United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

MUHS

Bulletin of GSMC MUHS UNESCO Bioethics Unit

October 2020

World Bioethics Day
Benefit and Harm
19th October 2020

Theme : 2020
Benefit and Harm

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GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
Benefit and Harm
19th October 2020

Poster Competition on
'Benefit and Harm'

First Prize

Nikita Rajendra Badhe Second Year Nursing,
LTMCH, Sion

Index:

Introduction

Advances in biomedical sciences have made ethical lens imperative for medical practitioners, researchers and society at large so that adherence to moral values of beneficence, justice, autonomy in medical practice and research are up held.

Warren Reich's encyclopedia of Bioethics defines Bioethics as *'an area of interdisciplinary studies'* concerned with systematic study of human conduct in the area of life sciences and health care. Dr. James Drane calls the discipline paradigmatic because the dilemmas force the scholars to examine the essential life and death questions in the context of medical conditions. Scholars from diverse disciplines like philosophy, theology, sociology, law, biomedical sciences alongside medicine have contributed to development of the field. With their contributions to the development of bioethics core principles since 1960s, these streams have been instrumental in guiding medical practitioners towards rights based approach to health. So in way it is a union of the two trees of knowledge- humanities and philosophy on one side and medicine and biosciences on the other; that leads to growth of an integrated approach towards not only human but also environmental well-being and growth.

The Oxford dictionary defines the word *'Inarch'* as a plant graft created by connecting a growing branch without separating it from its parent stock. The term conveys the spirit of synergy between the two streams. Hence we chose this name for our bulletin which will bring to you articles on bioethical issues by medical faculty, students, ethicists, philosophers.

Our bulletin is intended for undergraduate, postgraduate students in medical, paramedical subjects and nursing as well as practitioners and teachers. It aims to open up discussion on ethics of practice, research, curriculum content and advances in biomedical sciences.

Editorial:

This year is the year of reflection and introspection for mankind in many senses, as well as a testimony to victory of hope and resilience over despair and surrender. The year of COVID 19 taught us so many things about how with all advances in medicine, we are still far from invincible, how public health and civic sense are still neglected by common man, how the political systems have failed the poor and vulnerable whereas rulers were supposed to stand for the ruled and protect them. The internet was rife with the stories of communities labelled, ostracised and penalised due to political agendas.

Some new terms were coined this year. 'Corona warriors' was one of them. Initially fancied as a title, later it became a symbol of reverse oppression of the angels who were bestowed this title on. Out of fear, repulsion and sometimes the usual arrogance, the hitherto revered warriors were assaulted or discriminated against, their salaries were not paid, their fatigue and need for revitalisation not acknowledged. Besides the infections, mental health was the biggest issue in these warriors especially the residents doctors. The whole system runs on the efforts and sacrifice of the resident doctors who have united against the virus and multitasked effortlessly, keeping their fears away. Their sensitivity is the fraternity's gift to humanity.

The health systems fell short of resources for the chronic illnesses. Policy makers struggled with data and medical recommendations coming in by the hour, writing and rewriting advisories.
Invisible shadow pandemic of domestic violence - something that our society always ignores is a huge humanitarian issue.

How have the medical educators, practitioners and researchers responded to COVID?
On violence against women and trans people, medical fraternity has done lip service at the most.
Educators are silent too on this.

Mental health practitioners have responded positively to the needs of the communities. Numerous initiatives have been started with the community as well as with frontline healthcare providers and police.
Therapists too have adopted tele rehabilitation as a means of outreach. Nurses are working shoulder to shoulder with physicians to provide quality care.

Academic bodies of medical specialities have been conducting webinars to keep up continuing medical education activities. Undergraduate teaching too has taken a great setback and teachers of grappling with the challenge of creating human interface for hands on learning experience for trainees.
Researchers have new challenges conducting scientifically robust and ethical research within restrictions thrust by the pandemic.

This issue of INARCH deals with ethical issues surrounding COVID; but there are other issues that are very present like the periviable births and intervention and laws in relation to gender equity. Current edition of INARCH has tried to highlight these debates and dilemmas.

We hope that reading this issue makes for an interesting reading.

Dr. Padmaja Samant

United Nations Educational, Scientific and Cultural Organization · UNESCO Chair in Bioethics University of Haifa

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Message

It gives me great pleasure to know that the GSMC MUHS UNESCO Bioethics Unit is bringing out its Annual Bulletin INARCH 2020 as part of the World Bioethics Day celebrations 2020.
The World Bioethics Day celebrations are held on 19th October every year in conjunction with all the Bioethics units of the International network of the UNESCO Chair in Bioethics (Haifa). This year the theme chosen is Article 4 of the Universal Declaration on Bioethics and Human Rights, which is related to Benefit and Harm
.
I hope that this year's theme will give us all a chance to reflect on the importance of cultural diversity and pluralism and also reaffirm a commitment to human dignity, human rightsand fundamental freedoms.
I am sure that all the Units of UNESCO's Chair of Bioethics throughout the world will developa series of initiatives to reflect, encourage awareness, debate and involve an ever-increasing number of people, towards these important and fundamental concepts.
I wish the GSMC unit all the very best in their future endeavours and may they continue to carry the message of the UNESCO Chair forward in the days ahead.
Best wishes

Professor Russell D'Souza MD
Melbourne, Australia

United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

As the Head of the Indian Program of the International Network of the UNESCO Chair in Bioethics (Haifa), I wish to congratulate the Bioethics Unit of Seth G S Medical College for their active contribution to the Indian program. My commendation to Dr. Mariya Jiandani as the new head of the unit and her team for planning an elaborate program for the World Bioethics Day on Oct 18th, 2020. I wish theBioethics Unit of Seth G S Medical College success in all their future endeavors.

Dr. Mary Mathew
Head, Indian Program
UNESCO Chair in Bioethics (Haifa)

Municipal Corporation of Greater Mumbai

Seth G S Medical College and K E M Hospital, Parel, Mumbai

Dr. Hemant Deshmukh

Message

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I hope that this year's theme will give us all a chance to reflect on the importance of Benefit and Harm while providing medical care to the patients and in research.

I am sure that all the Units of UNESCO's Chair of Bioethics throughout the world will develop a series of initiatives to reflect, encourage awareness, debate and involve an ever-increasing number of people, towards these important and fundamental concepts.

I wish the GSMC unit all the very best in their future endeavours and may they continue to carry the message of the UNESCO Chair forward in the days ahead.

Best Wishes,

Dr. Hemant Deshmukh

Dean, Seth G.S.M.C. & K.E.MH.

Municipal Corporation of Greater Mumbai

Seth G S Medical College and K E M Hospital, Parel, Mumbai

Dr. Milind Nadkar

Message

The whole purpose of bioethics discourse is to understand disparities, inequalities, existing healthproblems of the communities by joining the dots and to provide healthcare which will maximally benefit the society. The main aim of medical profession is to provide best patient care by maximizing the benefits and by following the principle of 'Do no Harm'.

The theme for this year's 'World Bioethics Day' is "Benefit and Harm" which is most fitting in that context. The GSMC MUHS UNESCO Bioethics Unit and Students' Wing, Seth GS Medical College and KEM Hospital are actively involved in training of undergraduate and postgraduate students of our institute. There are many new and interesting events organized by this unit time to time that help the students to learn bioethics and inculcate good patient care practices.

It is heartening to witness that enthusiasticteachers and students of GSMC MUHS UNESCO Bioethics Unit are holding events and competitions based on the theme and alsoreleasing the annual bulletin – INARCH as per the tradition.

In today's fast paced world, it is vital that medical fraternity is aware of all the ethical dimensions related tohealthcare and bioethics unit of our institutions is working towards creating the awareness amongprofessionals and students

My best wishes to the Unit in all its endeavors.

MMN.

Dr. Milind Nadkar
Academic Dean,
Seth GS Medical College and KEM Hospital, Mumbai

THE NEW NORMAL - The story of Human Resilience

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Department of Physiotherapy,
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Background:

The month of March in Maharashtra generally coincides with the beginning of Hindu new year, and is Gudhi Padwa the first day is the most auspicious. However, this year in March 2020, the Hindu new year began with the 'new normal' - a worldwide lockdown with the COVID-19 Pandemic. Almost all socio-cultural-economic human transactions ground to a standstill. Restaurants, shopping malls, theatres, public & private transport, most industrial activities as well as many private health establishments were shut. The only people seen moving around were the health care providers, conservancy workers and our police force - all essential services- who were allowed to leave their homes in the service of society.

The situation which was initially considered as a passing one; brought about many changes in the way we live and interact with our environment. Health care focus shifted to prevention, containment and treatment of SARS CO V2 (COVID19). Health care infrastructure was continually modified, upgraded and expanded to admit those who would be affected. Open grounds were converted to domes, wards to ICUs. Continuous attempts were made to meet the ever increasing ventilator requirements. Social justice demanded that the resources be redistributed to save lives. Suddenly there was a change in health statistics of patients visiting OPDs and in hospital admissions as though the innate ability to heal themselves had strengthened.

Impact on mental health:

Risking one's own life and that of the family in the infection outbreak while performing duty is bound to cause lot of mental distress. These feelings needed to be respected. Fear of stigma and discrimination by the society on diagnosis or as potential carriers and ultimately fear of death were a few of the reasons of mental anguish. The thought of dying alone and not having a proper burial or cremation to satisfy the spiritual needs, warranted solidarity, care and compassion.

How people improvised-

- Allowing patients to talk to their relatives through video calls.
- Encouraging and training to maintain fitness during quarantine and isolation,,
- Accepting the disease and spreading awareness to modify the socializing habits
- Engaging themselves in activities that were long pending to learn, relearning simple tasks, hobbies and finding ways to contribute in family gave solace.
- Searching opportunities in the midst of danger.

As the focus shifted to the pandemic, those seeking rehabilitative services were badly hit. Those with non- communicable diseases, cardiac problems, chronic respiratory and neurological dysfunctions, vision issues; the pregnant, children and the elderly suffered too.

Impact on Rehabilitative services:

Owing to complete lockdown declared by the Government, transport, banking services were curtailed. As a result, many rehabilitation centres which were shut, temporarily and some even permanently. Lack of access and sensitivity to the need of those in need of rehabilitation left many with disabilities. The beneficial act of mitigation of COVID impact was being overshadowed by the harm

of loss of functional ability and freedom of movement. Patients who were operated before the declaration of the lockdown, who otherwise had to follow-up in the physical / occupational therapy OPDs, were unable to report. Planned Surgical Interventions were stalled and the pre as well as post-operative rehabilitation for such patients was put on hold. Patients with neurological dysfunction like hemiplegia and Parkinsonism who needed long term rehabilitation were unable to access rehab service. There were no private clinics running nor home visits by any therapists. Asthmatics, COPD, ILD , Tuberculosis patients did not dare to venture out. All cardio pulmonary rehabilitation patients who visited OPD regularly for nebulization, breathing and exercise were lost to follow up. Advanced Rehabilitation Centers of various specialities, including Asthma OPD, Neuro-OPD and musculo-Skeletal OPD reported negligible patient count owing to this lockdown. Fear of disease, Lack of transportation and financial issues constrained people from availing the skeletal services. In spite of facing deleterious health related issues, priorities of patients had now shifted to economic health. These multifactorial problems led to inadequate rehabilitation of the large spectrum of patients who were actually non COVID patients. The family members of these patients faced a lot of hardships; physical, because patients could not become functionally independent in the speculated time due to lack of rehabilitation, & psychological as a consequence of the COVID-19 pandemic.

Along with their regular medications and fixed daily/weekly expenditure, families were faced with an added expenditure now - that of acquiring masks, sanitizers, gloves and other protective equipments for the patients and caregivers. After 2 months of lockdown, the crisis heightened as there were no jobs. Persistent disabilities made patients unproductive for family and society. Some patients migrated to their native places as and when transport was available- these places mostly being small towns or villages with no rehabilitation services.

Tele-rehabilitation:

Though telemedicine is age old it gathered footage in the pandemic. Use of social media served as boon for the therapists to connect with patients and their relatives. As a mode of communication some patients were contacted through mobile (Voice & Video calls) and rehabilitation guidelines were given. This is how therapists started 'Tele-Rehabilitation', as a need of the hour. Patients became more receptive and responsible to follow and abide by the instructions given by the therapist, following home exercise program. Voice call, messages, WhatsApp call or video call all became a part of tele-rehabilitation program as approach to reach the patients. However it was the means only for those who had smartphone or those who could visit a centre to connect or with good network connectivity. Still, majority of patients remain unattended. Any physical form of exercise or instruction would compromise on safety leading to undertreatment.

Changing Lifestyles:

This Global Pandemic led to a rise of hardships and difficulties in each and every sector. Psychological distress was evident in all. Only source of communication, recreation or facilitation was on social media based on information technology. The IT sector, with long hours of work-from-home, started reporting health issues due to poor posture, long hours of screen time, sedentary behaviour , altered sleep habits and altered meal patterns.

With the gymnasia and public parks shut, outdoor physical activity was zero. Release of new television series and movies on popular internet channels made the entire population 'Sofa-ridden' as though there was no options at their disposal. Benefit vs harm needed to be balanced. Webinars, online schools and classes, work from home was the new norm.

Quality Time:

Working from home gave many a lot of spare time, and they started being involved in recreational activities, and were stress-free, at least for a short period after decades. Career-tied individuals who seldom had time for themselves and their families, got an opportunity to emotionally bond with their families. Hostel students who were away from their homes, and who managed to reach their homes well before lockdown, got a golden opportunity of spending quality time with their families.

Individuals who were 24x7 occupied with their work schedules, now had free time to focus and develop some hobbies, and to do what they always wanted to. Each one tried to give meaning to their life, the pandemic brought out resilience of mankind.

Looking back, looking ahead:

Nature healed itself with clearer skies and pollution free air to breathe, along with healing of mankind by building a sense of community. COVID 19 taught us to make hitherto unimagined changes overnight to sustain ourselves. It taught us to be adaptable and resilient minimizing our wants and needs. It showed new ways to serve others with care and compassion. Life did course correction to the **new normal** accepting the changes around teaching us to be more resilient. Whether the pandemic came as a boon in disguise only time can tell!

'Life doesn't get easier or more forgiving, we get stronger and more resilient.'

- Steve Maraboli

BENEFIT AND HARM : In the Context of Nursing as Profession

Sr. Tutor Vaishali Chavan
K.E.M.Hospital & G.S. Medical College

This year's World Bioethics Theme is Benefit and Harm. Let us consider these two frequently used terms in the context of healthcare, particularly Nursing Profession.

The bioethical principle of Beneficence (Benefit)states that the actions one takes should promote good. Beneficent actions imply sense of 'Not to harm' or 'working towards possible benefits while minimizing the risk'. The term also implies supportive appropriate action to safeguard the health of individuals including the providers.

- Levels of beneficence as an active intervention could be stated as [1]
- Not inflicting evil or harm.
- Preventing evil or harm.
- Removing evil or harm.
- Promoting good.

Benefit can assume one of the following forms in the context of healthcare –

a)Access to quality health care by performing daily task for patient who are unable to carry them out. This is a guiding principle for nurses.

b)Offer of new diagnostic and therapeutic modalities or the products of the research to detect and expeditiously address health problems.

c)Giving Right healthcare services at right time to the right people.

d)Updating self with scientific and technical knowledge as a guidance/to find out appropriate solutions to client's problems

e)Creation of adequate and safe research training facilities in all perspective is duty of the state.

f)Determining and implementing desirable standards of nursing practice.

g)Balancing of benefits of treatment against the risks and costs by selecting intervention that maximise patients' welfare also is a principle of social justice.

h)Promotion of the health, prevention the infection by universal vaccination.

Occupational safety as duty of the employers- Benefit and Harm .

Sets of rules are recommended in all states to minimize the job risk to employees; e.g.exposure to hazardous waste/environment ex: Bio-medical waste management comes under occupational safety.

Employer's administrative responsibilities are

- Creating and implementing standards and procedures to enhance employee safety- Infection Control Committee executes this duty.
- Safety research is undertaken for recommendations about planning of welfare.

Occupational safety and health review committee (OSHRC) in the United States reviews allegations of noncompliance with the standards contested by employers.[2]

No Harm– This principle states that avoiding harm to others or no harm or refraining from causing unnecessary harm.

It is unreasonable to expect a health intervention with zero potential harm but harm should not be disproportionate to the benefit of treatment. [3]

No harm may mean one or many of the following forms-

a) Protection of the health of communitye.g. Immunization: Prevention of harm
b) Maintenance of comfort by providing resources: Prevention of harm and promotion of wellbeing
c) Minimizing the pain and risk in medical interventions.
d) Moral justification behind why the harm may be or is caused e.g. Explaining the procedure in advance in case of research or interventions respectively. [4]
e) Preventing further harm to a patient/client, by providing (or seeking) urgent medical attention to prevent injury or death.
f) No defeating or setting back one person's interest through invasive action by another.
g) Moral obligation. e.g.- A psychiatric nurse's duty to keep patients' secrets.

The nurse may 'not act deliberately to terminate life'; however, the nurse and physician have a moral obligation to 'provide intervention to relieve pain via analgesic medication in a dying patient even if the intervention might hasten death'.This is also called double effect.[5]

Under the Occupational Safety, Health and Working Conditions Code 2020 -The code provides detailed instructions on cleanliness, disposal of waste, ventilation, maintenance of temperatureetc.- in work place. [6]

Every employeris obligated to protect his/ her employees against health hazard through

- Devoting adequate attention to working environment, sanitary facilities, waste management etc.
- Providing protective clothing and equipment e.g. PPE kit, mask, face shield, gloves etc.

Section 11 to 20 make up the health chapter of the factories act 1948 and ensure artificial humidification, avoiding overcrowding, provision of lighting, safe drinking water supply, latrines, urinals and spittoons for the employees.

Besides overlapping principles with other ethical mandates, we have briefly dwelt on 'Benefit and Harm' in nursing practice.

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'Nursing is not for the faint of heart nor the empty of heart.' – **Unknown**

Covid -19 Nursing Resource Management- Balancing Benefit and Harm

Arya Ajay Deshmukh
Sister Tutor K.E.M Hospital

Introduction

As COVID-19 is a new disease, vaccines and treatments are still in developmental stage. Behaviour and virulence of the virus was unknown for a very long time. Due to this, nurses face a risk of infection as well as immense work-related anxiety in dealing with COVID 19 patients. The rapid spread of COVID-19 poses a serious threat to human health and has severe impact on public health, global communications, and economic systems worldwide. Nurses are key members of healthcare teams charged with responsibility to control and prevent the spread of infectious diseases. Moreover, nurses are front line providers, in direct contact with individuals infected with COVID-19. Concerted efforts are necessary to develop strategic recommendations and to integrate new knowledge into nursing education. Here strategies of Municipal Corporation of Greater Mumbai in risk reduction for nursing personnel[1]

Education: We have been providing comprehensive education to nurses, and training content includes the use of personal protective equipment (PPE), hand hygiene, ward disinfection, medical waste management. We have prepared smart management what's app group to discus problem faced by nurses and to disseminate solutions for it.

Human resource management: With the rapid increase in the number of patients, which causes severe nurses shortages, it is extremely important to establish a scientific, reasonable nursing shift schedule. We have tried both- 3 shift schedules as well as 6 hours of continuous work; but problems do come in night shift management, and we have to break into it into two sub shifts. we have also provided nurses, accommodation in hospital campus to minimize exposure of their families. Working for 6 hours continuously pushes their physiological limits, as they require to ignore physiological needs when wearing PPE in the isolation area, and they often feel tired and dehydrated at the end of the shift. The risk of COVID-19 infection may cause significant psychosocial stress for nursing staff. Unfortunately, several young nursing staff members are infected with COVID-19.

Outbreak of COVID-19 has highlighted the risk of safety problems for healthcare providers and, especially, nurses. Human resource shortages during such outbreaks may be caused by infectious sources in the community as well as asymptomatic cases of infection among healthcare teams.[2] Policies from government and healthcare administration have helped to prevent the rapid spread of COVID-19 through measures including infection control education, protective equipment use, and isolating infected as well as suspect patients. Clinicians and nursing administrators play vital roles in developing and promoting effective anti-infection protective environments and strategies. Synergy and teamwork are helpful in this. Policies on employment benefits and incentives also help to increase staff retention during outbreaks .we have trained 3rd year G.N.M.students to work in pandemic situation. Some of our nurses have worked for community survey in Mumbai and also provided health education, screening services, and given support to general public and to individuals in high-risk categories.

How quarantine strategy benefits in COVID 19.

We have received quarantine strategy from our Community Medicine department for designed for

our nurses. To implement this plan special arrangements for accommodation for nurses were required. A separate building near the campus was identified to isolate the staff. Many NGO and donors helped in this exercise. This has helped the nurses to protect their families from COVID 19 infection. for students, isolation arrangements are made in hostel itself. Their emotional needs too are a big responsibility of the institute.

Role of Nurses in critical care:

Critical care nursing is not simply a list of services provided to critically ill patients; it requires the nurse to understand the complexities of each critically ill patient.[3] As a result of the COVID-19 pandemic, staff relatively less stressed departments hospital may be re-deployed to work in critical care units.

For optimum utilization of the workforce, a practical approach has to be adopted, the first choice for posting in COVID care are nurses with previous critical care experience or those with transferrable skills such as recovery nurses. Additional staff should be identified early and oriented to critical care before bed capacity is exceeded and before training becomes impossible due to lack of time. The aim must be to 'best match' the available skills with the acuity of patient needs, with supervision by a in charge nurse to maintain safe care. During the pandemic times, with staff shortage and increased beds, traditional staffing ratio recommendations may not be implementable. However, safe care must always be delivered.

An overall nurse-in-charge will manage a unit/ward, with the critical care medical team. With strained hospital services, maintaining an open or closed unit may br difficult. However, specialist input is sought from respiratory, cardiology, surgical and medical teams as appropriate. Strategic leadership is to be provided by the Matron and a consultant.

Key Challenges for Nursing Professionals and Nursing Teachers:

- Establishing Training program to train more nurses and nursing students to work in pandemic situation.
- Arranging webinars to provide knowledge to nurses.
- Preparing nurses and to work in critical care areas and give continued moral support in burn out.
- Managing effective and empathetic care in spite of shortage of ward servants and assistants.
- Handling distressed families with empathy.

Stressing upon dignity of the dead in nursing training.

These and other newer challenges like COVID 19 can be effectively managed with good team work and pragmatic management of resources.

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Impact of Online Teaching and Assessment on Teachers and Students of Medicine and Allied Health Science Courses during COVID-19 Pandemic

Dr.Praveen Iyer, Dr.Anjali Telang

Introduction

In the last few years, there has been a rapid rise of online teaching in every field. It has often been used to supplement the traditional classroom teaching.[1] This caters to the millennial generation of students who are technologically sound and appreciate online learning. However, due to the sudden occurrence of COVID 19 pandemic since the beginning of 2020, classroom teaching could not be held in colleges. Hence most of the colleges were forced to conduct online teaching, engage students and conduct assessments. The students also had no other option than to adapt themselves to these online learning and assessment methods. Online teaching and assessment of students of medicine and allied health science courses have their own benefits and harm.

Online sites support complex discourses and multiple relationships; they cross physical, cultural, and linguistic boundaries. Data of various kinds are automatically recorded in a relatively permanent form. The question that lingers in the minds of students and educators is whether online courses can give students the same discussion-rich, well-rounded learning experience as traditional "brick and mortar" classrooms can. [2]

While there is no question that online teaching can supplement the classroom learning, it is really a challenge to conduct the entire teaching of the curriculum in an online mode. The prevailing circumstances of COVID 19 pandemic provided an opportunity to students and teachers to take up this challenge and make it effective. Online teaching can be done in two ways viz synchronous where both the teacher and students are present simultaneously and asynchronous where teacher and students are not present simultaneously.

Asynchronous online teaching learning methods include discussion boards, quizzes, polls, email, recorded audio or video, recorded slides with narration etc. For this purpose, one can use platforms like google classroom, moodle, blackboard learn etc. Synchronous online teaching learning methods include virtual classroom, live presentation, live text chat, instant messaging, live audio or video chat, live quizzes etc. The platforms that can be used for synchronous learning include zoom, gsuite, Microsoft teams, webex, gotowebinar etc.[1,3]

Institutions across India took up the challenge to conduct online teaching and assessment for students of health science courses. There is variable availability of infrastructure, expertise of faculty and accessibility to the internet and resources amongst students of various institutions across the country. Hence there have been varying experiences of online teaching.

Local Context

Due to the sudden announcement of lockdown, when the outstation students travelled back home, little did they know that the lockdown would extend so long. They did not carry their books with them. Many of them stay in remote rural areas where access to high speed internet is an issue. Many of them do not have laptops or computers, hence, they had to depend only on their mobile phones for learning. It was a big challenge for many students who did not have access to high speed internet access. This became a big deterrent to conduct synchronous online teaching. Hence teaching was carried out by various departments using both synchronous and asynchronous methods. The students were also given periodic assignments in the form of MCQs, written tests to be submitted, pictorial quizzes etc. Interaction with teachers helped the students to clarify concepts and doubts of various topics. And finally, as per the university directives even the internal assessment exams were conducted online in an OPEN BOOK

Format.

Benefits of online teaching: General and in the current context

Generally, online teaching has the following benefits:

- Encourage student-centred learning
- Students do not have to commute and sit in a class continuously
- Students can learn at their own pace
- Techers can organize their content in a systematic way and deliver it in the current context of COVID 19 lockdown, the benefits are as follows:
- Students have been kept engaged in learning despite uncertainties of progress in academic year
- Students motivation has been kept up due to online teaching
- Periodic assessments have helped the students to gauge the extent of learning
- Asynchronous mode of teaching has been preferred and appreciated by the students
- Teachers have got the opportunity to explore different tools of online learning and enhance their skills in prepare educational resources for online teaching

Drawbacks of online teaching: General and in the current context

Generally, online teaching has the following drawbacks:

- Social environment of te campus is not experienced by the students
- Face to face contact amongst the teacher and the students is missing
- Practical skills are not imbibed in online teaching
- The interactivity between teachers and students is less and the feeling of learning together is missing
- Limited attention span and lack of attentiveness
- Lack of discipline
- Academic honesty of students in the assignments and assessment is questionable[4]
- Increased fatigue, headaches, lack of motivation, avoidance/procrastination ineffective time management, feelings of isolation due to limited socialization in-person, minimized awareness and understanding of others[5]

In the current context of COVID 19 lockdown, the drawbacks are as follows:

- Nearly one thirds of their syllabus was learnt exclusively through online teaching
- Students had to spend a lot of screen time for learning causing general fatigue and especially ocular fatigue
- Lack of 3 D orientation for certain subjects like anatomy made learning difficult
- Even a very honest student had a tendency to copy from books or from web resources in the online internal assessment examinations
- Teachers faced a lot of difficulty in assessing the student' submissions of assignments and assessment.

Conclusion

Online learning in medical education is a rreatively new concept and one which is rapidly expanding. The current circumstances of COVID 19 pandemic has provided an opportunity to explore online teaching methods far and wide. There are various benefits of online teaching but at the same time there a limitations, and it does cause some harms. But one can try and adopt good online teaching practices to increase their utility and have a sustainable impact on the learners. Online teaching-learning methods must match curriculum and objectives. They mustncourage synchronous and asynchronous teacher-student interaction. They must promote higher order thinking skills and communication skills. They must encourage active learning, teamwork and cooperation among students. They must encourage development of sf-directed learning. Online teaching must provide opportunities for formative assessment and have an inbuilt mechanism for prompt feedback.

Technology that is appropriate to the local contexts, with lower bandwidth cellular and online networks, will need to be considered and collaboration between institutions may have to be developed to optimize online medical education.[6] It is also important that medical colleges and their faculty are aware of the

barriers and solutions to the development and implementation of type of learning and of the need for a culture to be in place which strives to promote and support the use of online learning amongst staff.[7]

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Virtually nothing is impossible in this world if you put your mind to it and maintain a positive attitude."

- Lou Haltz

Impact of the Pandemic on Gender Discrimination: A Health systems Perspective

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Whenever man or family is under stress there is one shock absorber that works silently or suffers mutely to relieve the stress or divert the impact of stress- Woman!

Job losses, economic insecurity and frustrations of men and youngsters have inflicted high Gender Based Violence (GBV) stress on women and girls. Also already suffering women and girls are forced into confinement with their aggressors. This surge has been termed as Shadow Pandemic.

Lock down impact

Maternal health service:

Data released by National Health mission show staggering figures of reduction in maternal health service accessing / delivery. Detection of common pregnancy related morbidities like pregnancy induced hypertension, eclampsia, anemia was reduced indicating less women reached health systems.

Significantly less maternity related interventions also indicate the same.[1]

Abortion services:

As per data from various states in India, access to medical termination of pregnancy has been hampered due to lock down. Year on year percentage change for obstetric complications reaching health care services was -30.9 in March 2020. [1]

IPAS [2] has estimated that due to various effects of lockdown, ranging from supply of medical abortion drugs to transport to diversion of health services to COVID care; access to 1.85 million safe abortions was compromised. Of the restricted abortions, 80% are estimated to be due to reduced medical abortion drug sale by pharmacists. Over all impact of this leads to unsafe abortions, unintended pregnancies or need for second trimester termination all of which cause health risks to women.

One World Health Organization report says that during the period from mid May to early July 2020 two-thirds of 103 countries reported disruptions to contraception and family planning services. The U.N. Population Fund [3] has estimated that 7 million unintended pregnancies may occur globally.

The multiple jeopardy for women is

- Restricted access to antenatal care increasing physical risks,
- Burden of unwanted pregnancy causing psychological trauma,
- Violence from intimate partners due to fear of financial implications with job losses.

Child marriages:

Some of the more scary estimates are in the area of child marriages. As an economic fall out of the pandemic poor parents are likely to marry off their young daughters to reduce burden.This may result in 13 million additional child marriages in the next decade. UNFPA reports that intensive counselling is needed to avert child marriages , female genital cutting(FGC). With reduced community reach hampering sensitisation, an estimated 2 million girls may be subjected to FGC.[4]

Women with disabilities:

Lock down times has been Unthinkably hard for 11.8 million women with disabilities in India (5)

- Personal assistance is hard to get due to reduced mobility and fear of proximity,
- Access to health facilities to procure routine medications is impossible without passes and they cannot go to police stations for the same,
- Online purchases of medicines, sanitary pads are not possible for all

- Increase in intimate partner violence due to frustration has added to their woes,
- Avenues of income have closed due to
  a) economic slow down,
  b) no help for transport of produce, limited social media access for the poor.

What health systems can do:

- The health care practitioners (HCP) as well as health facilities have to gear up for the added burden of disease and maternal morbidity, due to missed opportunities for antenatal health check ups.
- Unintended pregnancies should be handled sensitively and counselling as well as safe termination of pregnancy should be available to the clients.

- Gender based violence is silent. Antenatal women must be screened for the same specifically. Even non pregnant women may feel more secure talking to their HCP than approach police or NGOs. This is more private conversation and may not raise hackles in partners. HCP should be extra vigilant for the potential cues from the clients' body language. possible safety plans, necessary referrals and even occasional indoor admissions may be required to mitigate immediate threats.
- Women with history of GBV have added burden of sexually transmitted infections. Counseling and testing as well as syndromic management through in-person and remote services can be the new strategy.

Conclusion:

Detection and documentation of domestic violence and domestic incident reporting is critically important. HCPs are partners of law enforcement agencies in dealing with the cases of GBV and it is a moral duty of general physicians as well as specialists to identify symptoms that point to GBV and address the effects of this shadow pandemic across all age groups and communities.

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Her wings are cut and then she is blamed for not knowing how to fly: Simone de Beauvoir

To Do or Not to Do: An Ethical Dilemma in the Periviable Neonate

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On a warm summer afternoon in August 1963, a 34 week old neonate was born weighing 2110 grams, who developed respiratory distress immediately after birth. He was diagnosed with respiratory distress syndrome (RDS) and shifted to a higher medical facility. As was the routine practice at the time, he was placed under oxygen with every attempt made to maintain blood chemistry as close to normal as possible. With increasing hypoxemia, he was given a trial of Hyperbaric Oxygen Therapy in a hyperbaric oxygen chamber with 100% oxygen pressurized to greater than one atmosphere. However, with no medical knowledge of surfactant or neonatal mechanical ventilation, this baby passed away after 39 hours. His name was Patrick Bouvier Kennedy, son of John F Kennedy, President of the United States of America. His death brought to the limelight the lack of understanding and treatment options for RDS, and opened a whole new dimension in Neonatology.

Fast forward 57 years - A 24 week neonate is born weighing 550 grams. The parents have already been counseled antenatally and give their consent for "everything to be done". The baby girl, who does not cry at birth, is quickly resuscitated, intubated, mechanically ventilated, has central lines placed, and receives surfactant, inotropes, and total parenteral nutrition as per the neonatal intensive care unit (NICU) protocol. Bedside Echocardiography is used to detect a hemodynamically significant ductus arteriosus for which she is promptly treated. She is later found to have bilateral grade III intraventricular hemorrhage, late onset sepsis, necrotizing enterocolitis, subsequently periventricular leukomalacia with hydrocephalus, and is on high frequency ventilation with bronchopulmonary dysplasia at 9 weeks of life.

The second baby received state-of-the-art, technologically advanced, and evidence based treatment, though the outcome may be the same. Worse still the baby may be discharged with severe neurological deficits - unable to communicate, sit, walk, or take care of herself; may even be on gastrostomy feeds and home oxygen. Technological advancements in medical science have unfortunately outpaced the ethical considerations, which is the primary cause of ethical issues in the NICU. Saving such younger, smaller and lighter babies has pushed the boundaries of the period of viability to unimaginable limits, and sparked even further ethical dilemmas.

Viability is defined as the ability of a fetus to survive in an extra uterine environment, and is dependent on biomedical and technological capacities. As this varies from country to country, and even within a country, the period of viability also changes depending on the place and level of care provided. For international comparison, WHO describes the period of viability as birth weight of ≥ 1000 g or ≥ 28 weeks gestation age (GA). However this cut off varies for most developed countries, with the period of viability being between 22-24 weeks. The GA is considered a good predictor of viability[1] and hence is the single most commonly used parameter to decide viability prior to birth, though some studies show birth weight to be equally effective in the extremely low birth weight neonates.[2] The American Heart Association,

in the neonatal resuscitation programme guidelines published in 2015, have recommended a GA cut-off of 25 weeks, above which resuscitation should be initiated.[3] The American College of Obstetricians and Gynecologists (ACOG) and Society of Maternal-Fetal Medicine consensus on periviable births recommends resuscitation from 24 weeks onwards, and recommends against it below 22 weeks. Decisions about resuscitation in between these cut-offs would be based on parental desires after a detailed counseling.[4]

However, assessment of GA itself has wide variability based on the technique used. Calculating GA based on first day of last menstrual period (using Naegele's formula) assumes the cycles are regular 28-days cycleswith ovulation occurring on the 14th day after the beginning of the menstrual cycle, and has an accuracy of ±2 weeks. Ultrasound in the first 16 weeks of gestation (if available) has been found to have a variability of upto one week on either side. The use of ultrasound later in the second trimester varied upto two weeks. The use of an inaccurate parameter to make a decision on life and death seems unreasonable. It has also been shown that various other clinically important factors such as birth weight, sex, place of delivery (primary vs. tertiary center), use of antenatal corticosteroid, infection in mother and plurality are all independent predictors of outcome in neonates. This makes accurate prediction of prognosis an extremely complex calculation which is not always practical at the time of antenatal counseling or birth.

Assessment of the neonate immediately after birth in the delivery room was also shown to be neither sensitive nor predictive for death before discharge, survival with a neurologic abnormality, or intact neurologic survival.[5] Hence, decision making even after "seeing the baby" was not helpful in the delivery room. Various subsequent events like intraventricular hemorrhage, periventricular leukomalacia, and bronchopulmonary dysplasia can drastically change the overall prognosis of the neonate, and hence, risk assessment is an ongoing process beyond the first few hours of even days of life.

The four basic ethical principles in medical practice as described by Morrison et al include autonomy, beneficence, nonmaleficence, and justice.[6]

1.Autonomy: The principle of autonomy describes the patient as an individual who is capable of taking decisions. It encompasses veracity, disclosure/informed consent, and confidentiality. Applying this principle to newborns who cannot communicate their wishes becomes difficult, leaving the parents as surrogate decision makers. However, this may seem impractical in the case of a 24 week baby whose mother wants to breastfeed her, or a 25 week baby with symptomatic anemia born to a Jehovah's Witness family, who refuses blood transfusion.

2.Beneficence: This principle of ethical practice refers to acting from a spirit of kindness to benefit others. But conflicts arise, particularly in cases of periviable birth, where parents wish for everything to be done - which may not be a well-thought out decision in the best interests of the child. The physician has to differentiate whether the medical treatment is actually prolonging life for the infant, or merely postponing death. A preterm who is seriously ill might meet criteria to be considered for extracorporeal membrane oxygenator (ECMO), but it may not be the best option.

3.Nonmaleficence: This ethical principle means non-harming or inflicting the least harm possible. In a periviable neonate, every procedure and treatment is associated with pain and discomfort. If the harm is more than the expected benefit, is it ethically right to go ahead with the treatment only because it is described? In a 25 week neonate with severe necrotizing enterocolitis with perforation, would subjecting a baby of such gestation to a major

surgical procedure be considered acceptable, knowing the risks and complications associated with anesthesia and surgery? In this case, the treatment may be futile, and prolonging treatment would be considered a violation of this ethical principle of nonmaleficence. Death might sometimes be a better option over a life full of intense suffering for the neonate and the family.

4.Justice: The ethical principle of justice refers to acting out of fairness for the patient and community at large. Utilization of advanced equipment, and medical and human resources, in a periviable neonate where outcomes are, at best, guarded to poor, might be misplaced when the same could have been utilized towards the curative treatment of another baby. This is especially important for a public health setup where the existing health infrastructure is always overwhelmed by the patient load, and misplaced priorities can be costly.

Each of these principles opens up a new set of questions that are specific to the periviable period. And while none of them have absolute answers, they all deserve a serious thought when dealing with a neonate born so early.

Importance of Data at Treating Centre:

Survival data from one's own institution is a key component of ethical decision making. However, selection bias associated with survival data is a major confounding factor which has led to skewed statistics and hence, inaccurate predictions of outcomes. A systematic review by Evans and Levene [7], which looked at 67 reports of survival outcomes in 55 preterm infant cohorts over a 20 year period, graded the studies according to the inclusion criteria - stillbirths and live births (Grade A), only live births (Grade B) and only neonatal unit admissions (Grade C). The more selective grade showed significantly higher survival between 23 and 26 weeks of gestation (grade C > grade B > grade A) ($p < 0.01$), with a 100% exaggerated survival at 23 weeks and 56% difference at 24 weeks. Also tertiary care centres were found to have higher or lower survival rates compared to overall statistics, which could be influenced by better infrastructure, facilities and man-power, or by a referral bias of sicker babies respectively.

The Ideal Outcome Indicator:

Even if the gestational age is accurately known, survival alone may not be an appropriate outcome. Information of proportion of neurological intactness or expected degree of neurodevelopmental disability, at each week of gestation should be available to the parents. Keeping this in mind, gestation age-based neurologically-intact survival rates and morbidity data from one's own institute are necessary to be able to provide accurate and realistic information to the parents during ethical decision making. These discussions require a quiet room, dedicated time from both parents and doctors, and a rational thought process to be able to clearly comprehend the information and come to a definite conclusion. This, as one would imagine, is extremely difficult in the setting of an unprepared onset of labour or emergency cesarean section so early in pregnancy. The situation itself can be overwhelming, making the process of decision making even more stressful and difficult. While doctors tend to rely on statistics and outcome data, parents tend to rely on emotions and attachment when making decisions; as assimilation of such complex data is difficult given their state of mind at the time of unplanned delivery.

In the event of indecisiveness, most doctors would err on the side of resuscitation. The debate then shifts to the ethical implications of withholding treatment versus withdrawing existing treatment, as these become the simplest way to protect these newborns from unwanted negative consequences of life-prolonging medical treatment. This relies heavily on the literal interpretation of actions and omissions, where everything that counts as an omission is acceptable while those that count as actions become

impermissible, though both have the same outcome. Massimo Reichlin questions the very existence of a moral difference between these two, keeping patient's best interests in mind.[8]The Ethics Working group of the Confederation of European Specialists in Pediatrics in their recommendation[9] mentions that withholding or discontinuation of life support measures are ethically equivalent, and states that the purpose of all measures and decisions should focus on the "best interests" of the patients.

However, in neonatal practice, the "best interest" of the infants can be unclear and vague. There is often conflict of interests between what the treating physicians and parents consider to be in the best interests of the child. Personal, cultural and religious influences can also play a major role in decision making, as in the case of the Jehovah's witness neonate with anemia requiring a blood transfusion.

Role of Parents:

Should all neonates be treated since their will is unknown, or can parents or guardians make the decision on behalf of the child, that the treatment is not in the child's best interest and therefore should be stopped? Under ordinary circumstances, the parents' decisions are usually in the best interest of the child. However, sometimes the parents' wishes may be conflicting with what is best for the neonate, and there arises a conflict of interests that can be challenging to deal with. In the periviable period, the distinction of what and how much neuromorbidity is acceptable, can vary from case to case. Parents, who have been trying unsuccessfully to have a child for many years and have finally resorted to artificial reproductive techniques, might consider survival itself to be an acceptable outcome, independent of the neuromorbidities. However a young and especially financially constrained couple might consider a baby with even a slight long term risk of neuro-disability absolutely unacceptable.

Role of Neonatologist:

In the case of a periviable birth, the doctor is required to inform the parents about resuscitation and potential outcomes for their preterm infants, as well as to obtain their consent to proceed with resuscitation and treatment. While the treating physician is bound by the Hippocratic Oath to keep their patients alive, they also pledge to prevent suffering as much as is possible, even to a point of refraining from certain treatment options when not in the best interest of their patient. If medical treatment is futile and only prolonging life, the doctor is obligated to explain that the same to the parents and help them reach a conclusive decision. There is an imbalance of knowledge, control, and expertise favoring medical professionals, who at times may have a different assessment of an infant's "best interest". Hence it is important to give the parents all the information and facts, as well as professional advice to aid them in making this difficult decision, all the while respecting their autonomy, even if there is a difference of opinion between the doctor and the parents.

Role of Society:

The society at large, also has a moral duty towards fighting for a health care system that can support the treatment and long term follow up of these fragile neonates. In extremely preterm deliveries, factors like availability of government hospital NICU beds and/or cost of treatment also play an important role. This is especially true in our country where out-of-pocket expenditure for health care is extremely high; with some parents considering it "cheaper to have another baby" – a portrayal of the appalling state of the health care system in our country.

Role of Legal System:

In 1982, the parents of "Baby Doe", a Down syndrome baby with a congenital defect requiring surgery, refused to give consent for the surgery – a decision upheld by the Indiana Court. In 1983, "Baby Jane Doe" was born with a meningomyelocoele, hydrocephaly and microcephaly. Both parents and

doctors felt that conservative management were best for the baby, but various groups alleged that it was a case of deliberate withholding of treatment – a stance that was over-ruled by the court. This led to the Baby Doe law in 1984 meant to safeguard the best interests of infants with life- threatening conditions. The recent past has seen two cases – one of Piergiorgio Welby, an adult with ventilator-dependent amyotropic lateral sclerosis, and Eluana Englaro, a post-accident tetraplegic, in whom ventilation and nutrition were withheld respectively. Both cases provoked wide-spread outrage and protests, though both physicians were cleared of all legal charges. The legal system, thus, plays an important role in safeguarding the interests of both, the patient and the doctor, especially in cases that involve withdrawing of medical treatment.

Role of Neonatal Palliative Care:

The decision to follow selective non-treatment or withdrawal of care must be followed by a detailed plan for palliation. While the goals of treatment change, the basic concept of caring for the patient still holds good. The focus shifts to symptomatic relief, basic nutrition to alleviate hunger, removing painful interventions, ensuring parents spend time with the neonates, and helping them create memories as they prepare for the inevitable end. A recent study showed that many parents, through a shared decision-making process, may choose palliative care for their baby at periviable gestations.[10] It has also been noted that parents whose babies received palliative care were significantly more satisfied with NICU care.[11]

While saving life is important, neonatal care should be focused on its capacity to develop, from a preterm fetus, a functional adult who has a meaningful quality of life. That would be the true success story to write home about. But the gray area will always continue to be an ethical dilemma, and there will be no clear answer to the question, "to do, or not to do".

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A woman is human.She is not better, wiser, stronger, more intelligent, more creative, or more responsible than a man.Likewise, she is never less.Equality is a given.A woman is human."

— Vera Nazarian

Ethical issues in Clinical Research during COVID-19 Pandemic

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Introduction:

The COVID-19 pandemic continues to hit human beings and has profoundly impacted healthcare and economy of the whole globe. There is no effective treatment available till date. The nature of the disease characterized by its rapid spread across the community, high fatality rate especially among susceptible individuals and absence of effective cure to contain the disease have fueled several clinical investigations. In the quest of remedial measures for this pressing unmet need, drugs and vaccines are being tested in large numbers in clinical studies. [1,2] Older drugs like hydroxychloroquine, azithromycin, favipiravir, ivermectin and tocilizumab are being repurposed. An advanced search in the Clinical Trials Registry of India (CTRI) showed that 332 interventional studies related to COVID-19 were registered since March 2020 till date. [3]

There are several issues faced by all stakeholders involved in undertaking clinical research during the pandemic. Strict containment measures such as lockdown and social distancing have posed challenges in planning and execution of the clinical trials. The Indian Council of Medical Research published ethical guidelines at the right time in April 2019 to help researchers and Ethics Committees (ECs) to address some of the ethical concerns. [4] This review sheds light on a few commonly faced ethical issues.

Issues in Design and Conduct of COVID related Clinical Research Studies

The study design related issues like ethics of using placebo as control, defining an appropriate standard of care for comparison, adequacy of sample size, deciding appropriate efficacy endpoints (viral load or antibodies), accuracy of methods of measurement of endpoints, duration of follow-up and ensuring uniformity in conduct across sites in multi-centric studies are some of the aspects which the researchers and ECs need to consider. [5] If a study is not scientifically planned or if it is not powered adequately, the data generated from such a study lacks generalizability. [6]

a) Interventional studies invariably involve clinical specialties. When many studies are ongoing, the dual role of treating doctor and investigator played by a clinician may be demanding. This is due to the increasing number of COVID cases, especially in the public hospitals. The recruitment of patients may become biased. Additional care needs to be taken when there is an overlapping selection criteria of two studies being conducted in the same department/ institute. In such a scenario, can EC decide to put a cap on number of COVID studies undertaken by one principal investigator (PI) / in one department?

b) The need for provision of COVID safety measures to participants, protective gears for study team, quarantine facilities, separate wards, sanitation, etc can increase the trial budget.

c) The investigational agents which are being tested for COVID treatment/ vaccines are available to general public only under the auspices of clinical trials. The state of despair due to non-

availability of medicines / timely medical care and fear of death due to COVID may drive patients and asymptomatic healthy volunteers to participate in COVID studies in large numbers. Researchers have to ensure that participants are aware of the nature of the study, uncertainty about treatment effect and risks involved before they take informed decision about participation. The informed consent document should contain required information about the study procedures and risks involved to the satisfaction of EC. [7]

d) Another major barrier is the limited transportation facilities due to nation-wide lockdown which affect participants' recruitment, follow-up, availability of the laboratory staff and the study team members. Sponsors and investigators have adopted means like telephonic calls, videoconferencing, allowing alternative local assessment centers (laboratory/ radiology investigations) and telemedicine to partially overcome this problem.

e) The study drug supply is yet another issue. Due to participants' inability to visit the site during lockdown, investigators have to courier or personally deliver the study drugs. The investigations, compliance assessment and study procedures may not be conducted as planned. These difficulties lead to minor and major protocol deviations impacting the quality of study data. [8]

Review of COVID Research Studies by Ethics Committee (EC)

a) Research studies on drugs, vaccines, biologicals, cell products, devices, diagnostics, questionnaire based studies, socio-behavioral research, complementary and alternative systems of medicine research related to COVID are being extensively carried out and ECs are having a difficult time coping up with the volume of studies. E-submissions of research studies for EC review has now become a norm for most of the ECs. There are requests for EC approval within a short time. The clinical trials have to be reviewed expeditiously as per the ICMR guidelines; hence EC meetings are held frequently on virtual platform. EC members may get incomplete document-set and inadequate time to review. In a meeting on virtual platform, there are limitations as all members (especially nonscientific members) may not get a chance to speak or may be hesitant. [5] Despite all the limitations, ECs are coping up and approving studies within a day (French Hydroxychloroquine study) [9] to a fortnight. The requirement of data safety and monitoring board by the sponsor for drug trails should be insisted by ECs especially for high risks protocols.

b) Obtaining a valid consent during the pandemic has been another major obstacle. [7] The protection of participants in the study needs to be ensured. New data emerging from ongoing clinical trials and updates in management of COVID may require changes in the protocol and informed consent document from time to time. Hence there may be need to re-consent the recruited participants. Obtaining consent from legally acceptable representative (LAR) is acceptable when participant is incapable of giving consent. LAR may not be available if he/she is quarantined. ECs may allow patient recruitment on case to case basis without LAR provided re-consent of patient or LAR consent followed by patient's re-consent is obtained as soon as possible.

c) Onsite monitoring of ongoing clinical research studies in COVID by ECs is not feasible due to members' concerns about visiting the site. Sponsor's monitoring visits as well as EC monitoring are being held on virtual platform.

ECs have to make policy on whether to allow sharing of patients' electronic hospital records with sponsors as there are issues related to breach of privacy and confidentiality.

d) COVID trials having government funding or those involving foreign collaboration, data ownership, patenting, benefits to community and other issues need careful consideration by researchers and ECs too.

e) Post-trial access provision in case the study intervention is effective and appropriate referral of patients withdrawn midway from the study are some other pertinent concerns in COVID research studies.

f) COVID vaccines trials are being conducted. Are vaccines being tested in sufficiently large number of individuals? Will the vaccine be available for everyone in the community or will it be reserved for special population?

Publication Ethics

Published data on COVID studies is huge and increasing by the day with researchers running the race to be first to place their findings on record. This may also be due to political and media pressure. A PubMed search using "COVID [tiab]" yielded '53,443' results; out of which 870 have been lined up ahead of print. [10] Faster acceptance of articles, sometimes even before a complete scientific peer review may cause erroneous information in published papers. Many journals have started exclusively publishing COVID research or have dedicated special issues on COVID.

There were 29 COVID related studies found on the "retraction watch database," which gives an online record of retracted articles which were earlier published. The main issues associated with these retractions were plagiarism, duplication, lack of requisite approvals (EC) and concerns over results. [11] Another example of a retracted study is the one which was retracted by the Lancet recently. This study had published that hydroxychloroquine was ineffective in treatment of COVID-19. However, there were doubts raised regarding the reliability of the study results and complete raw data was not made available by the researchers to the third party for review. [12]

Non-COVID Research Studies

a)Most of the private and public sector hospitals have been dedicated to COVID treatment from March 2020. COVID trials are prioritized over other research studies. Most of the other studies are either suspended or halted. The relative neglect of non-COVID research has compromised the interest of cancer patients and other patients suffering from chronic and critical diseases. [8]

b)The ECs may face dilemma as to whether to compensate patient if the participant develops COVID while undergoing a non-COVID research tudy in the hospital and whether to report it as SAE.

c)The speed with which previously approved drugs are repurposed for the treatment for COVID trials is overwhelming. This may lead to acute shortage of supply of the drugs for the treatment of primary indication e.g. hydroxychloroquine in rheumatoid arthritis.

Conclusion

In a catastrophe like this pandemic when research is imperative, all the stakeholders in research should be aware of the accompanying ethical concerns and they should take appropriate measures. The rights, well-being and safety of the participants should be protected while generating scientific and credible evidence.

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"Hope is a renewable option: If you run out of it at the end of the day, you get to start over in the morning." **- Barbara Kingsolver,**

Laws, Medicine and Sexual Health- Weighing Benefit and Harm

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Abstract:
Deficiencies in serving the societal needs of sexual wellbeing stem from silence around sexuality and ethics of sexuality. Similarly, medical responses to sexual and domestic violence are rooted in patriarchal view of women's social status and lack rights based approach. Limited application of legally permissible grounds for medical termination of pregnancy by healthcare providers seems to stem from their lack of understanding of gender inequities and the nuances of masculinities. Feminist ethical lens can effectively put into perspective this male-centric approach to individual care as well as state health laws. It can also explain to the health care providers what society need from them to achieve good sexual health.

Introduction:

Many ethical concerns become legal dilemmas and vice versa. Some ethical issues like- gender and human rights - are at best ignored and at worst silenced by the society. Sexuality ethics has always taken the unenviable prime place in this list.

Divided on many other issues, the society has been almost unanimously against gender equity. This has created a shroud of silence around sexual health, sexual rights and sexual crimes issues. On the other extreme is feminist ethics that has been trying to look at the wider concerns than mere sexuality and the issues surrounding it. Medicine is somewhere in between.

Sexuality has been inadequately understood and presented, in the presently taught clinical medicine.

Gender is taught as binary by most and other expressions are considered deviant. Currently in academic training and practice, the topic of sexuality and sexual health revolves only around reproductive health issues of women and men. Sexual health gets limited to prevention and treatment of sexually transmitted and reproductive tract infections. Adolescent sexual health came into focus only in last two decades mainly due to HIV AIDS. It covered only how to prevent STDs, HIV AIDS and that is the end of it!

What is the cause of apathy towards sexuality ethics? On a lighter note, have we never realised that sexuality is in the brain first, then the body?[1]This apathy and ignorance combined with patriarchy, have created a large gap in the sexual health needs of society and medical approach to provision of sexual healthservices.

Lack of awareness, lack of regional language vocabulary, lack of training and last but not the least, lack of sensitivity aggravate the healthcare deficiencies in ensuring sexual autonomy, safe motherhood, and lastly, justice to survivors of sexual and domestic violence. The United Nations document on sexuality education acknowledged the need to address sexuality early on in adolescence.[2] Comprehensive sexuality educationto young people is expected to create a generation of sexually responsible and gender sensitive society. The professional bodies like theAmerican College of Obstetricians and Gynecologists recommend that sexuality education should be continued throughout a person's life and should include sexuality expression, gender identity and sexual autonomy.[3]

The argument:

Koplan and McPheeters made a very valid

point that science which is used to validate political agenda that is trying to drive public policy through public health is dangerous.[4] It should be science that lays down public health guidelines and these in turn should dictate policies. We are witnessing this anomaly on daily basis in not only national but international health scenario in COVID-19 era.[5]

Let us look at some case studies of laws vis-a-vis sexual health of women and men through the lens of the feminist and sexuality ethics. We also take a stock of medical education deficiencies and possible responses.

The Medical Termination of Pregnancy Act, 1971 [6]:

1. The value laden approach in the act stating that failure of contraception used by a **married** woman or her husband can be an indication for termination (as it would cause mental anguish) requires revision considering the following:

a. Changing sociocultural trends in man woman relationship and even the state having legalised live-in relationship, marriage as a precondition should be removed.

b. Acknowledgement of suppression of women and their lack of autonomy in sexual and reproductive health matters should be considered when onus for not using contraceptive is put on women.

c. Acknowledgement of hitherto unrecognised entity of 'Marital Rape' entity will go a long way in helping many women to deal with forced pregnancies.

Until these factors are taken into account by the policy makers as well as healthcare providers, safe abortion cannot be a reality.

2. Even the age bar set for consent creates fear, recourse to unsafe abortion and possibility of self harm among girls under eighteen years. The provisions in the act should be sensitive to the fact that a sizeable number of girls under 18 experience pregnancy and childbearing, risking their lives.[7] Fortunately, the legally permissible gestational age limit for termination of pregnancy is may be advanced soon as the bill is in the pipeline. This will definitely help advanced terminations on eugenic and humanitarian grounds.

The Protection of Children from Sexual Offences Act, 2012 (POCSO Act):

Though the act is protective and gender neutral on minor survivors - meaning it acknowledges male child abuse too; it recognises only male as the offender. The problem with this is that a female perpetrator is invisible.

Male child exploitation is rarely reported as it is much more difficult for male children to come forward to complain about the sexual exploitation even to their own parents and if the perpetrator is a woman, it becomes all the more difficult for boys. Societal misconceptions about masculinity tend to push male abuse under the carpet.

The act considers even consensual sexual intercourse among young people under 18 years as an offence. This has created a legal obligation for health care providers, teachers, NGOs to report the same when they discover sexual activity among adolescents below 18 years. This is in conflict with societal realities.The Madras High Court, in 2019 while acquitting a boy sentenced by the lower court for kidnapping and being in sexual relationship with a 17 year old girl, remarked that age of consent for sexual relation should be lowered from 18 to 16 under the POCSO Act, 2012.[8]

The POCSO Act also seems to mean that an older woman will never be in a sexual relationship with a boy below 18 years. This kind of thinking about sexuality and sexual morality is immature as well as unrealistic.

Due to mandatory reporting of sexual activity in minors, they may avoid approaching a right counsel about relationship issues, sexual and reproductive problems.It also deprives them of a much needed safe

contraception. Whatever the law, teenagers will continue to explore their sexuality. They require knowledge and resources to protect themselves from diseases as well as unwanted pregnancy. Perspective building about sexuality will\ also equip them with ability to defend themselves from sexual exploitation.

Marital Rape: **Status in the section 375 of IPC**

India has the dubious distinction of being one of the thirty six countries in the world still not having criminalised marital rape. The exception 2 under section 375 of Indian Penal Code exempts - forced sexual intercourse by a man with his wife who is over fifteen years of age - from definition of rape. This violatesthe rights provisions in article 14 and article 21 of the Constitution of India. Justice Verma in his Committee Report has categorically stated that the exceptional status of marital rape should be removed.[9] The report quotes Prof. Sandra Fredman from Oxford University who opined that all levels of the criminal justice system should be provided training to ensure awareness that - she says and we quote- "**marriage should not be regarded as extinguishing the legal or sexual autonomy of the wife**". There couldn't be a more eloquent feminist critique on this issue.

Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act [10]:

A sceptic may question the connection between sexual harassment act and health systems. Workplace harassment has manifold effects on a person. Anxiety, depression can stem from fear, frustration. A woman may confide in her healthcare provider and documentation of the possible reason for stress goes a long way. Women have, for many decades, worked shoulder to shoulder with men in medical services. But world over, women have had to face hostile environment at work including medical field. Nursing is a woman dominated work force and many times, they face harassment from men at work as well as from patients and their relatives. Under this act, safe workplace is every employer's legal responsibility.

This is a welcome act although it is not gender neutral. On one hand, India has brought in Transgender Persons' Protection of Rights Act. So it is needless to say that besides men who are in a relatively subordinate position at workplace, transgender persons also require safe workplaces free of sexual harassment.

Another criticism of the act is that if the complaint is deemed false, it is considered a punishable offence. Many times it is hard to prove the accusation as there may not be witnesses or even any evidence. This may create apprehension in the complainant's mind.

The Protection of Women from Domestic Violence Act, 2005:

Domestic violence (DV) is a major public health issue and currently being called a shadow pandemic. Sensitive questioning, documentation, treatment as required and referral to appropriate services; is duty of every health care team member.

Unfortunately though, playing out of patriarchal mindset couldn't be more visible than in implementation of this act. The very mindset that avoids taking a stand on criminalisation of marital rape is the cause for trivialising the offences reported under the provisions of the act. [11] Good documentation will help justice to prevail for these survivors.

Live in relationships in the ambit of Domestic Violence act 2005:

Women in live in relationship have always been considered to be of loose character and have been denied right to respect and security unlike a legally wedded wife. Under the Domestic Violence act 2005, rights of female live in partners are protected. The supreme court in case of S. Khushboo vs Kanniammal held that a man and a woman could live together

without being married. But status and rights of the children born in such relationship are considered variedly by the judiciary. This requires a clarity in the act. [12]

The Transgender Persons (Protection of Rights) Act, 2019[13]:

Sexual identity was rigidly binary in society for centuries. Intersex or disordered physical differentiation was another matter but self assertion of gender other than physical was scoffed and crushed. The biggest problem with the provisions in the act seem to be in the area of gender recognition and certification. After a lot of advocacy, certification as a transgender is permitted without medical certificate or surgery. But certification for a male as a female or vice versa is granted only after medical examination and certification. Also an extremely complex and sensitive issue is dealt with by district magistrates without gender training. This leaves the matter to individuals with diverse levels of understanding about gender.

Talking of transgenders, we cannot ignore the sexual harassment and threats that they experience. According to numerous activists, section 375 and 376 are silent on sexual assaults on transgender people.

PCPNDT Act- Implementation issues:

Gender discrimination in society and lack of biomedical ethics on part of medical fraternity created the monster of female feticide. Greed and gender discrimination are feeding each other to fail this act.This offence can't take place if the medical fraternity decides not to compromise with the principles of beneficence and gender non-discrimination. Without active participation of the medical fraternity, people have no way to get sex determination done.

Tragically, in spite of the act, lack of witnesses, lack of evidence and out of court settlements were the reasons cited for low conviction rates under the act by the tenth Common Review Mission by the Government.[14] It is a matter of disgrace that the culprits are among the saviours of human life.

Medical Training Deficiencies and possible interventions:

- Gender as a social determinant of health is taught in community medicine; but active reinforcement of the fact is urgently required in clinical training.
- Gynecologists are many times the first contact for the women even for matters of sexual and domestic violence. But they are not reminded that it is their responsibility to ask a woman about the black eye seen at antenatal check up. No one bothers to ask the lady if she has any other place to go or if she needs any temporary shelter. Mandatory inclusion of these questions in antenatal history may help remind young trainees to ask about DV.
- There is little training and discussion on sexuality [15] in the undergraduate and postgraduate gynecological curriculum. The discussion always focuses on sexual violence and sexually transmitted infections. This reinforces the belief that women are passive agents in sexual relationship. Training of teachers is required to cover this gap.
- Autonomy of women[16] is culturally not considered important even in matters of reproductive health issues like consent for procedures.Adolescent autonomy is a distant dream. Hence, when faced with issues of adolescent or transgender sexuality which are even bigger taboos, this ignorance and gender blind attitude culminate into avoidance, unfair treatment and health risks. Visibility to these taboo topics requires an imaginative platform.
- Healthcare providers consider domestic violence a private matter and may not record the same as routine, though recommendations mandate the same.[17] Academic conferences should have dedicated sessions on violence against women.

- Examination of sexual assault survivors, under the guidelines by the central ministry is now largely streamlined; but is more focused on evidence collection and survivor's autonomy and rights take a back seat. So most survivors don't avail the follow up services that are critical to mitigate long term effects. This picture can change only with training in bioethical issues around sexual assault.
- The medical fraternity requires to wake up to the onus of poor implementation of the PCPNDT act and the future doctors have to be responsive to the issue of female feticide.

Conclusion:

Though the Medical Council of India has mandated Bioethics Training in the foundation course, applied ethics has to be integral to undergraduate and postgraduate training so that sound science on the bedrock of strong ethics drive public health .

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Can Human Challenge Trials Principles be Applied to COVID 19

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Background:

Infectious disease is a substantial cause of morbidity and mortality, most of which occurs in the less developed countries. Recently the corona virus pandemic has affected global community is responsible for more than a million deaths. Continuous research is crucial to find a way to safeguard human life. Over the period of time, scientists have developed various methods to conduct studies to find appropriate treatment. In this article we discuss about 'Human Challenge Trials'- advantages, indication, contraindication, ethical challenges and so on.

Definition *Human Challenge Trials (HCT) are trials in which participants are initially challenged (whether or not they have been vaccinated) with all infectious disease organisms. The organism may be close to wild type and pathogenic, adapted and/or attenuated from wild type with less or no pathogenicity or genetically modified in some manner.[1]*

Possible purposes of human challenge trials as per the WHO Expert Committee [1]

1.Characterization of the organism's behavior: titration, symptoms, organism shedding, and infection transmissibility,

2.Enhanced knowledgeabout the pathogenesis of and imune reponse to the organism insight for designing the vaccine,

3.Identification of potential immune correlates of protection with validation later ivy efficacy studies,

4.Determination of optimal design for efficacy trial

5.Hypotheses generation to be tested by efficacy trials;

6.Selection of potential lead vaccine candidates to expedite only the best to large pilot efficacy trials and to eliminate others,

7.Reducing risk of failure in vaccine development programme;

8.Studying the impact of pre existent immunity to prevalent endemic diseases,

9.Justification for emergency use of an investigational vaccine (e.g. influenza);

10.Grounds for licensure matters (exceptionally);

11.Determination of need for booster doses for durable protection;

Rationale

HCT involves deliberate exposure of human volunteer to a disease. This conflicts the guiding principal of medicine to do no harm. This experiments seems unethical and such actions can only be justified by their contribution to vital scientific knowledge leading to benefit of large population preventing morbidity and mortality. [1] HCT can hasten the process of development of vaccine, drugs or any other treatment.e.g.- In experiments where cases are vaccinated and controls are not vaccinated, when both groups are challenged with disease, the result obtained are faster than waiting for natural incidence to occur and the inference is more certain. It is essential to weigh the benefits and harm for making sound judgement pertaining to the experiment. It should not be driven by the researcher's professional interest. The health of people is at stake and

researcher's self interest should not ignore this fact.

Regulation

HCT should be conducted for diseases that are either self limiting or can be fully treated and facilities to monitor serious complication are available. International ethics guidelines mention that research involving human subject should be conducted in accordance to three basic principal namely respect for persons autonomy, beneficence, and justice. In India, Indian council of medical research (ICMR) set the rules for conduct of clinical trials. After the unethical human experiments in Nuremberg, Germany during the World War II, Nuremberg code [2], a set of research ethics principle for human experiments were created to guide human trials. Human Challenge Trials too must be guided by these principles.

C**OVID – 19 and HCT** (Author's view)

More than 38000 people have volunteer for HCT through **1daysooner**[3], an online recruitment organization but the question is whether it is beneficial. In my opinion it is not justified as:

- I don't think it will reduce the time of vaccine development as the incidence of disease is very high and incubation period is short.
- The induced disease can cause death, which is unaffordable in an experiment.
- We don't have standard treatment for the disease for rescue of those manifesting severe symptoms and complications.

CONCLUSION

HCT have considerable moral and ethical issues but can be justified where there is a greater good of the society. However, determining valid indication is a complex and demanding task which lies on the researcher under the framework of existing regulation.

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Winning is the fun, but those moments that you can touch someone's life in a very positive way are better

- Tim Howard

Residency in COVID Times : Hope and Despair

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COVID-19 is a stark testimony to our dysfunctional relationship with nature and even humanity. Just as people are wondering when life will get back to normal after the COVID-19 crisis, shouldn't we rather be asking if we can use this opportunity to learn from our mistakes and build a better world? What about us as health care providers and our social milieu?

Science apart, COVID 19 has taught us to marvel at brief snapshots of courage of the ordinary, to

We as health care personnel have been the poor helmsmen who rose to the occasion when the pandemic struck, to navigate and sail our through this storm helping as many survivors as possible to overcome the crisis.

There have been new challenges catching us off guard almost every day. We find our colleagues, our families being undeservedly exposed to the virus and sometimes some among us have had the unwelcome opportunity to host this virus! But that inner fire douses the fear and brings us back to the battlefield. Did Corona actually make us feel like warriors? I wouldn't know about that; but I am grateful for the appreciation. I also think, we as humanity have a lot to be grateful for! In worlds of William Blake "The thankful receiver bears a plentiful harvest". Gratitude is all we need, and that's what was missing all this while.

Our experience as obstetricians at the tertiary hospital has definitely been exigent and arduous; as stepping out of our comfort zone of training to work as triage experts one day while learning and spending time with ventilators the other … and then flying back to our domain to ensure safe delivery services! The only bright spot in all the chaos at the end of the day is remembering a happy mother leaving the hospital with her newborn,relieved at either "being untouched by the virus or having defeated the virus".

There have several dilemmas and concerns that we residents have been facing in this race of life against the virus. Someday, while rushing in and out of the wards, there are times I start suspecting I may have been exposed to the infection. So should I open up about my concern and stay away from workplace till I confirm my COVID-19 status, or continue to go about my work? Wouldn't I be risking the lives of my colleagues?

How do I balance my physical and mental health needs against the call of duty in these testing times? And the biggest concern- What about my surgical training for which I am here? What are we here for? Medicine is not my branch? I wanted to train as an obstetrician. Why must I risk my life in a field that's not mine? Then, one look at those women, and The doubt dissipates. I am here for them.

At times, we have a pregnant patient who has tested COVID positive but due to lack of vacancy in specialized COVID centres, are left with no option but to come to our facility, and we in spite of shortage of adequate isolated spaces for conducting deliveries, cannot say "No" to that helpless woman writhing in labor pain. It's almost like she is the real warrior trying hard to put up a brave front trying to protect her unborn! so who are we to say NO?

Protocols of eligibility for COVID testing have been changing every other day! Many times, we have asymptomatic patients, who because they belong to high risk area, need to be tested. The patients' fear for

that little life inside - already twisting and kicking to come out into this sinful world overwhelmed by the virus - makes them refuse testing, but test we have to, given the stringent screening guidelines.

And the treachery of the test! I remember one instance when, with soporific eyes and heavy foot, all clad in PPE, entering the labor room for a new shift, I saw a teary eyed woman lying numb and motionless, staring at the woman in the next bed cuddling her baby. I could clearly recall this lady as I had ended my call two days ago with her delivering a healthy crying baby. on further asking, I got to know that her baby tested positive while the lady was still negative so the baby had been isolated in the intensive care.

One day, walking into the ward, I saw one of the beds being vigorously cleaned. I could remember that there was a lady on this bed last night screaming in pain. When I tried to calm her down, trying to empathise-'I could understand labor pain is the most painful thing'- she replied "No Didi, knowing the child is dead after all that pain is more painful! ", I was stunned into silence. I now got to know that she tested positive.

COVID 19 has been a rollercoaster of emotions; but a silver lining in all this is that we have learnt to listen to our silences, learn about ourselves better and deal with life like a 'warrior and not a worrier'.

In the end, it has been rightly said by someone, 'WE FALL, WE BREAK ,WE FAIL BUT THEN WE RISE, WE HEAL, WE OVERCOME'.

"I don't think of all the misery, but of the beauty that still remains."
- Anne Frank.

- Shruti Tilak
Third Minor MBBS
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Inarch- My experience thus far.

What started with a nervous interview in 2017, has grown into a uniquely rewarding experience; one that has left me more edified and cultivated year after year.

I consider myself fortunate to have the opportunity to grow under the careful mentoringof our excellent and convivial teachers in the GSMC Bioethics unit. Equally as important in smoothening out my rough edges have been the ever-smiling, infinitely patient student wing seniors and peers.

The organisation of workshops, photography, poster competitions and so much more taught us about learning responsibility and cultivating an environment of positive co-operation and gave us a chance to witness various events with the interesting themes of each year. The diverse activities of the unit made me amore proactive learner.

As I write, I wonder in disbelief at my progress from a wide-eyed first year MBBS student, completely daunted in the presence of prestigious and awe-inspiring faculty, to learning the ropes of organising the World Bioethics Day events and eventually having the confidence to contribute and participate, even having my tentative, hesitatingideas met with open-hearted, encouraging professors will to extend their kind support to shaping and curating our thoughts, to bring them into purposeful reality. A big thank you to all the people in this unit for such a great opportunity to delve into the thought-provoking field of Bioethics. I hope to continue to have this avenue for knowledge and develop a lifelong interest and ethical awareness.

"If you have positive attitude and constantly strive to give your best effort, eventually you will overcome your immediate problems and find you ready for greater challenges"

- Pat Riley

GSMC MUHS UNESCO Bioethics Unit.

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MUHS

Nurturing Ethical values.....
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Vision :

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Mission:

"To inculcate the basic ethical, professional and humanitarian values in medical students right from the first day of training in order to make them not only expert clinicians but also compassionate human beings."

The 'GSMC-MUHS UNESCO Bioethics Unit' was formed in the month of August 2015. The solemnisation of the Unit under the MCGM Nodal Bioethics Unit and affiliation with UNESCO, Chair in Bioethics Haifa Australia was on 9th November 2015. The MCGM nodal unit was established at an event held in Topiwala National Medical College auditorium.

The objective of Bioethics Unit is to integrate the MUHS approved UNESCO Bioethics curriculum in the undergraduate and postgraduate students education and to train the faculty in effective implementation of the same.

1. To introduce and deliver bioethics and professionalism training in undergraduate and postgraduate curriculum.
2. To prepare an updated and modern curriculum, reflecting the need for integration of ethics during the training period and for its effective implementation in clinical practice.
3. To increase interest and respect to values involved in health care delivery and raising awareness for competing interests. To introduce various non-medical facets of medicine: sociology, economics, and public administration to students.
4. To add new chapters to present curriculum that will relate to new dilemmas, accommodating medical, technological and scientific progress.
5. To create training programs for teachers and instructors of ethics in medical institution.
6. To initiate, collaborate, facilitate and participate research related to bioethics.

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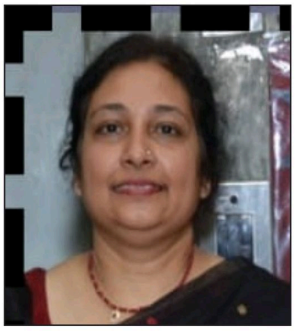

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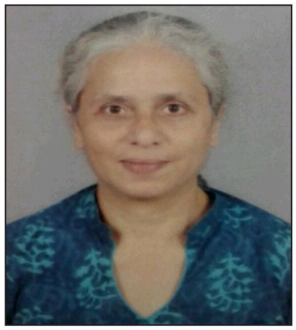

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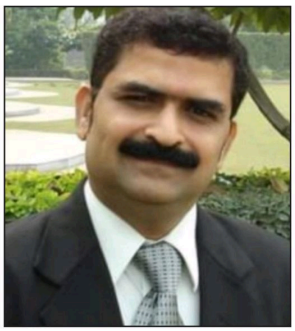

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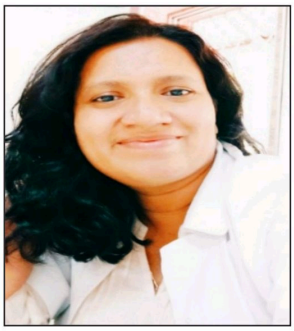
Dr. Venkatesh Rathod
Member
PHYSIOLOGY

Dr. Varsha Kulkarni
Member
GENERAL SURGERY



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Member
OCCUPATIONAL THERAPY

Dr. Jyotsna Thosar
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PHYSIOTHERAPY

Dr. Praveen Iyer
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ANATOMY

Dr. Dilip Kadam
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Member
MICROBIOOGY

Sister Vaishali Chavan
Member
NURSING

Sister Arya Deshmukh
Member
NURSING

Brother Ravindra Markad
Member
NURSING

GSMC MUHS UNESCO BIOETHICS UNIT Students'Wing

Pratik Debaje
MBBS

Shruti Tilak
MBBS

Piyush Vinchurkar
MBBS

Jayesh Urkude
MBBS

Paras Arora
MBBS

Vaibhavi Tapade
MBBS

Vaishnavi Miskin
MBBS

Alisha Sayyad
MBBS

Himani Nahta
OCCUPATIONAL THERAPY

Sarah Sarosh
OCCUPATIONAL THERAPY

Janvi Panchal
OCCUPATIONAL THERAPY

Mrinmayi Sanap
OCCUPATIONAL THERAPY

Shreya Shah
OCCUPATIONAL THERAPY

Sayoni Shah
PHYSIOTHERAPY

Natasha Mehta
PHYSIOTHERAPY

Param Sampat
PHYSIOTHERAPY

GSMC MUHS UNESCO BIOETHICS UNIT Students'Wing

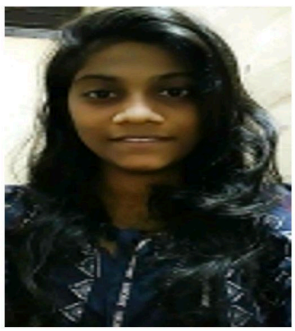
Eshita Shah
PHYSIOTHERAPY

Dhrishti Sheta
PHYSIOTHERAPY

Samruddhi Samant
NURSING

Nitika Sawant
NURSING

Suraksha Thakur
NURSING



Asmita More
NURSING

We all are here to for some special reason. Stop being a prisoner of your past. Become architect of your future.

-Robin S .Sharma

GSMC MUHS UNESCO BIOETHICS UNIT
WORLD BIOETHICS DAY CELEBRATION 2019

The World Bioethics Day 2019 celebrations started with various competitions for undergraduate students, postgraduate students and staff on the theme of World Bioethics Day 2019**"Respect for Cultural Diversity in Health"**The celebrations culminated into the mega event held on **Monday, 14th October 2019**.

POSTER EXHIBITION 2019

The World Bioethics Day 2019 Celebrations began in the morning with aposter exhibition on the theme "Respect for Cultural Diversity in Health". The postercompetition for staff, undergraduate and postgraduate students and non-medicalemployees of the institution was held earlier as a part of World Bioethics day Celebrations.

RANGOLI COMPETITION -14th October 2019

Winners of Rangoli Competition 2019		
First Prize	Mrs Varsha Pitale	KEM Staff
Second Prize	Renuka Jagtap	Third Year, Nursing
Third Prize	Hetvi Vira	Second Year, OT
Consolation Prize	Samiksha Jadhav	Second Year, Nursing
Consolation Prize	Dejul Dedhiya	Intern, OT

WORLD BIOETHICS DAY CELEBRATION 2019
19th October, 2019

Symposium: Cultural Diversity and Health Care

Dr Jayita Deodhar,
Psychiatrist for Tata Memorial Hospital

Mrs. Sujata Ashtekar
MSW: Organ Transplantation

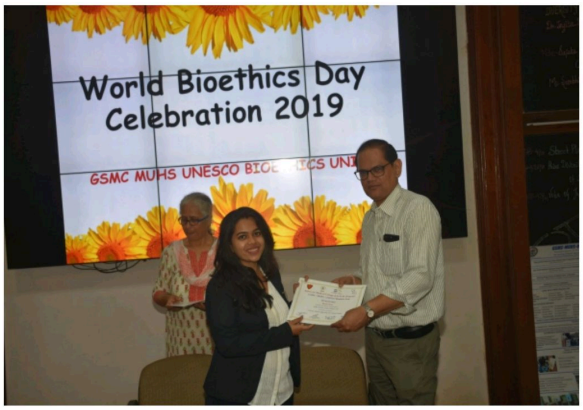
Ms Surabhi Mittal
IIT Mumbai

RELEASE OF 'INARCH BULLETIN 2019'

Key note address by Dr Armida Fernandez, renowned Neonatologist, Former Dean of Sion Hospital

STREET PLAY PERFORMANCE BY NURSING STUDENTS

Student's Wing felicitation and Prize distribution



BEST STUDENTS' WING MEMBER AWARD 2019
PRATIK DEABAJE
Third Year, MBBS

PEER MENTORING FOR POSTGRADUATE STUDENTS on 27th Feb 2020

The students were sensitized to the objectives and need of peer mentoring. This workshop was conducted by **Dr. Ajita Nayak**, Professor& Head, Department of Psychiatry, **Dr. Praveen Iyer**, Professor (Adl), Department of Anatomy, Seth GSMC &KEMH. .

POSTGRADUATE GRAND ROUNDS ON ETHICAL DILEMMAS 14th February, 2020

- **"BIOETHICS GRAND ROUNDS"** were conducted for postgraduate students of Medicine and Obstetrics & Gynecology**. Dr Akash Shukla,** Professor, Department of Gastroenterology & **Dr Kamakshi Bhate**, Professor, Community Medicine, KEMH were the guest faculty for these rounds. Various ethical dilemmas were discussed by PG students and Faculty

Publications, Awards and Honours & Conference presentation

Publications

• Annual bulletin of the unit, "INARCH" based on the theme "Benefit and Harm"will be released during the WorldBioethics Day celebration on 19th October 2020. Dr Padmaja Samant is the editor of this bulletin.

• 'Communication Skills for the Leaders in Health Professions Education' chapter by Dr Santosh Salagre in a book 'Effective Medical Communications'.

• Physiotherapy in the Covid Ward: Where Compassion Overcomes Fear' a narrative by Mariya Prakash Jiandani was published in Indian Journal of Medical Ethics, in August 2020

Awards & Honours-

- Ms Nidhi Ranka won first prize in undergraduate category at Scientifica, Pune for oral presentation on research titled 'Perception of Knowledge, Attitude and Practices in Bioethics in Physiotherapy'.

Workshops, Conferences & Paper Presentations-

- Dr Santosh Salagre was a invited faculty for 'Bioethics Faculty Development Workshop' at MUHS Nashik in February 2020
- Dr Santosh Salagre was a invited faculty for '3T Training of Faculty in Bioethics' at Karpagya Vinayaga Institute of Medical Sciences, Chennai in February 2020
- Dr Santosh Salagre attended and participated as a faculty in 'BIOETHICON 2019' International Conference on Bioethics in Health Sciences at SRM University Chennai. He also conducted a Preconference Workshop on 'Professionalism and Bioethics' for undergraduate students
- Dr Mariya Jiandani participated as Indian representative in 'International Global Conference on Ethical Issues faced by Physiotherapists during COVID 19 Pandemic'
- Oral presentation by Nidhi Ranka at Scientifica, Pune of research titled 'Perception of Knowledge, Attitude and Practices in Bioethics in Physiotherapy'. Nidhi Ranka, Omkar Thakur, Mariya Jiandani
- Oral presentationby Dr Devi Bavishi at an International Conference of Bioethics- World Congress of Bioethics Philadelphia, USA University of Pennsylvania of research titled 'Assessment of Ethics and Professionalism among Medical Undergraduate Students in a Tertiary Care Teaching Hospital: A Questionnaire Based Cross-sectional Survey'. Marathe PA, Bavishi D, Pooja SG, Kokate DK, Mulkawar A, Rege NN

Looking Ahead: Training of Postgraduates in Bioethics and clinical ethics

BIOETHICS Education program for Undergraduate

Date	Discipline & Batch	Topics covered
February 28, 2020	160 Second MBBS and 15 Second year Occupational Therapy and 29 Physiotherapy Students of 2018 Batch attended this session	Research Ethics & Empathy
March 2, 2020	155 Interns attended this session	Doctor patient relationship and Communication Skills and Professionalism
October 12, 2020	18 Interns attended this session	Principles of Bioethics, Respect for Autonomy, Privacy andConfidentiality, Informed Consent, Benefit and Harm, Doctor patient relationship, Communication Skills and Professionalism

STUDENT WING ACTIVITIES

The unit has a strong student wing that carries out various activities. The theme of World Bioethics Day 2020 is 'Benefit and Harm'. The poster making and photography competitions were based on the same theme. Due to the current situation of COVID 19, all competitions were held online mode on virtual platforms. Students were involved in planning, organizing and execution of these events. Experts from outside and within the institute are invited as judges.

E-Poster Making Competition

The 'Poster Making Competition' was one of the events conducted as a part of 'World Bioethics Day Celebrations - 2020'. We got an overwhelming response in the form of 47 beautiful and thoughtful posters.

Prizes

First Prize	Nikita Rajendra Badhe	II year GNM LTMGH, Sion
Second Prize	Elizabath James	III year GNM LTCN, Churchgate
Third Prize	Zoya Khatri	II year MBBS GSMC KEMH

Best Poster on Cover Pages

PHOTOGRAPHY COMPETITION 2020

First Prize

Second Prize

Third Prize

Prizes

First Prize	Mansi Bande	I year MBBS
Second Prize	Prajwal Varak	II year BPTh
Third Prize	Pallavi Gavit	III year BPTh

JIGYASA: Questioning the Ethics of COVID-19

• A competition to reflect on and present a structured critique of a bioethics journal research article about the medical ethics of the COVID-19 pandemic.Sayoni Shah of the student wing member and anchor for Jigyasa, started the event by welcoming the judges, faculty, paticipants and audiences invited through the circulation of PDF Flyers with the
meeting link.
• Time limit for each participant to present their critique in a live ppt presentation was 8 minutes.
Articles for critique (to present any 1 of 4):
1) The "invisible" among the marginalised: Do gender and intersectionality matter in the Covid-19 response?
2)Building trust while influencing online COVID-19 content in the social media world.
3)Burnout among healthcare providers during COVID-19: Challenges and evidence-based interventions.
4)COVID-19 human challenge studies: ethical issues

Prizes

First Prize	Saloni Dedhia	II Year BPTh
Second Prize	Tejaswi Patil	I Year MBBS

IDEON: Ideas Combating The Pandemic

Here is a Hypothetical situation , **"Consider yourself to be a Medical Officer ofa Primary Health Care Centre (PHC) , how will you solve the problems stated below (any 2 out of 4) in a novel , innovative and techy way "**

1. Immunisation of infants
2. Medical Follow up of geriatric patients
3. ANC checkups and aseptic deliveries
4. Education and training of people in your area to control the pandemic.
Individual participants were expected to make a short PPT explaining the solution for 5 minutes , followed by question answer round for 6 min.

Prizes

First Prize	Tejaswi Patil	I year MBBS
Second Prize	Ayushi Dubey	Final year MBBS
Third Prize	Devanshi Vora	I year MBBS

STORY TELLING COMPETITION

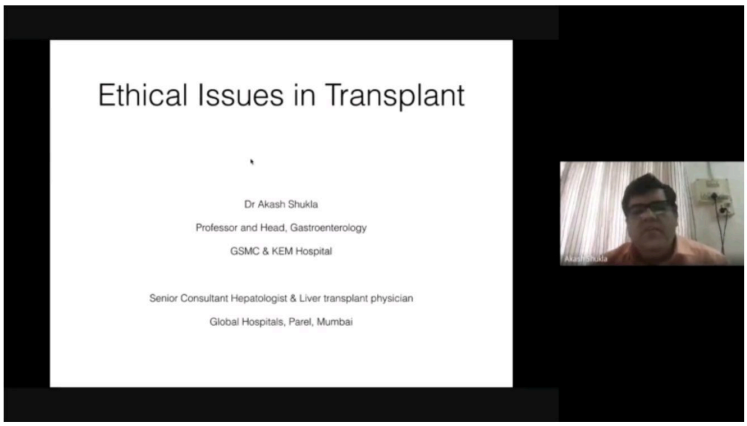
In the storytelling competition participants had to narrate orally and share stories on Google Meet Some stories were real life experiences and some adaptations of actual circumstances. Participants were from different health care fields and through their stories they were able to bring different perspectives to the table. In as less as 5 minutes which was the time limit of the competition, participants were able to take us to a different world through their narration.

Prizes

First Prize	Surbhi Raghoji	I Year Nursing
Second Prize	Ansh Agarwal	I Year MBBS
Third Prize	Manjiri Madkholkar	II Year Nursing

Guest lecture by eminent speakers

Dr.Sewanti Limaye
Director of Clinical and Translational research,Oncology
Kokilaben Dhirubhai Ambani Hospital and Medical Research Institute



Dr.Akash Shukla
Professor and Head of Department of Gastroenterology, GSMC KEMH

ACKNOWLEDGEMENT

GSMC MUHS UNESCO BIOETHICS UNIT

Expresses its gratitude to judges of all competitions.

-: JUDGES NAME :-

Artistic Poster :

Dr. Gita Nataraj, Dr. Padmaja Marathe, Dr. Ajay Rana

Photographs :

Dr. Avinash Supe ,Dr. Hemant Nadgaonkar and Dr. Padmaja Samant

Jigyasa :

Dr.Urmila Thatte, Dr. Ajita Nayak, Dr. Yuvraj Chavan

Ideon :

Dr. Niranjan Mayadeo, Dr. Ravindranath Sahay, Dr. Dilip Kadam

Story Telling :

Dr. Aparna Deshpande, Neha Madhiwala, Dr.Nayana Ingole

Gratitude to all participants and audience.

"Life is a gift, and it offers us privilege, oppurtunity, and responsibility to give something"

-Tony Robbins

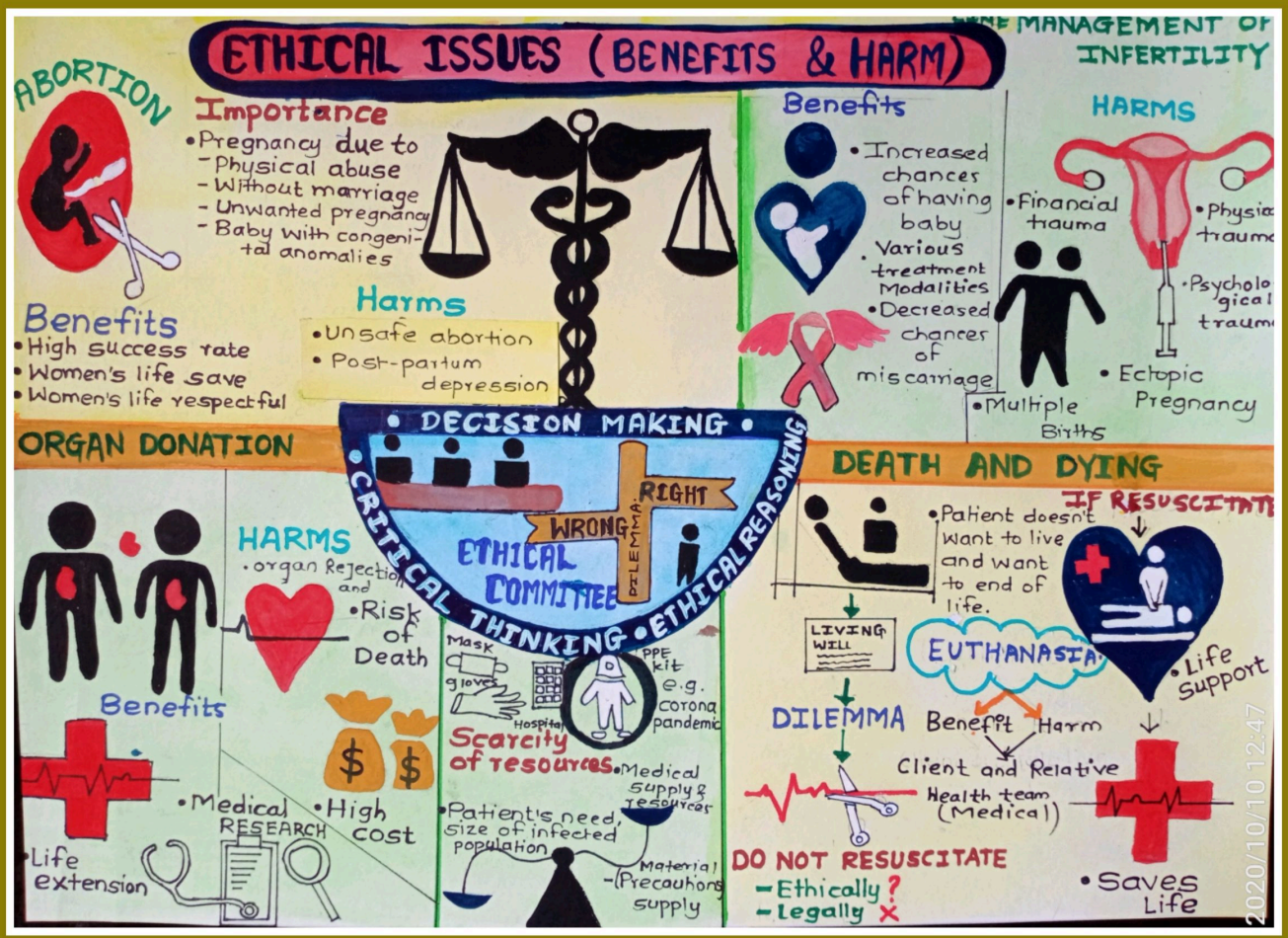
Fifth Prize

Shruti Suhas Raut Second Year Occupational Therapy, GSMC KEMH

GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
Benefit and Harm
19th October 2020

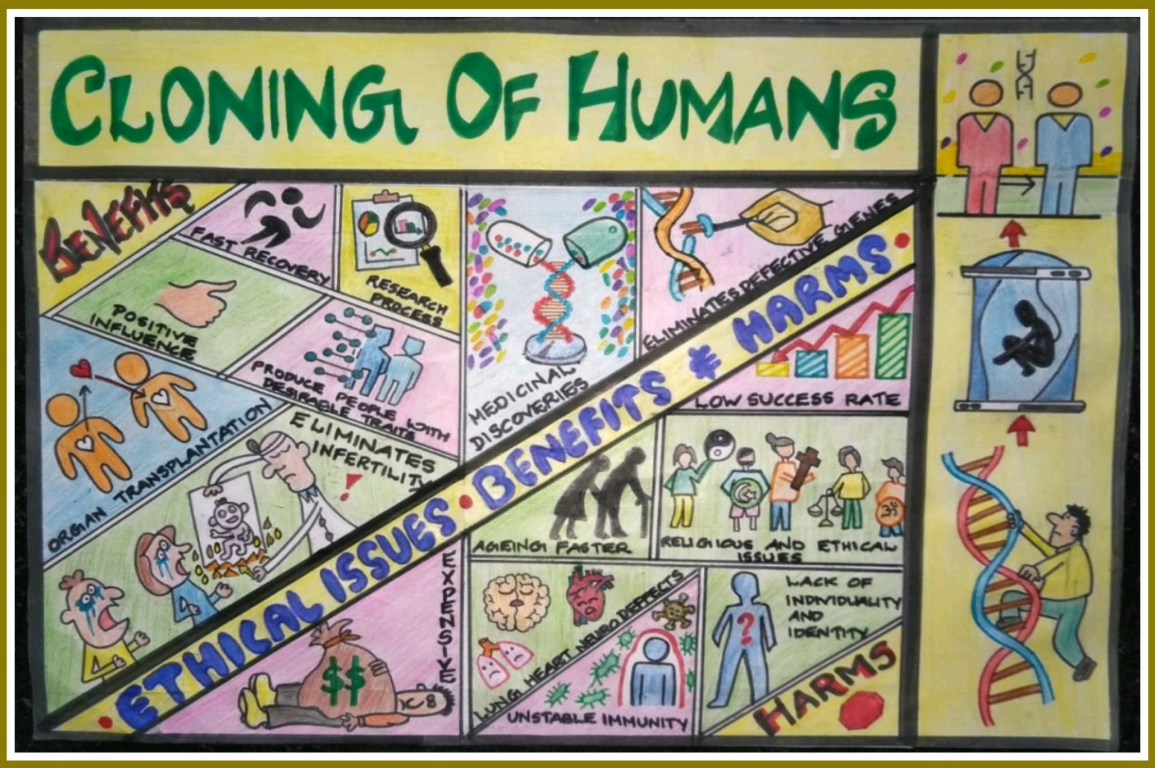
Poster Competition on
'Benefit and Harm'



Fourth Prize

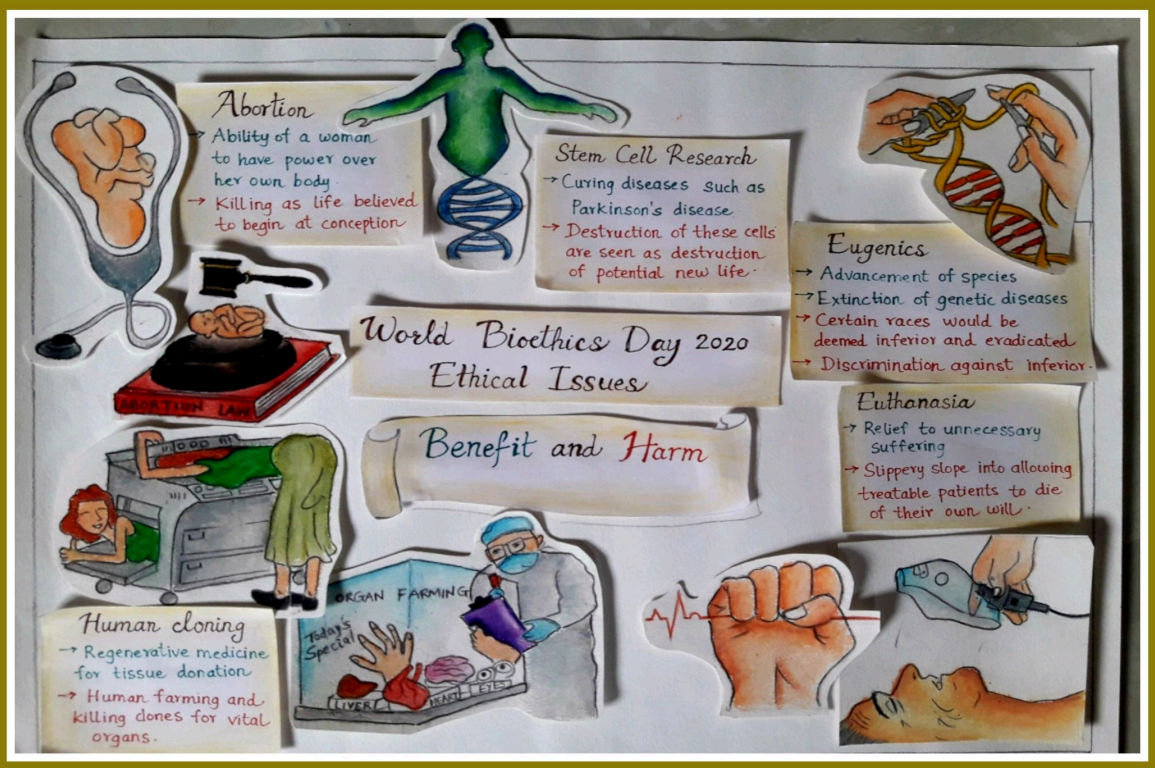
Meena Bamane, Third Year, Nursing

GSMC MUHS UNESCO Bioethics Unit



Second Prize

Elizabath James, Third Year Nursing, LTCN, Churchgate



Third Prize

Zoya Khatri, Second Year MBBS
GSMC KEMH