FRONTIERS IN MEDICAL ETHICS pdf

1: Philosophy and ethics in the frontiers of brain science - On Medicine

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Yet most strikingly, even official paying members of the Committee on Publication Ethics COPE are not really bound to follow the rules of good editorial practice this organization advices. In fact, the COPE council even appears partially managed by the very publisher which openly admits to ignoring its publication ethics guidelines: After the Swiss publisher Frontiers was listed by Jeffrey Beall as a potential, possible, or probable predatory scholarly open-access publisher, the Frontiers Communications Office provided a comment under the relevant news article in Nature. In fact, Frontiers writes on their website , under the heading Publication Ethics and Malpractice: One clue might be: As a reminder, the editorial conflict at Frontiers arose because medical chief editors felt they had little influence on which papers were accepted for publication in their journals and on which criteria. They also perceived the publisher-imposed rules, which strongly discourage manuscript rejection, as hurdles to their editorial duties to prevent the publication of seriously flawed medical papers. Yet in a reply to the editorial Manifesto, Frontiers wrote: We are now formalizing this by officially registering our journals with these associations. On the latter, it says: Journal owners should not interfere in the evaluation, selection, scheduling, or editing of individual articles either directly or by creating an environment that strongly influences decisions. This was the unsigned reply I received: As is noted at our website: Frontiers COPE membership is official and it costs. Exactly one year before, the COPE council member Mirjam Curno, joined Frontiers in her main professional occupation as journal manager. It proved rather difficult to engage with Curno on the matter of editorial ethics in regard to her current main employer, Frontiers. My inquiry was about the shortfall of editorial independence at Frontiers, as perceived by the former medical editors and detailed in their editorial Manifesto. Since that email two months ago, I never received any reply at all from my direct addressee Curno. Curno with another round of questions. In his follow-up email, Fenter stated the following: If you have queries for COPE, please use their well-established procedures. Questions concerning Frontiers should be addressed to me. There is absolutely no conflict between our way of operating and the COPE guidelines. Fenter then proceeded on to explain the Frontiers principles, most of which I have already relayed in a comment to the relevant article. While I am very grateful to Dr. In fact, I was somewhat surprised that a COPE trustee is, for some reason, not able to correspond on her own about the implementations of COPE guidelines by its publisher members. I was left confused as to whether Dr. Curno is a dedicated academic, appointed as COPE trustee against her numerous highly qualified competitors for her engagement and contributions to publication ethics, or if she is currently rather a non-autonomous COPE delegate of her main employer, the publishing house Frontiers. Publishing is evolving rapidly and new models are being tried out. Another such example is the much bigger Nature Publishing Group which mother company, the German publisher Holtzbrinck , also partially owns Frontiers. The COPE website also insists: Also, in several instances the Code unmistakably stipulates the demand for editorial independence, the deficit of which Frontiers has been accused of. Understandably, as a discussion and advisory forum COPE is in no position to enforce the adherence of its members to the guidelines they have voluntarily subscribed to. But even then, do such journals and publishers have to be welcomed or tolerated by COPE as its members? One could argue that it is a wiser approach to engage uncooperative publishers as COPE members, with the expectation that they would little by little eventually adjust their editorial practices to the COPE guidelines on publication ethics. This might be one very enticing future outcome. Another, less desirable one, could be that the new COPE members, likely together with their financially dependent representatives on the COPE council, could simply write a new set of publication ethics guidelines, which may be very different from the current one. Who knows, if in the future COPE code of conduct, a demand for editorial independence might actually be deemed as editorial misconduct. After all, there are not many industries where such high profits are being made as in academic publishing. Barbour has been corrected as a former one, according to her own feedback s.

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I apologise for using outdated information from the PLOS website http:

2: Frontiers in Type 2 Diabetes: The Role of Nutrition in Health

All manuscripts submitted to Frontiers in Medicine that have been conducted in human subjects must conform with current regulations and the Declaration of Helsinki. Ethics committee approval and informed patient consent are required for studies involving human subjects.

Open in a separate window Balancing beneficence and non-maleficence The first important ethical question is whether DBS is beneficial and does not harm the patient. This must be assessed both at a group-level and at the level of individual patients. At the group-level, this means that the available evidence regarding effectiveness, risks, and side effects of DBS for various conditions, in various target areas, and for various patient-populations must be assessed. The risks and complications associated with DBS surgery include hemorrhage 1. Side effects depend partly on the stimulation target and include effects on cognition, behavior and psyche, including speech disturbances The principle of subsidiarity implies that DBS should only be used when other less risky or burdensome treatment options have been exhausted. Patient selection In order to secure a favorable riskâ€"benefit ratio for individual patients, careful patient selection is necessary. Patients need to stand a good chance to benefit from the procedure, have severe functional impairments and be refractory to other, less invasive or less burdensome, treatments. Also, candidates should be physically, cognitively, and emotionally capable of tolerating surgery and participating in postoperative care Bell et al. This is best assessed in a multidisciplinary team Kubu and Ford, For example, it may prove to be beneficial for PD patients to start DBS treatment earlier in the disease process, because this may have a neuroprotective effect, or because it may prevent psycho-social problems related to advanced PD. In essential tremor, on the other hand, earlier intervention may not be beneficial because tolerance may develop. Good care With regard to the side effects of DBS it is increasingly recognized that these include not only physical or psychiatric symptoms. The psycho-social impact of the DBS treatment and the effects on overall quality of life should be included as well. It was found that quality of life on aspects such as emotional well-being, social support, and interpersonal relationships may actually decrease after surgery, even when physical symptoms improve. These findings may be partly due to unrealistic expectations of patient. This emphasizes the need for good pre-operation counseling and the provision of clear and honest information in the informed consent process. Moreover, these findings point to the unsettling effects of successful treatment. Paradoxically, regained functioning may upset established social and relational patterns. Many patients have difficulties with psycho-social adjustment after surgery, especially with regard to their marital relationships, self-perception, and work. After surgery, a period of adaptation is necessary for both patients and their families. Changes in personal identity â€" A special kind of side effect? A useful distinction can be made between numerical identity and narrative identity Schermer, a ; Schechtman, The first refers to continuity of the same person over time, defined by bodily criteria like DNA , or psychological criteria such as autobiographical memory or a set of core-characteristics. A change in numerical identity would mean that someone literally became someone else. If DBS would cause changes in mood, cognition, or behavior that would affect numerical identity e. This is not the case, however. Changes in narrative personal identity are not necessarily ethically problematic in themselves â€" that is, apart from possible harmful consequences for others. People always change in many respects throughout their lives; personal identities are not static but develop over time. Other changes may not be intended but can still be welcomed by the patient, for example an elevated mood or increased libido. The same changes can, however, be evaluated differently by different patients. The relevant ethical point is therefore whether or not the patient himself perceives the changes in his personality, mood, behavior, or cognition brought about by DBS as disruptive of his personal narrative identity Schermer, a ; Synofzik and Schlaepfer, This may well account for the adjustment problems discussed above. Finally, if changes in personality and behavior negatively affect others, this may raise the problem of responsibility see Schermer, b. Justice Little has been written on the issue of justice with regard to DBS treatment. DBS is an expensive form of treatment, although it has been argued that DBS may turn out to be cost effective in the longer run as compared to alternative treatment options Bell et al. In the face of scarcity of resources, it may be necessary to

prioritize between groups of patients. From a perspective of justice, ideally, priority should be given to those who are most seriously impaired and who will benefit the most from the intervention. Anyway, one should be careful not to exclude patients who might benefit from the procedure on grounds not related to expected benefit, for example because of their age. Autonomy and consent Patients undergoing DBS must give their voluntary and fully informed consent to this procedure, just like for any other medical intervention. In practice this may be problematic for a number of reasons. First, some patients may be desperate because of their hopeless situation, suffering as they are from a serious, progressive, and treatment-refractory disease. They may feel they have no other option but to consent to the proposed treatment. However, this is not a unique situation for DBS and the fact that there are no other treatment options left does not imply that consent is not voluntary. Balanced and realistic information is therefore needed, not only regarding risks and side effects of the procedure but also regarding the expected benefits and the limitations of this treatment. It must be clear to patients, for example, that DBS will not cure their PD and will not stop its progression. Competence can be challenged by the primary neurological disorder, or by co-morbidity like cognitive impairments or depression. It can however also be affected by DBS itself Glannon, Deep brain stimulation can, for example, induce a hypo manic state in patients and there are case reports of such patients who subsequently refuse adaptation of the stimulator settings because they are not aware of their disturbed mental state. These patients may harm themselves or others, for example by excessive gambling or reckless driving. If an incompetent patient inflicts severe harm on himself or others, it is ethically justified to intervene, under conditions of proportionality and subsidiarity. In this way, the patient can be enabled to make his own autonomous decisions considering the further course of action. Fortunately, dramatic dilemma-situation as in the case report by Leentjens et al. Children Deep brain stimulation treatment in children or adolescents, e. First, because children are incompetent to decide for themselves about risks and benefits and are therefore more vulnerable to abuse. While this is no reason to exclude them from beneficial treatment â€" parents can act as representatives and make decisions in the best interest of their child â€" it necessitates an extra careful assessment of the riskâ€"benefit ratio. Second, research on DBS in children is scarce. Only 35 children have been treated for dystonia and so there is little evidence regarding benefits and risks in children especially regarding long term effects on the developing brain Lipsman et al. DBS treatment for neurological disorders in children should therefore be regarded as experimental and should only be performed by highly specialized teams and within well-designed and independently reviewed research protocols. A consensus seems to be developing that only in extreme cases where tics cause spinal cord injury or myelopathy DBS may be considered as last-resort treatment in children Lipsman et al. For clinical research involving human subjects the fundamental ethical challenge is to promote high-quality scientific research in the interest of future patients, while at the same time safeguarding the rights and interests of vulnerable research subjects. In the United States and Europe, national and international regulations apply to scientific research with human subjects and Institutional Review Boards IRBs or local ethics committees oversee their observance. With regard to DBS research in psychiatric disorders a number of ethical requirements have been specified and guidelines have been proposed by experts from the field Nuttin et al. Table 2 Ethical guidelines for DBS research based on:

3: Neuroethics - Wikipedia

Note: Citations are based on reference standards. However, formatting rules can vary widely between applications and fields of interest or study. The specific requirements or preferences of your reviewing publisher, classroom teacher, institution or organization should be applied.

This may consist in, but is not limited to, patient input to achieve more patient-friendly protocol design, endpoint, and comparator selection as well as disease-adapted study conditions in a pre- or post-marketing clinical trial. Ethical aspects and especially the balance of benefit and risk in a clinical trial are frequently judged differently by clinical researchers, regulators, ethics committees, and patients due to their different focus. The final assessment of the ethical aspects of a planned clinical trial is provided by an independent ethics committee consisting of physicians and other experts in healthcare and clinical trial methodology as well as of lay persons. The participation of patients in ethics committees is a much-discussed concept, its suitability disputed in many countries, and only limited experience on best practices is available. In order to be effective and yield the best results for all stakeholders, integration of patients into the medicines development process needs to be structured and governed by clear, mutually agreed rules and modes of operation. Communication and collaboration processes need to be systematically implemented to establish transparency, trust and respect between those developing new medicines and their users, respectively between those involved in design and approval of clinical trials and participants. Overarching guidance on meaningful and ethical interaction is missing. In addition to a presentation of the full text of the Guidance, this article aims at providing additional background information on the development process of the Guidance, as well as insight into the current debate on this topic. Minimal standards for composition, operations, and procedures of ethics committees have been defined in the ICH-GCP guideline. However, countries have chosen to implement varied ethical review systems, performed by ethics committees with very different composition and focus of their work. Nevertheless, in all countries, their aim is to provide sponsors and researchers with a thorough, unbiased ethical opinion formed by a multi-disciplinary committee of scientific experts in their field, supported by lay person input. In a few countries also patients are members of an ethics committee, either based on national legal requirements orâ€”more recentlyâ€”on the initiative of the individual ethics committee. As a result of the growing interest and willingness of patients to contribute to a more patient-centered medicines development process more and more patients are prepared to join ethics committees. They want to provide their expertise of living with the disease, their insight into potential benefits and risks of the new medicine and feel comfortable contributing additional aspects. However, involvement of patients in the work of ethics committees is not their only possibility to improve the ethical acceptability of clinical trials for participating patients. Specific patient input on ethical aspects should be enabled all along the clinical trial preparation process because decisions pertaining to ethics are made at many timepoints before the submission of the clinical trial dossier to the ethics committee. The Guidance presented here has been developed as one of four EUPATI guidances addressing key areas of interaction and generally agreed collaboration principles for different stakeholders and patients in the medicines development process. An introductory part provides information on the background of EUPATI and the benefits of patient education and engagement throughout the medicines development process. In the main part of the guidance an overview of the options for involvement of patients in ethics committees is presented that reflects the diverse and rapidly changing situation in Europe. Concrete proposals for ethically correct, trustworthy and transparent patient involvement in ethics committees are given, based on the multi-stakeholder work of the EUPATI guidance task force, feedback from workshops, webinars, and a survey on experiences and expectations on patient involvement in the ethical review of clinical research projects as well as a broad public consultation. EUPATI does not focus on disease-specific issues or therapies, but on the process of medicines development in general. Indication-specific information, age-specific or specific medicine interventions are beyond the scope of EUPATI and are the remit of health professionals as well as patient organizations. To find out more visit www. The great majority of experts involved in the development and evaluation of medicines are

scientists working both in the private and public sector. There is an increasing need to draw on patient knowledge and experience in order to understand what it is like to live with a specific condition, how care is administered and the day-to-day use of medicines. This input helps to improve discovery, development, and evaluation of new effective medicines. Structured interaction between patients of all age groups and across conditions, their representatives and other stakeholders is necessary and allows the exchange of information and constructive dialogue at national and European level where the views from users of medicines can and should be considered. It is important to take into account that healthcare systems as well as practices and legislation might differ. Experience to date demonstrates that the involvement of patients has resulted in increased transparency, trust and mutual respect between them and other stakeholders. The EUPATI guidance documents aim to support the integration of patient involvement across the entire process of medicines research and development. These guidance documents are not intended to be prescriptive and will not give detailed step-by-step advice. Users may deviate from this guidance according to specific circumstances, national legislation, or the unique needs of each interaction. This guidance should be adapted for individual requirements using best professional judgment. There are four separate guidance documents covering patient involvement in: These guidances should be periodically reviewed and revised to reflect evolution. The following values are recognized in the guidances and worked toward through the adoption of the suggested working practices. Patients have knowledge, perspectives and experiences that are unique and contribute to ethical deliberations. Patients have the same rights to contribute to the ethical review of clinical trials as other stakeholders and have access to knowledge and experiences that enable effective engagement. Patient involvement in the ethical review process contributes to equity by seeking to understand the diverse needs of patients with particular health issues, balanced against the requirements of the industry. Patient involvement processes address barriers to involving patients in ethical reviews and build capacity for patients and ethics committees to work together. All subsequently developed guidances should be aligned with existing national legislation covering interactions as stated in the four EUPATI guidance documents. These guidances should be used according to specific circumstances, national legislation, or the unique needs of each interaction. These guidances should be adapted for individual requirements using best professional judgment. Where these guidances offer advice on legal issues, it is not offered as a definitive legal interpretation and is not a substitute for formal legal advice. If formal advice is required, involved stakeholders should consult their respective legal department if available, or seek legal advice from competent sources. EUPATI will in no event be responsible for any outcomes of any nature resulting from the use of these guidances. Specific Guidance for Patient Involvement in Ethical Review of Clinical Trials Introduction To ensure optimal benefit for patients from a new medicine, and resulting commercial success, pharma companies focus the selection of compounds to develop and the definition of relevant research outcomes around the needs of patients with the respective disease. It requires new strategies, new organizational structures, and culture change across the pharma sector. It requires partnership with patient experts who are capable of providing advice on the value of treatments and on what health outcomes are relevant to patients. However, the concept of patient centricity is also relevant for other stakeholders in the medicines development process, especially for research ethics committees who advocate for the protection of patients in clinical trials. Good clinical trial design is both ethical and scientifically sound. Design decisions include whether the new medicine is to be compared to another medicine or a placebo, how study participants should be selected, and what kind of tests and assessments are to be made and how often. The risk of potentially harmful side effects needs to be balanced against the potential benefits for the patients taking part, such as early access to a new medicine, more intense diagnostics and supervision, and the chance to contribute to the development of new treatments for other patients with the same disease. Clinical trials are subject to a framework of very strict laws. Before a clinical trial can start it needs approval from the competent authority which must ensure that all legal conditions are fulfilled, that the trial is scientifically sound, that the study medication is of proven quality and safe based on preclinical andâ€”if availableâ€”previous clinical evidence; and that there is a favorable balance between expected benefits and risks. In parallel to the review by the national competent authority, one or more multi-disciplinary research ethics committees review the study protocol and related documents in order to safeguard the study

participants. They ensure that the information to patients is comprehensive and understandable. They assess the balance between benefits and risks, ensure that this balance is acceptable, and that the trial is scientifically relevant for patients with the disease in question. In most European countries patients, carers, or patient representatives are only marginally or not at all involved in the ethical and scientific review of clinical trials. Ethics committees are expert advisory groups providing advice on the ethical acceptability of research projects carried out in human beings. They have an obligation to the public to protect the research participants. To fulfill these obligations, ethics committee members need to be independent, neutral, objective and competent in scientific, ethical and methodological topics. The inclusion of a lay member is supposed to support this neutrality and to enlarge the scope of advice. Adding patient members to an ethics committee means a paradigm shift: There is a need for a generally accepted guidance outlining the conditions for collaboration of ethics committees and patients in ethical review. This guidance covers patient involvement in ethical review of clinical trials. Ethical aspects need to be considered in any step of the clinical trialâ€"from definition of the research questions and protocol conditions, to informed consent preparation, to ethical review by ethics committees and to provision of information on trial results to the public. See Figures 1 , 2. This guidance covers patient involvement in any of these steps, although special emphasis is given to patient involvement in research ethics committees. A roadmap where patient involvement may occur in ethical review of clinical trials. Patients can meaningfully contribute across the clinical trial process. This diagram distinguishes between areas in the clinical trial process that require a high level or a medium level of expertise in the respective indication. This guidance is based on the discussions and conclusions from a multi-stakeholder roundtable discussion and a webinar on patient involvement in ethical review organized by EUPATI, contributions from national ethics committees, consultation within the EUPATI consortium and a comprehensive external consultation process. They may or may not be affiliated with an organization. There may be reservations about involving individual patients in collaborative activities with stakeholders on grounds that their input will be subjective and open to criticism. However, EUPATI, in line with regulatory authorities, instills the value of equity by not excluding the involvement of individuals. The type of input and mandate of the involved person should be agreed in any collaborative process prior to engagement. Current Status of Patient Involvement in Ethical Review Best practice examples have shown that patient involvement in ethical considerations concerning clinical trials as early as in the trial design and protocol preparation stage can be beneficial to strengthen the awareness about ethical issues in the research project. Involvement at this stage can ensure that the focus on the patient is maximized and the outcomes to be measured are relevant to patients. Similarly, in clinical trials being driven by academia, patient experts could provide meaningful advice. At the time of ethical review of the clinical trial by the ethics committee, the protocol details have been decided. Focus of this review is the acceptability of the specific benefit-risk balance, the patient protection elements and research site qualification as well as the information to patients during the informed consent process, by ethics committee members bringing in their respective expertise. While participation of at least one lay person in ethics committees is longstanding practice and of undisputed value, the type and extent of patient involvement varies widely betweenâ€"and even withinâ€"European Member States. In some countries patient representation is required by law and the conditions are clearly defined. Different practices exist for the following reasons: There is no established match-making process. The independence of representatives from patient organizations has been questioned on the grounds that their personal interests and financial support from the pharmaceutical industry might lead to conflicts of interest. So far, a limited number of patient organizations decided to make efforts to identify and educate individual members for a role with relevant contributions in ethical review and specifically in an ethics committee. Involvement of patients in the ethical review process is not stipulated in this Regulation, although the legislation states that lay persons, in particular patients or patient organizations, should be involved in the assessment of the clinical trial authorization application. The assessment process and the make-up of the assessing bodies national competent authorities and ethics committees are subject to national legislation, consequently the involvement of patients in the ethical review process will continue to vary from country to country. Timing and Nature of Patient Involvement in Ethical Review Patients can be involved in the ethical review of clinical trials at different time

points: In the Trial Design Phase patient experts can advise on the specifics of the clinical trial that need to be defined in such a way that: Input from the kind of patient that these documents are developed for can improve their readability, user-friendliness, and completeness. We recommend that patient experts should be involved in the Trial Design Phase - whether a trial is being sponsored by a company or academic centre - to support the acceptability of the trial conditions for participants and the relevance of its outcome for the respective patient community. In the Ethical Review Phase, performed by one or more ethics committees, patient experts, or patient advocates can provide important input into the elements described above. In addition, patients can advise on local conditions for the trial such as: Sponsors sometimes involve patients in communication with trial participants after the end of the trial, but this has been very limited in the past. Patient input to lay summaries will be essential to ensure they are suitable and readable for patients. Practical Aspects of Patient Involvement in Ethics Committees National legislation outlines the constitution, organization and responsibilities of ethics committees, and reflects the roles of different types of ethics committees in the protection of trial participants and research integrity.

4: Is Frontiers a potential predatory publisher? â€“ For Better Science

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Was this decision justified? I wish to share here some of my recent investigations. Previously, I reported about an editorial conflict at the Frontiers medical section in Laborjournal and Lab Times. In May Frontiers sacked almost all of its medical chief editors. At the same time, chief editors claimed to have had little, if any, influence over the editorial processes at Frontiers. Medical ethics requirement for publication, originally introduced by the previous chief editors, were not implemented in the Frontiers instructions for authors. Some of these associate editors are no strangers to controversy themselves; Alfredo Fusco, who is also a frequent author at Frontiers in Medicine, has had several of his papers retracted and is facing a criminal investigation over alleged data manipulations. What I learned is that even the associate editors often find their power limited: This may explain how controversial papers came to be published in Frontiers, e. On the other hand, Frontiers is quite popular with many scientists and research organisations. How can a publisher which helped pioneer such innovations as open access and name-signed peer review, have come to this? One of its very first accepted articles, before the new journal was officially accepting submissions, was a theory on the origins of autism by journal founders Kamila and Henry Markram. Since then, their Intense World Theory formerly Intense World Syndrome has been published in various Frontiers neuroscience-related journals. Yet these two authors have an apparent ownership interest in the journals they publish. The mass sacking of medical chief editors suggests, they might be in a position to decide on the employment and remuneration of their editors. Some Frontiers editors I communicated with were quite content with the publisher. Unlike the medical chief editors, Simon says she was never was left in the dark about submitted manuscripts or witnessed their inappropriate handling by associate editors or reviewers. Maybe this is why Frontiers in Virology is one of the best cited Frontiers journals, because the chief editors are free to do their jobs? Apparently Frontiers in Medicine can operate without an Editor-in Chief, and indeed it has done for months now. But what about the ethical duties Simon was mentioning? Matthias Barton, cardiology professor at the University of Zurich and former EiC of Frontiers in Medicine and Frontiers in Cardiovascular Medicine, told me that when he and his fellow editors were sacked, their ethical policies were also shown the door. New medical ethics guidelines, which he and his colleagues had established to preserve clinical safety and patient protection, were revoked. Instead, the corresponding author simply has to make one click to verify COI status on behalf of others. Another example of the post-purge reform: The guidelines for manuscript submission are the same for both. No mention is made that human patient identity must be specifically respected and protected, in fact the new Frontiers guidelines there are same as for horses and cattle. For Frontiers in Medicine, these rules are now a thing of the past. However, this does not appear to be the case for the new head of Frontiers in Cardiovascular Medicine. Cardiovascular medicine is a branch of internal medicine and requires an utterly different medical specialization than cardiac surgery. A heart surgeon cannot replace a cardiovascular internist. In basic science, this is, to a degree, a laudable approach indeed. Many scientists convincingly argue that every single research study should be published and judged by the scrutiny of scientist colleagues in post-publication peer review. Yet this option is not available at Frontiers, and while the reviewers are named, their peer review reports are kept confidential. With medical studies, which go beyond laboratory experiments, the issue of proper editorial process is even more serious. Doctors adjust their patient treatments according to recent developments and publications in their field. Therefore, there can be many reasons for a submitted manuscript to be rejected. However, at Frontiers, the rejection option is not always available. Generally, a peer reviewer can only withdraw from the peer review; recommending rejection is not an available option. If a reviewer does withdraw, the handling editor is automatically prompted to find a replacement reviewer. Theoretically, this can go on back and forth until two positive peer reviews are finally obtained. Occasionally, associate editors skip the search for willing reviewers altogether and perform the peer review themselves. Tamas Szakmany, honorary senior lecturer in intensive care medicine at the Cardiff University in UK, reports of his experience as a reviewer for Frontiers in Medicine: I made it very clear at the first response to the authors that the paper

was unacceptable in this format and although they made some small changes, they did not address any of my major comments. He received a reply from the journal manager who explained: Yet just in the previous sentence, the journal manager also explained: This sounds somewhat like a Catch situation, in which the very act of sending out a paper for peer review precludes the ability to reject this paper on the basis of the review, should it turn out negative. Yet under certain conditions, Frontiers has no problems with rejections at all, even of positively reviewed manuscripts. She submitted a rather critical Commentary a publication type generally published by Frontiers free of charge on a certain Frontiers in Human Neuroscience article which dealt with visual shape perception. Her manuscript was assigned an associate editor, but soon rejected. No specific criticisms from this reluctant reviewer were forwarded to Maniatis. Instead, the associate editor reviewed the manuscript himself, despite being a child psychologist and autism specialist rather outside the field. Maniatis later published her criticisms on PubPeer and PubMed Commons and was finally able to engage with the authors of the paper. Then, at the beginning of , a break came. One could assume that NPG has sold or withdrawn their investment in Frontiers, however one fact suggests that there has not been a total financial divorce: Certain editors told me that they did not succeed in having their Loop account fully deleted. Loop may help Frontiers and NPG scientists to connect, but not every account belongs to a bona fide user. The network contains a number of obviously inappropriate or bogus accounts, and Frontiers has been informed by then-EiC Barton about certain questionable Loop profiles. Frontiers thanked Barton in January for sharing the information on these strange researcher profiles, but has yet to remove them. Coincidently or not, prior to this the Frontiers journal manager Mirjam Curno joined the committee as council member. Some of these employees have little experience in the research fields they are now supervising. One is a former earth scientist, now in charge of veterinary science, neurology and psychiatry. Another studied English and Croatian at university but is now an oncology, endocrinology and public health specialist. Yet another, who supervises several Frontiers life science journals despite having studied earth sciences, has no PhD. All of this would not necessarily be a problem if these managers were assisting and answering to the senior academic editors of their respective journals. Instead, as the sacked medical chief editors have experienced, these journal managers interfered with the editorial process, by occasionally advising these editors to keep recruiting further reviewers or dissuading them from rejecting a manuscript. Editorial independence, free from the meddling of the owner and publisher is a key principle of good editorial practice in science publishing, as stipulated by highly respected organizations such as ICMJE and COPE. These events however do not mean that Frontiers is bound to change its internal policies. More on this soon. The institutional affiliation of Lydia Maniatis has been corrected -LS Or several of small tips, just increase the amount as you like. Your generous patronage of my journalism, however small it appears to you, will greatly help me with my legal costs.

FRONTIERS IN MEDICAL ETHICS pdf

5: Library Resource Finder: More Details for: Frontiers in medical ethics : applicatio

Abernethy, VirginiaAbram, Harry S., eds. Frontiers In Medical Ethics: Applications In A Medical Setting. Cambridge, Mass.: Ballinger Pub., Print. These citations may not conform precisely to your selected citation style. Please use this display as a guideline and modify as needed.

The field is so young that any attempt to define its scope and limits now will undoubtedly be proved wrong in the future, as neuroscience develops and its implications continue to be revealed. At present, however, we can discern two general categories of neuroethical issue: In the first category are the ethical problems raised by advances in functional neuroimaging , psychopharmacology , brain implants and brain-machine interfaces. In the second category are the ethical problems raised by our growing understanding of the neural bases of behavior, personality, consciousness, and states of spiritual transcendence. Historical background and implications of neuroscience ethics[edit] Primitive societies for the most part lacked a system of neuroethics to guide them in facing the problems of mental illness and violence as civilization advanced. Trepanation led through a tortuous course to " psychosurgery ". Neuroscience ethics neuroethics must keep up with advances in neuroscience research and remain separate from state-imposed mandates to face this challenge. In the 20th century in both the communist USSR and Nazi Germany , medicine regressed after these authoritarian systems corrupted the ethics of the medical profession and forced it to descend to unprecedented barbarism. However, the early 21st century saw a tremendous surge in interest concerning the ethics of neuroscience , as evidenced by numerous meetings, publications and organizations dedicated to this topic. In , there were several meetings that drew together neuroscientists and ethicists to discuss neuroethics: This last meeting was the largest, and resulted in a book, Neuroethics: Mapping the Field, edited by Steven J. Marcus and published by Dana Press. That same year, the Economist ran a cover story entitled "Open Your Mind: The Ethics of Brain Science", Nature published the article "Emerging ethical issues in neuroscience". Thereafter, the number of neuroethics meetings, symposia and publications continued to grow. The over 38 members of the Society for Neuroscience recognized the importance of neuroethics by inaugurating an annual "special lecture" on the topic, first given by Donald Kennedy , editor-in-chief of Science Magazine. Several overlapping networks of scientists and scholars began to coalesce around neuroethics-related projects and themes. For example, the American Society for Bioethics and Humanities established a Neuroethics Affinity Group, students at the London School of Economics established the Neuroscience and Society Network linking scholars from several different institutions, and a group of scientists and funders from around the world began discussing ways to support international collaboration in neuroethics through what came to be called the International Neuroethics Network. Stanford began publishing the monthly Stanford Neuroethics Newsletter, Penn developed the informational website neuroethics. Several relevant books were published during this time as well: The mission of the International Neuroethics Society "is to promote the development and responsible application of neuroscience through interdisciplinary and international research, education, outreach and public engagement for the benefit of people of all nations, ethnicities, and cultures". Judy Illes is the current President, who like Hyman and Sahakian, was also a pioneer in the field of neuroethics and a founder member of the INS. Over the next several years many centers for neurotics were established. Sources of information[edit] The books, articles and websites mentioned above are by no means a complete list of good neuroethics information sources. For example, readings and websites that focus on specific aspects of neuroethics, such as brain imaging or enhancement, are not included. The scholarly literature on neuroethics has grown so quickly that one cannot easily list all of the worthwhile articles, and several journals are now soliciting neuroethics submissions for publication, including the American Journal of Bioethics â€" Neuroscience, BioSocieties, the Journal of Cognitive Neuroscience, and Neuroethics. The web now has many sites, blogs and portals offering information about neuroethics. A list can be found at the end of this entry. Key issues[edit] Neuroethics encompasses a wide range of issues, which can only be sampled here. For example, how should incidental findings be handled when a presumed healthy research subject is scanned for neuroscience research and the scan reveals an abnormality? How safe are the drugs used to enhance normal brain function? These are

neuroethical issues with clear precedents in traditional bioethics. In contrast, many neuroethical issues are at least partly novel, and this accounts for some of the intellectual fascination of neuroethics. These relatively newer issues force us to think about the relation between mind and brain and its ethical implications. Brain interventions[edit] The ethics of neurocognitive enhancement, that is the use of drugs and other brain interventions to make normal people "better than well", is an example of a neuroethical issue with both familiar and novel aspects. On the one hand, we can be informed by previous bioethical work on physical enhancements such as doping for strength in sports and the use of human growth hormone for normal boys of short stature. On the other hand, there are also some arguably novel ethical issues that arise in connection with brain enhancement, because these enhancements affect how people think and feel, thus raising the relatively new issues of " cognitive liberty ". The growing role of psychopharmacology in everyday life raises a number of ethical issues, for example the influence of drug marketing on our conceptions of mental health and normalcy , and the increasingly malleable sense of personal identity that results from what Peter D. Kramer called "cosmetic psychopharmacology". Nonpharmacologic methods of altering brain function are currently enjoying a period of rapid development, with a resurgence of psychosurgery for the treatment of medication refractory mental illnesses and promising new therapies for neurological and psychiatric illnesses based on deep brain stimulation as well as relatively noninvasive transcranial stimulation methods. Research on brain-machine interfaces is primarily in a preclinical phase but promises to enable thought-based control of computers and robots by paralyzed patients. As the tragic history of frontal lobotomy reminds us, permanent alteration of the brain cannot be undertaken lightly. Although nonpharmacologic brain interventions are exclusively aimed at therapeutic goals, the US military sponsors research in this general area and more specifically in the use of transcranial direct current stimulation that is presumably aimed at enhancing the capabilities of soldiers. One of the most widely discussed new applications of imaging is based on correlations between brain activity and intentional deception. Intentional deception can be thought of in the context of a lie detector. This means that scientists use brain imaging to look at certain parts of the brain during moments when a person is being deceptive. A number of different research groups have identified fMRI correlates of intentional deception in laboratory tasks, and despite the skepticism of many experts, the technique has already been commercialized. Researchers are also finding brain imaging correlates of myriad psychological traits, including personality, intelligence, mental health vulnerabilities, attitudes toward particular ethnic groups, and predilection for violent crime. Unconscious racial attitudes may be manifest in brain activation. These capabilities of brain imaging, actual and potential, raise a number of ethical issues. The most obvious concern involves privacy. For example, employers, marketers, and the government all have a strong interest in knowing the abilities, personality, truthfulness and other mental contents of certain people. This raises the question of whether, when, and how to ensure the privacy of our own minds. Another ethical problem is that brain scans are often viewed as more accurate and objective than in fact they are. Many layers of signal processing, statistical analysis and interpretation separate imaged brain activity from the psychological traits and states inferred from it. There is a danger that the public including judges and juries, employers, insurers, etc. A related misconception is called neuro-realism: In its simplest form, this line of thought says that something is real because it can be measured with electronic equipment. A person who claims to have pain, or low libido, or unpleasant emotions is "really" sick if these symptoms are supported by a brain scan, and healthy or normal if correlates cannot be found in a brain scan. Memory dampening[edit] While complete memory erasure is still an element of science-fiction, certain neurological drugs have been proven to dampen the strength and emotional association of a memory. Propranolol, an FDA-approved drug, has been suggested to effectively dull the painful effects of traumatic memories if taken within 6 hours after the event occurs. This has begun the discussion of ethical implications, assuming the technology for memory erasure will only improve. Originally, propranolol was reserved for hypertension patients. However, doctors are permitted to use the drug for off-label purposesâ€”leading to the question of whether they actually should. Whether or not it is ethical to fully or partially erase the memory of a patient, it is certainly becoming a more relevant topic as this technology improves in our society. The field of stem cell research is a very new field which poses many ethical questions concerning the allocation of stem cells as well as their possible uses. Since most stem cell

research is still in its preliminary phase most of the neuroethical issues surrounding stem cells are the same as stem cell ethics in general. More specifically the way that stem cell research has been involved in neuroscience is through the treatment of neurodegenerative diseases and brain tumors. In these cases scientists are using neural stem cells to regenerate tissue and to be used as carriers for gene therapy. In general, neuroethics revolves around a cost benefit approach to find techniques and technologies that are most beneficial to patients. This study shows a positive outcome in the use of stem cells for neurological purposes. In this case stem cells were used to treat animal models who had been injured in a way that mimicked CP. This brings up a neuroethical issue of animal models used in science. Since most of their "diseases" are inflicted and do not occur naturally, they can not always be reliable examples of how a person with the actual disease would respond to treatment. The stem cells used did survive implantation, but did not show significant nerve regeneration. However, studies are ongoing in this area. One form of a degenerative disease that can occur in the brain as well as throughout the body is an autoimmune disease. Autoimmune diseases cause the body to "attack" its own cells and therefore destroys those cells as well as whatever functional purpose those cells have or contribute to. One form of an autoimmune disease that affects the central nervous system is multiple sclerosis. In this disease the body attacks the glial cells that form myelin coats around the axons on neurons. This causes the nervous system to essentially "short circuit" and pass information very slowly. Stem cells therapy has been used to try to cure some of the damage caused by the body in MS. Hematopoietic stem cell transplantation has been used to try and cure MS patients by essentially "reprogramming" their immune system. The main risk encountered with this form of treatment is the possibility of rejection of the stem cells. If the hematopoetic stem cells can be harvested from the individual, risk of rejection is much lower. But, there can be the risk of those cells being programmed to induce MS. Considering that there are fairly good treatments for MS, the use of stem cells in this case may have a higher cost than the benefits they produce. However, as research continues perhaps stem cells will truly become a viable treatment for MS as well as other autoimmune diseases. In general, the future looks promising for stem cell application in the field of neurology. However, possible complications lie in the overall ethics of stem cell use, possible recipient rejection, as well as over-proliferation of the cells causing possible brain tumors. Ongoing research will further contribute in the decision of whether stem cells should be used in the brain and whether their benefits truly outweigh their costs. The primary ethical dilemma that is brought up in stem cell research is concerning the source of embryonic stem cells hESCs. As the name states, hESCs come from embryos. To be more specific, they come from the inner cell mass of a blastophere, which is the beginning stage of an embryo. However, that mass of cells could have the potential to give rise to human life, and there in lies the problem. Often, this argument leads back to a similar moral debate held around abortion. On the other end of the spectrum, people argue that the small ball of cells at that point only has the potential to become a fetus, and that potentiality, even in natural conception, is far from guaranteed. Much of the ethical dilemma surrounding hESCs relies on individual beliefs about life and the potential for scientific advancement versus creating new human life.

6: Frontiers in Medical Ethics: Applications in a Medical Setting

Methods. A quasi-experimental, observational, comparative, prospective and mixed (qualitative and quantitative) study was conducted in order to analyse the correlation between the palliative doctor-patient relationship and ethical judgments regarding everyday bioethical dilemmas that arise in palliative clinical practice.

7: Psychedelic Medicine â€“ New Frontiers in Palliative Care | www.enganchecubano.com

He brings this vision to discussions of some of the most exciting issues at the frontiers of medical ethics todayâ€”including doctor-assisted suicide, gene therapy, and the headline-grabbing case of Dolly the sheep and the possibility that human beings might one day be cloned.

8: Wearable devices: Useful medical insights or just more data? â€“ Science & research news | Frontiers

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Patient participation in ethics committees is a much-discussed concept, its suitability disputed in many countries, and limited experience on best practices is available.

9: Gregory Pence - Wikipedia

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