualities of the doctor's personality must remain unshakable. So that the prestige of the medical profession in society does not fall, this baton of humanism and high moral qualities should be taken up by young people. Overcoming the negative impact of high psycho-emotional stress and the closely related risk of emotional burnout is possible only by developing the best human qualities.

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СОВРЕМЕННАЯ ЭТИКО-ПСИХОЛОГИЧЕСКАЯ КОЛЛИЗИЯ ИНФОРМИРОВАННОГО ДОБРОВОЛЬНОГО СОГЛАСИЯ (НА ПРИМЕРЕ ЧАСТНОЙ СТОМАТОЛОГИЧЕСКОЙ ПАТОЛОГИИ)

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Аннотация. Результаты анкетирования 129 родителей, детям которых было проведено оперативное вмешательство по поводу анкилоглоссии, показали: 67,5 % родителей считали, что врачи-стоматологи предоставили им достаточно полную информацию о данной медицинской услуге, но при этом только 25,6 % из них дали информированное добровольное согласие исключительно самостоятельно, а 74,4 % – после консультирований с другими людьми и/или ознакомления с иными источниками (среди последних, в первую очередь, фигурировал Интернет, где часто встречается тематически скандальная или алармистская информация). Соответственно, данную этико-психологическую коллизию следует учитывать врачам при реализации практики информированного добровольного согласия, а организаторам здравоохранения целесообразно более широкое публичное проведение мероприятий, посвященных актуальным медицинским проблемам как федерального, так и, особенно, регионального характера (с участием в них людей, представляющих самые различные, вплоть до диаметрально противоположных точек зрения по обсуждаемой проблеме).

Ключевые слова: информированное добровольное согласие, этико-психологическая коллизия, оперативное лечение анкилоглоссии, анкетирование родителей

Original article

MODERN ETHICAL AND PSYCHOLOGICAL COLLISION OF INFORMED VOLUNTARY CONSENT (ON THE EXAMPLE OF A PRIVATE DENTAL PATHOLOGY)

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Abstract. The results of a survey of 129 parents whose children underwent surgery for ankyloglossia showed: 67.5 % of parents believed that dentists provided them with sufficient information about this medical service, but only 25.6 % of them gave informed voluntary consent exclusively independently, and 74.4 % – after consulting with other people and / or getting acquainted with other sources (among the latter, first of all, the Internet appeared, where thematically scandalous or alarmist information is often found). Accordingly, this ethical and psychological collision should be taken into account by doctors when implementing the practice of informed voluntary consent, and healthcare organizers should better conduct public events on topical medical problems of both federal and, especially, regional nature (with the participation of people representing the most various, up to diametrically opposed points of view on the problem under discussion).

Keywords: informed voluntary consent, ethical and psychological conflict, surgical treatment of ankyloglossia, questioning of parents

Introduction. In accordance with the generally accepted vector of changes in the ethical and legal regulation of medical activity in the first decade of the 21st century, the active implementation of the principle of informed voluntary consent (IVC) begins in the national healthcare [1, 2, 3, 4]. After 10–15 years, due to the ongoing (and ongoing) institutionalization of this social practice, IVC has become an integral attribute of the treatment and diagnostic process. In particular, an informed patient agrees to the provision of one or another medical service (MS) by signing the corresponding document, or draws up a waiver of it (without giving consent to its provision). The practice of IVC is carried out practically with all MS of the most diverse orientation, which a priori implies certain nuances (for example, if MS turns out to be minor children, then IVC is given by their parents or legal representatives). In this context, it is of interest to consider the implementation in modern conditions of the practice of IVC in pediatric dentistry using the example of a particular pathology – performing frenectomy / frenulotomy (PF / F) in ankyloglossia.

In children, ankyloglossia is a common anomaly of the maxillofacial region (according to different authors, in 3–22 % of the child population), the correction of which involves surgical treatment – PF / F [5, 6].

Questioning the parents of 129 children who underwent PF / F with ankyloglossia (at the age of 3–6 years, this operation was performed 45.0 % of children, at 7–9 years old – 40.3 %, at 10–12 years old – 14.7 %; boys were 49.6 %, girls – 50.4 %) showed the following. The majority of parents – 67.5 % believed that dentists provided them with sufficient information about the upcoming operation; 17.8 % – that they were partially informed; 2.3 % – that there was practically no information and 12.4 % found it difficult to answer. 33 parents (25.6 %) gave their consent to this operation exclusively independently; 96 (74.4 %) – after consulting with other people and /or getting acquainted with other sources.

Agents of influence on the decision of these 96 parents to carry out the operation (it was possible to indicate several): other doctors in other medical organizations for 37.5 %; information found on the Internet – for 32.3 %; recommendations received on social networks – for 17.7 %; family members' advice – for 16.7 %; opinions of parents, whose children have already undergone a similar operation for – 14.6 %; advice from friends / girlfriends / colleagues who do not have medical education – for 6.3 %.

It turns out that the majority of parents (67.5 %) assessed the information provided by dentists about the upcoming operation as quite complete, but, nevertheless, 74.4 % of parents gave their consent to it only after receiving information from other sources. In this perspective, it is of interest to compare the results of the survey in the two groups. The first group consisted of parents who rated the information provided to them as "sufficiently complete" (87 people); among them, 27.6 % gave their consent to the operation exclusively on their own, not interested in other opinions, and 72.4 % – after consulting with other people, their advice or getting to know other sources (such as the Internet). The second group included parents who were critical of the information provided to them ("practically did not provide", "partially provided", "find it difficult to answer") – 42 people in total. In this group, 21.4 % agreed to the operation exclusively on their own, without being interested in other opinions, and 78.6 % – after consulting with other people, their advice or acquaintance with other sources. Thus, we can say that 3 out of 4 parents have expressed, to one degree or another, distrust of the information provided by doctors; at the same time, satisfaction with its volume or dissatisfaction was of fundamental importance (of course, this does not negate the need to implement the IVC principle).

It is also worth paying attention to the main agents influencing the decision of the parents (their consent or disagreement). It is clear that such agents of influence are mainly (but not the only) dentists. However, 32.3 % of parents in this context noted the information found "simply" on the Internet; 17.7 % – recommendations received on social networks. At the same time, the special literature has repeatedly summarized the critical assessment of these sources due to the frequent erroneousness of the information they contain [7, 8].

To a large extent, such a large number of references to the aforementioned electronic media is due to the fact that 20 years ago, when the principle of IVC really began to be implemented in domestic health care, the Internet was available to a limited contingent of Russians. The main types of media were television, newspapers, magazines, and radio. However, in the third decade of the 21st century, the Internet became generally available, and paper versions of newspapers and magazines practically disappeared, as did the "traditional radio hanging on the wall". At the same time, if earlier the materials of television, newspapers, magazines, radio passed a certain preliminary control, then on the Internet any information is possible, in particular the "most incorrect" opinion (most often for the sake of likes, HYIPs and increasing followers on Instagram). In fact, the Internet makes it possible to implement one of the fundamental principles of the functioning of the media on a much larger scale – scandalous or alarmist information attracts the most attention (in fact, thanks exclusively to the Internet, bloggers have appeared, the activities of most of which are based on this approach).

Conclusion. Based on the consideration of the situation with IVC in a particular dental pathology, it seems possible to draw the following generalizing conclusion. Even if consumers of medical services are satisfied with the information provided by doctors, most of them give their consent only after researching other sources, among which the Internet predominates.

It seems that the solution of the revealed ethical and psychological collision in principle implies at least two main directions. First, when implementing the practice of IVC, doctors should take into account that the information they provide will be cross-checked and therefore must be extremely complete and accurate. Secondly, there are contradictions between "official" and "unofficial" information in the media, with a growing distrust of Internet materials posted on the websites of federal and municipal structures. In this regard, it is advisable for healthcare organizers to conduct more public events on topical medical problems

of both federal and, especially, regional nature, with the participation of people representing the most diverse, up to diametrically opposed points of view on the problem under discussion.

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ЭТИКО-СОЦИОЛОГИЧЕСКАЯ ОЦЕНКА ОТНОШЕНИЯ К ВАКЦИНАЦИИ В МОЛОДЕЖНОЙ СРЕДЕ РОССИИ

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Аннотация. Затянувшаяся пандемия COVID-19 на фоне дефицита государственных ресурсов в сфере здравоохранения вызвала волну псевдонаучной информации в интернет-пространстве. Особенно подвержена такому влиянию молодежная среда, коммуникация в которой носит характер информационного хаоса. Для оценки отношения к вакцинации в молодежной среде России проведено социологическое исследование, N = 480, средний возраст – (20,8 ± 1,41) года. Согласно полученным данным, 36,71 % респондентов категорически против личной вакцинации. В то же время только 65,71 % студентов, давших отрицательный ответ, смогли объяснить свою позицию. Полученные результаты демонстрируют тенденцию к формированию в молодежной среде социально негативной моды – «вакцин-диссидентов». Проведен сравнительный анализ по проблеме отношения к вакцинированию в странах Европы. Рассмотрены официальные механизмы, предлагаемые ВОЗ для достижения справедливого доступа к вакцинам, в частности на примере Декларации о равном доступе к вакцинированию 2021 г. Показано, в чем заключается принципиальная разница – стигматизация невакцинированных за рубежом может быть спровоцирована неравенством к доступу вакцин, а не является протестным проявлением инфодемии, как среди молодежи России. В связи с этим возрастает востребованность социолого-психологического сопровождения профессионального образования, где в условиях образовательной среды представляются наиболее реальными и социологический мониторинг, и нравственно-психологическая коррекция. В таких условиях возрастает востребованность гуманитарного образования в медицинских вузах, позволяющего ориентировать на этические нормы и нравственные ценности профессии в рамках учебного процесса.

Ключевые слова: пандемия, вакцинирование, биоэтика, социальные группы

Original article

ETHICAL AND SOCIOLOGICAL ASSESSMENT OF ATTITUDES TO VACCINATION IN THE YOUTH ENVIRONMENT OF RUSSIA

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Abstract. The prolonged COVID-19 pandemic on the background of a shortage of state resources in the healthcare sphere, caused a wave of pseudoscientific information in the Internet. The youth environment is particularly susceptible to such influence, communication in which has the character of information chaos. To assess the attitude to vaccination in the youth environment of Russia, a sociological study was conducted, N = 480, average age (20.8 ± 1.41). According to the data obtained, 36.71 % of respondents are categorically against personal vaccination. At the same time, only 65.71 % of students who gave a negative answer were able to explain their position. The obtained results demonstrate a tendency to the formation of a socially negative "fashion" among young people – "dissident-vaccines". It is shown that the fundamental difference is that the stigmatization of those who are

not vaccinated abroad can be provoked by inequality in access to vaccines, and not a protest manifestation of infodemia, as among young people of Russia. Because of this, the demand for socio-psychological support of vocational education is increasing, where in the conditions of the educational environment, sociological monitoring, moral and psychological correction seems to be the most realistic. In such conditions, the demand for humanitarian education in medical universities is increasing, which allow to focus on ethical norms and moral values of the profession within the educational process.

Keywords: pandemic, vaccination, bioethics, social groups

Introduction. The COVID-19 pandemic dictates more and more strict strategies of combat at the global level. Each wave of virus spreading is a new examination for the national health systems, citizens dissatisfaction with endless lockdowns and new restrictive measures by the state is growing. In the winter of 2021, when the third wave began in Europe and the UK, it became finally clear that the expectation of natural population immunity would lead to huge losses and irreversible economic changes. The World Health Organization has declared vaccination as a priority strategy in the fight against the pandemic.

On the 18th January 2021 a Declaration on the Equality of Vaccination appeared on the official website of WHO, in the preamble of which the Director-General of WHO, Dr. Tedros Adhanom Ghebreyesus noted the importance, as well as the need to ensure the fairness of vaccination. Dr. Gebreyesus believes that achieving equitable access to vaccination is possible through the COVAX mechanism and the COVID 19 Technology Access Pool (C-TAP), because international mechanisms for the exchange of know-how, rapid production of vaccines in large volumes are already exist. COVAX, which unites more than 190 countries, has already ensured the production of 2 billion doses of vaccines in 2021. While by mid-October 2020, more than 40 candidate vaccines were just undergoing clinical trials, more than 150 others vaccines were at more earlier stages. Out of the top 10 candidate vaccines, companies or research institutes with headquarters in China, Germany, Russia, the United Kingdom and the United States participated in their development. The vaccines developed by Russian scientists were highly appreciated in the publications of the authoritative scientific publications "The Lancet" and "Nature", because on the June 2021 there is convincing evidence of the effectiveness and safety of the vaccine named "Sputnik-V".

At the same time, the overall coverage of vaccination among the population of Russia remains at an unacceptably low level. The third wave led to an increase in cases in the age group from 18 to 48 years. This indicates a serious threat to young Russians who determine the labor, creative and defense potential of the country.

The purpose of the research is an ethical and sociological assessment of the attitude to vaccination in the youth environment of Russia.

Materials and Methods. The empirical basis of the research was the materials of a sociological survey of students of the Volgograd State Medical University, N = 480, average age is (20.8 ± 1.41). The author's questionnaire was examined in the Department of Ethical, Legal and Sociological Expertise in Medicine sphere of the Volgograd Medical Research Center (No. 27/I-2021). The standards of confidentiality and autonomy of respondents were observed. The preliminary colloquy with explanations of the purpose of the research, clarification of the questionnaire questions and methods of conducting were carried out in the format of an online conference (Zoom platform), a sociological survey was conducted by using Google forms.

Mathematical data processing was carried out by methods of variational statistics with the calculation of parametric (Student's t-criterion) criteria of difference using the Excel application software package for Windows 17.0.

Results. Our research showed that only every second respondent (61.41 %, $p > 0.1$) clearly positively perceives vaccination as an effective strategy against COVID-19. 36.71 % of respondents are categorically against personal vaccination. At the same time, only 65.71 % of students who gave a negative answer were able to explain their position. Approximately the same results were obtained when distributing the respondents 'answers to the question: "When do you plan to be vaccinated against COVID-19?" (Fig.).

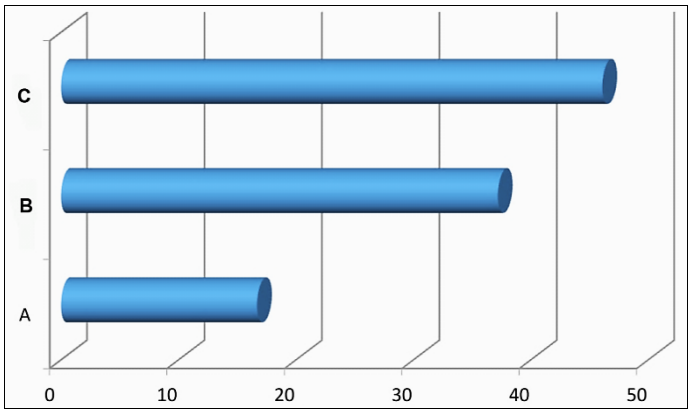

Fig. Distribution of respondents into groups depending on the attitude to personal vaccination.
On the abscissa axis: the number of respondents in %, On the ordinate axis: groups of respondents: A – want to be vaccinated in the near future, B – do not exclude the possibility of vaccination after longer-term data on the absence of side effects, C – categorically deny any possibility of personal vaccination

The attitude of medical students to the introduction of so-called vaccination passports reflects more their civil rather than professional position ("covid-passports", QR codes, certificates and etc.), allowing to move abroad and access to public places, which have already been approved in the countries of the European Union, introduced in a number of countries of the Pacific region, and at the end of May 2021 integrated into the practice of visiting public places in Moscow.

According to the results of a survey conducted by us in March 2021, the majority of respondents (88.2 %, $p < 0.01$) consider this approach unacceptable because of the possible stigmatization of the unvaccinated (for example, for people with medical withdrawals – 96.4% chose such a comment to the answer). Approximately half of the respondents (46.7 % of respondents) consider mandatory vaccination a violation of the rights and freedoms of a citizen.

Of course, the model group of respondents represents the youth population, which is generally inclined to negativism and conformism [1]. At the same time, the presence of initial biomedical knowledge in the study sample causes confusion about the spreading of "dissident vaccines" among future doctors. Of course, the influence of negative information from media is manifested, and for the youth environment, especially received from the Internet space.

At this moment, a whole campaign has been launched abroad against the introduction of the "covid-passports", which, in the understanding of ordinary people, merge with criticism of mandatory vaccination under pretence of the protection of human rights and freedom. On the one hand, the rhetoric appealing to ethical values always seems to be reasonable [2]. At the same time, the problem of discrimination, which was raised in the countries of the European Union, that have been seriously affected by the COVID-19 pandemic is primarily due to access to vaccines.

Despite the fact that there is an acute shortage of vaccines, the European Commission is studying proposals for the introduction of a vaccinated passport, for the opportunity to travel within the EU. Since, in most countries of the European Union, the vaccine is not yet available for most, travel – something that was common for Europe-becomes a privilege. While waiting for the vaccine, new forms of discrimination may appear among the unvaccinated, although they didn't even have such opportunity. At the same time, statistics confirm that vulnerable groups predominate among the unvaccinated, for example, pregnant women and children, for whom the vaccine hasn't yet been approved in most countries.

The identification of priority groups for vaccination (first-line) by European countries sometimes leads to surprise. For example, in Hungary, football players enjoy priority over the population [3]. But in most countries, medical workers who are in professional contact with unvaccinated patients enjoy priority in this matter.

A shortage of vaccines creates hierarchical relationships between groups of vaccinated and non-vaccinated people (for example, in a doctor-patient relationship or an employee-client relationship) [4]. As long as pregnant women and children are not vaccinated on national level, obstacles are creating in general for the family, for example, with regard to visiting public places and traveling. By doing so, the expensive demographic policy of recent years is put at risk [5, 6]. The slow process of licensing vaccines in the European Union worsens the situation, because it's difficult to gain confidence in vaccines that havn't yet been approved (for example, Russian ones). The Council of Europe has recognized that equal access to vaccination has crucial meaning. On the ethical and legal field new concepts are emerging – "immunity-privileges" and "vaccine nationalism". Because of this, human rights defenders in Europe oppose "covid-passports" and support measures that are not so popular, but accessible to the majority (including vulnerable groups), such as using of personal protective equipment, social distancing, etc.

At the same time, in Russia, as part of negative influence of the global infodemia, effect of Internet sources on the formation of a social fashion for vaccine dissidence feels [7]. The fundamental difference is that even in the countries of Europe there is a shortage of vaccines. In particular, related to the violation of contractual obligations by the biopharmaceutical company Astra-Zeneca. The Russian Federation is increasing the pace of reproduction of national vaccines that are available to everyone and professional groups. But one campaign for vaccination, without a convincing popular scientific (accessible to the population and focused on individual groups) arguments, doesn't seem effective.

Conclusion. The pandemic of a new coronavirus infection hasn't only initiated an unprecedented crisis in all spheres of society around the world, but also changed the approach to evaluating scientific research and implementing their results in practice. At the beginning of the pandemic, the measures taken by States were perceived axiomatically, trust in social institutions was based on the suddenness of the situation and the lack of medical knowledge among the population. The prolonged pandemic, against the background of a shortage of state resources, naturally caused a wave of paranientific information in the Internet space, broadcast by the mass media. The youth environment is particularly susceptible to such influence, communication in which has the character of information chaos.

In this regard, the demand for socio-psychological support of vocational education is increasing, where in the conditions of the educational environment, sociological monitoring and moral and psychological correction seems to be the most realistic [8]. In relation to medical education, the most optimal tool for such an impact is humanitarian education, which allows focusing on the ethical rules and moral values of the profession within the educational process [9]. Volgograd State University has established

a unit-department of the International Network of Bioethics Departments, which unites about 200 departments abroad, within the framework of which h there is a constant exchange of experience in bioethical education in various forms of international collaboration (a forum of bioethics teachers, joint research, publications, competitions for students).

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РЕДАКЦИОННАЯ ЭТИКА ЖУРНАЛА
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2.4.1. Неопубликованные данные, полученные из представленных к рассмотрению рукописей, нельзя использовать в личных исследованиях без письменного согласия Автора. Информация или идеи, полученные в ходе рецензирования и связанные с возможными преимуществами, должны сохраняться конфиденциальными и не использоваться с целью получения личной выгоды.

2.4.2. Редакторы должны брать самоотвод от рассмотрения рукописей (а именно: запрашивать Соредактора, Помощника редактора или сотрудничать с другими членами Редакционной коллегии при рассмотрении работы вместо самоличного рецензирования и принятия решения) в случае наличия конфликтов интересов вследствие конкурентных, совместных и других взаимодействий и отношений с Авторами, компаниями и, возможно, другими организациями, связанными с рукописью.

2.5. Надзор за публикациями

Редактор, предоставивший убедительные доказательства того, что утверждения или выводы, представленные в публикации, ошибочны, должен сообщить об этом Издателю (и/или в соответствующее Научное общество) с целью скорейшего уведомления о внесении изменений, изъятия публикации, выражения обеспокоенности и других соответствующих ситуации заявлений.

2.6. Вовлеченность и сотрудничество в рамках исследований

Редактор совместно с Издателем (или Научным обществом) принимают адекватные ответные меры в случае этических претензий, касающихся рассмотренных рукописей или опубликованных материалов. Подобные меры в общих чертах включают взаимодействие с Авторами рукописи и аргументацию соответствующей жалобы или требования, но также могут подразумевать взаимодействия с соответствующими организациями и исследовательскими центрами.

3. Обязанности Рецензентов

3.1. Влияние на решения Редакционной коллегии

Рецензирование помогает Редактору принять решение о публикации и посредством соответствующего взаимодействия с Авторами также может помочь Автору повысить качество работы. Рецензирование – это необходимое звено в формальных научных коммуникациях, находящееся в самом «сердце» научного подхода. Издатель разделяет точку зрения о том, что все ученые, которые хотят внести вклад в публикацию, обязаны выполнять существенную работу по рецензированию рукописи.

3.2. Исполнительность

Любой выбранный Рецензент, чувствующий недостаточно квалификации для рассмотрения рукописи или не имеющий достаточно времени для быстрого выполнения работы, должен уведомить Редактора журнала **«Биоэтика (Bioethics)»** и попросить исключить его из процесса рецензирования соответствующей рукописи.

3.3. Конфиденциальность

Любая рукопись, полученная для рецензирования, должна рассматриваться как конфиденциальный документ. Данную работу нельзя открывать и обсуждать с любыми лицами, не имеющими на то полномочий от Редактора.

3.4. Требования к рукописи и объективность

Рецензент обязан давать объективную оценку. Персональная критика Автора неприемлема. Рецензентам следует ясно и аргументировано выражать свое мнение.

3.5. Признание первоисточников

Рецензентам следует выявлять значимые опубликованные работы, соответствующие теме и не включенные в библиографию к рукописи. На любое утверждение (наблюдение, вывод или аргумент), опубликованное ранее, в рукописи должна быть соответствующая библиографическая ссылка. Рецензент должен также обращать внимание Редактора на обнаружение существенного сходства или совпадения между рассматриваемой рукописью и любой другой опубликованной работой, находящейся в сфере научной компетенции Рецензента.

3.6. Политика раскрытия и конфликты интересов

3.6.1. Неопубликованные данные, полученные из представленных к рассмотрению рукописей, нельзя использовать в личных исследованиях без письменного согласия Автора. Информация или идеи, полученные в ходе рецензирования и связанные с возможными преимуществами, должны сохраняться конфиденциальными и не использоваться с целью получения личной выгоды.

3.6.2. Рецензенты не должны участвовать в рассмотрении рукописей в случае наличия конфликтов интересов вследствие конкурентных, совместных и других взаимодействий и отношений с любым из Авторов, компаниями или другими организациями, связанными с представленной работой.

4. Обязанности Авторов

4.1. Требования к рукописям

4.1.1. Авторы доклада об оригинальном исследовании должны предоставлять достоверные результаты проделанной работы так же, как и объективное обсуждение значимости исследования. Данные, лежащие в основе работы, должны быть представлены безошибочно. Работа должна содержать достаточно деталей и библиографических ссылок для возможного воспроизведения. Ложные или заведомо ошибочные утверждения воспринимаются как неэтичное поведение и неприемлемы.

4.1.2. Обзоры и научные статьи также должны быть точными и объективными, точка зрения Редакции должны быть четко обозначена.

4.2. Доступ к данным и их хранение

У Авторов могут быть запрошены необработанные данные, имеющие отношение к рукописи, для рецензирования Редакторами. Авторы должны быть готовы предоставить открытый доступ к такого рода информации (согласно ALPSP-STM Statement on Data and Databases), если это осуществимо, и в любом случае быть готовы сохранять эти данные в течение адекватного периода времени после публикации.

4.3. Оригинальность и плагиат

4.3.1. Авторы должны удостовериться, что представлена **полностью оригинальная работа**, и, в случае использования работ или утверждений других Авторов, должны предоставлять соответствующие библиографические ссылки или выдержки.

4.3.2. Плагиат может существовать во многих формах: от представления чужой работы как авторской до копирования или перефразирования существенных частей чужих работ (без указания авторства) и до заявления собственных прав на результаты чужих исследований. Плагиат во всех формах представляет собой неэтичные действия и неприемлем.

4.4. Множественность, избыточность и одновременность публикаций

4.4.1. В общем случае Автор не должен публиковать рукопись, по большей части посвященную одному и тому же исследованию, более чем в одном журнале как оригинальную публикацию. Представление одной и той же рукописи одновременно более чем в один журнал воспринимается как неэтичное поведение и неприемлемо.

4.4.2. В общем случае Автор не должен представлять на рассмотрение в другой журнал ранее опубликованную статью.

4.4.3. Публикация определенного типа статей (например, клинических рекомендаций, переводных статей) в более чем одном журнале является в некоторых случаях этичной при соблюдении определенных условий. Авторы и Редакторы заинтересованных журналов должны согласиться на вторичную публикацию, представляющую обязательно те же данные и интерпретации, что и в первично опубликованной работе.

Библиография первичной работы должна быть представлена и во второй публикации. Более подробную информацию о допустимых формах вторичных (повторных) публикаций можно найти на странице www.icmje.org.

4.5. Признание первоисточников

Необходимо всегда признавать вклад других лиц. Авторы должны ссылаться на публикации, которые имеют значение для выполнения представленной работы. Данные, полученные приватно, например, в ходе беседы, переписки или в процессе обсуждения с третьими сторонами, не должны быть использованы или представлены без ясного письменного разрешения первоисточника. Информация, полученная из конфиденциальных источников, такая как оценивание рукописей или предоставление грантов, не должна использоваться без четкого письменного разрешения Авторов работы, имеющей отношение к конфиденциальным источникам.

4.6. Авторство публикации

4.6.1. Авторами публикации могут выступать только лица, которые внесли значительный вклад в формирование замысла работы, разработку, исполнение или интерпретацию представленного исследования. Все те, кто внес значительный вклад, должны быть обозначены как Соавторы. В тех случаях, когда участники исследования внесли существенный вклад

по определенному направлению в исследовательском проекте, они должны быть указаны как лица, внесшие значительный вклад в данное исследование.

4.6.2. Автор должен удостовериться, что все участники, внесшие существенный вклад в исследование, представлены как Соавторы, и не приведены в качестве Соавторов те, кто не участвовал в исследовании, что все Соавторы видели и одобрили окончательную версию работы и согласились с представлением ее к публикации.

4.7. Риски, а также люди и животные, выступающие объектами исследований, согласно Международному комитету редакторов медицинских журналов (ICMJE – «Единые требования к рукописям, представленным в биомедицинские журналы»).

4.7.1. Если работа предполагает использование химических продуктов, процедур или оборудование, при эксплуатации которых возможен какой-либо необычный риск, Автор должен четко обозначить это в рукописи.

4.7.2. Если в работе предполагается участие животных или людей как объектов исследования, Авторы должны удостовериться, что в рукописи указано, что все стадии исследования соответствуют законодательству и нормативным документам исследовательских организаций, а также одобрены соответствующими комитетами. При представлении клинических экспериментов Авторам следует указать, соответствовали ли эти процедуры этическим стандартам ответственного комитета по экспериментам человека (институциональным и национальным) и Хельсинкской декларации 1975 года, пересмотренной в 2000 году. Если существует сомнение в том, проводилось ли исследование в соответствии с Хельсинкской декларацией, Авторы должны объяснить обоснование своего подхода и продемонстрировать, что орган по институциональному контролю четко одобрил этот вариант или варианты исследований. При представлении результатов экспериментов на животных авторы должны указать, соблюдались ли институциональные и национальные рекомендации по уходу и использованию лабораторных животных.

4.7.3. В рукописи должно быть четко отражено, что от всех людей, ставших объектами исследований, получено информированное согласие, которое должно быть указано в опубликованной статье. Необходимо всегда следить за соблюдением прав на неприкосновенность частной жизни. Идентификационная (личная) информация, включая имена пациентов, инициалы или номера больниц, не должна публиковаться в письменных описаниях, фотографиях и генетических родословных, за исключением случаев, когда эта информация представляет большую научную ценность и пациент (или родитель, или опекун) дает письменное согласие на ее публикацию. Информированное согласие для этой цели требуется, чтобы идентифицируемому пациенту была представлена рукопись, подлежащая публикации. Авторы должны указывать лиц, которые предоставляют помощь в написании, и раскрывать источники финансирования этой помощи. Детализация данных должна быть минимальна, если она не является существенной. Однако полной анонимности трудно достичь, и информированное согласие должно быть получено, если есть какие-либо сомнения. Например, маскировка области глаз на фотографиях пациентов является недостаточной защитой анонимности. Если идентификационные характеристики изменены для защиты анонимности, например, в генетических родословных, авторы должны обеспечить уверенность в том, что изменения не искажают научный смысл, и это должно быть отмечено в рукописи.

4.8. Политика раскрытия и конфликты интересов

4.8.1. Все Авторы обязаны раскрывать в своих рукописях финансовые или другие существующие конфликты интересов, которые могут быть восприняты как оказавшие влияние на результаты или выводы, представленные в работе.

4.8.2. Примеры потенциальных конфликтов интересов, обязательно подлежащих раскрытию, включают работу по найму, консультирование, наличие акционерной собственности, получение гонораров, предоставление экспертных заключений, патентную заявку или регистрацию патента, гранты и другое финансовое обеспечение. Потенциальные конфликты интересов должны быть раскрыты как можно раньше.

4.9. Существенные ошибки в опубликованных работах

В случае обнаружения Автором существенных ошибок или неточностей в публикации, Автор должен сообщить об этом Редактору журнала **«Биоэтика (Bioethics journal)»** и взаимодействовать с Редактором с целью скорейшего изъятия публикации или исправления ошибок. Если Редактор или Издательство получили сведения от третьей стороны о том, что публикация содержит существенные ошибки, Автор обязан изъять работу или исправить ошибки в максимально короткие сроки.

5. Обязанности Издательства

5.1. Издатель должен следовать принципам и процедурам, способствующим исполнению этических обязанностей Редакторами, Рецензентами и Авторами журнала **«Биоэтика (Bioethics journal)»** в соответствии с данными требованиями. должен быть уверен, что потенциальная прибыль от размещения рекламы или производства репринтов не повлияла на решения Редакторов.

5.2. Издательство должно оказывать поддержку Редакторам журнала **«Биоэтика (Bioethics journal)»** в рассмотрении к этическим аспектам публикуемых материалов и помогать взаимодействовать с другими журналами и/или Издательствами, если это способствует исполнению обязанностей Редакторами.

5.3. Издатель должен способствовать надлежащей практике проведения исследований и внедрять отраслевые стандарты в целях совершенствования этических рекомендаций, процедур изъятия и исправления ошибок.

5.4 Издатель должен обеспечить соответствующую специализированную юридическую поддержку (заключение или консультирование) в случае необходимости.

6. Политика раскрытия и конфликты интересов

Неопубликованные данные, полученные из представленных к рассмотрению рукописей, нельзя использовать в личных исследованиях без письменного согласия Автора.

Информация или идеи, полученные в ходе рецензирования и связанные с возможными преимуществами, должны сохраняться конфиденциальными и не использоваться с целью получения личной выгоды.

Рецензенты не должны участвовать в рассмотрении рукописей в случае наличия конфликтов интересов вследствие конкурентных, совместных и других взаимодействий и отношений с любым из Авторов, компаниями или другими организациями, связанными с представленной работой.

7. Заимствования и плагиат

Редакционная коллегия журнала «**Биоэтика (Bioethics journal)»** при рассмотрении статьи может произвести проверку материала с помощью системы Антиплагиат. В случае обнаружения многочисленных заимствований редакция действует в соответствии с правилами COPE.

Aim and Scope

The Journal's aim is to generalize scientific and practical achievements in a field of bioethics.

Objectives:

- Coverage of new results in bioethics.
- Promotion of openness and availability of scientific works results of scientific and pedagogical workers, postgraduate students in bioethics field.
- Formation of a stable interest of scientific and pedagogical society, especially of beginner scientists to contemporary issues and problems of bioethics, covered in the Journal.
- Upgrade of professional level of medical, scientific, and pedagogical workers, by publishing original articles, results of researches on a wide spectrum of bioethics problems.

Enlargement of the audience of authors and readers building with the participation of Russian and foreign scientists and experts, who work in the bioethics field, as well.

«Биоэтика (Bioethics joural)» is an open access journal. All articles are made freely available to readers immediatly upon publication.

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ТРЕБОВАНИЯ И УСЛОВИЯ ДЛЯ ПУБЛИКАЦИИ

PAPER SUBMISSION GUIDELINES

Оформление статей согласно ГОСТ Р 7.0.7–2021

1. Основные сведения об авторе (приводятся на русском и английском языках) содержат:

– имя, отчество, фамилию автора (полностью);

– наименование организации (учреждения), ее подразделения, где работает или учится автор (без обозначения организационно-правовой формы юридического лица: ФГБУН, ФГБОУ ВО, ПАО, АО и т. п.);

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– электронный адрес автора (e-mail);

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Например:

Сергей Юрьевич Глазьев

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2. Аннотацию формируют по ГОСТ Р 7.0.99 на русском и английском языках. Объем аннотации не превышает 250 слов. Перед аннотацией приводят слово «Аннотация» (“Abstract”).

3. Ключевые слова (словосочетания) должны соответствовать теме статьи и отражать ее предметную, терминологическую область. Не используют обобщенные и многозначные слова, а также словосочетания, содержащие причастные обороты. Количество ключевых слов (словосочетаний) не должно быть меньше 3 и больше 15 слов (словосочетаний). Их приводят, предваряя словами «Ключевые слова:» (“Keywords:”), и отделяют друг от друга запятыми. После ключевых слов точку не ставят.

4. После ключевых слов приводят слова благодарности организациям (учреждениям), научным руководителям и другим лицам, оказавшим помощь в подготовке статьи, сведения о грантах, финансировании подготовки и публикации статьи, в рамках или по результатам которых опубликована статья. Эти сведения приводят с предшествующим словом «Благодарности:». На английском языке слова благодарности приводят после ключевых слов на английском языке с предшествующим словом “Acknowledgment”.

5. Основной текст статьи желательно структурировать из следующих частей:

– введение;

– текст статьи (с выделением разделов «Материалы и методы», «Результаты», «Обсуждение» и др.);

– заключение.

Надписи и подписи к иллюстративному материалу приводят на языке текста статьи и повторяют на английском языке.

6. Ссылки на источники литературы – в тексте указываются в квадратных скобках. Библиографические записи в перечне затекстовых библиографических ссылок нумеруют и располагают в порядке цитирования источников в тексте статьи. Перечень затекстовых библиографических ссылок помещают после основного текста статьи с предшествующими словами «Список источников». В перечень затекстовых библиографических ссылок включают записи только на ресурсы, которые упомянуты или цитируются в основном тексте статьи.

Списки источников представляются в двух вариантах:

1) в соответствии с ГОСТ Р 7.0.5-2008 (русскоязычный вариант вместе с зарубежными источниками).

Например:

Седова Н.Н. Образование в области биоэтики как интернациональная проблема // Биоэтика. 2012. № 2 (10). С. 22–26.
Деларю В.В., Туровская Н.Г. Специальная психология: учебное пособие. Волгоград : Изд-во ВолгГМУ, 2018. 164 с.
Шкарин В.В., Доника А.Д., Ягупов П.Р. Волгоградский опыт гуманитарного образования в медицинском вузе // Биоэтика. 2020. № 1 (25). С. 22–27.
Размышления о человеке: коллективная монография / В.И. Петров, Н.Н. Седова, Г.С. Табатадзе [и др.]. Волгоград : Изд-во ВолгГМУ, 2020. 188 с.
Donika A. Sociolodical studies in medicine: bioethical content (Russian experience) // Medicine and Law. 2018. Vol. 37, no. 2. P. 315–326.

2) вариант на латинице (References) представляет собой перевод на английский язык, повторяя список источников к русскоязычной части, независимо от того, имеются или нет в нем иностранные источники, оформляется согласно Vancouver Style.

Например:

Sedova N.N. Bioethics education as an international problem. Bioetika = Bioethics. 2012; 2(10):22–26. (In Russ.).
Delarue V.V., Turovskaya N.G. Special psychology: Textbook, Volgograd: Volgograd State Medical University Publishing House; 2018. 164 p. (In Russ.).
Shkarin V.V., Donika A.D., Yagupov P.R. Volgograd experience of humanitarian education in a medical. Bioetika = Bioethics. 2020;1(25):22–27. (In Russ.).
Petrov V.I., Sedova N.N., Tabatadze G.S. et al. Reflections on a person: collective monograph. Volgograd: Publishing house of Volgograd State Medical University; 2020. 188 p. (In Russ.).
Donika A. Sociolodical studies in medicine: bioethical content (Russian experience). Medicine and Law. 2018;37(2):315–326.

ПРИМЕР ИЗДАТЕЛЬСКОГО ОФОРМЛЕНИЯ СТАТЕЙ

Первая полоса статьи

Зерновое хозяйство России. 2020. № 2. С. 29–33.
Grain Farming in Russia. 2020;(2):29–33.

Проблемы и решения

Научная статья
УДК 633.15:631.521(470.61)
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Анализ сортовой структуры кукурузы, возделываемой на зерно в Ростовской области

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Аннотация. В статье представлена динамика урожайности зерна кукурузы в России и в Ростовской области. Определено, что наибольшее количество гибридов кукурузы возделывалось в 2018 г. из числа внесенных в Госреестр РФ за период с 2009 по 2013 г. (52 шт.). Определены популярные гибриды кукурузы, возделываемые в Ростовской области в 2018 и 2019 гг. Рассчитан удельный вес отечественных гибридов (сортов) в посевных площадях и отмечено стоимостное преимущество отечественных семян кукурузы.

Ключевые слова: кукуруза, урожайность, сортосемена, сортовая структура

Для цитирования: Арженовская Ю. Б. Анализ сортовой культуры кукурузы, возделываемой на зерно в Ростовской области // Зерновое хозяйство России. 2020. № 2. С. 29–33. https://doi.org/10.31367/2079-8725-2020-68-2-29-33.

Problems and solutions

Original article

The analysis of varietal structure of maize cultivated for grain in the Rostov region

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Abstract. The current paper presentes the dynamics of the maize productivity in Russia and in the Rostov region. An analysis is given of sown maize hybrids and varieties in the Rostov region according to the year of including them into the State List of the Russian Federation. It is determined that the largest number of maize hybrids was cultivated in 2018 from the number included into the State List of the Russian Federation for the period from 2009 to 2013 (52 pcs.). The most popular maize hybrids cultivated in the Rostov region in 2018 and 2019 are identified. The share of domestic hybrids (varieties) in the sown areas and the cost advantage of domestic maize seeds are calculated.

Keywords: maize, productivity, variety changing, varietal structure

For citation: Arzhenovskaya Ju. B. The analysis of varietal structure of maize cultivated for grain in the Rostov region. *Zernovoe khozyaistvo Rossii = Grain Farmimg in Russia*. 2020;(2):29-33. (In Russ.). https://doi.org/10.31367/2079-8725-2020-68-2-29-33.

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