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classrooms – so that these can be included in the body of knowledge available for study to student teachers. University departments and research institutions need to undertake such research.

In addition, there is a need to innovate with different models of teacher education. Institutional capacity and capability to innovate and create are pre-requisites for the pursuit of excellence. These are facilitated when the inputs to the institution are of high quality. In teacher education, the reality on the ground rarely reflects this. Curriculum innovation at the institutional level gets restricted to its transaction within the institution. At the state level, there is a trend of applying standard solutions and common strategies to many a problem of teacher education. The central admission procedure, common curriculum, centralized examination and evaluation system have stifled institutional initiatives in admission, curriculum design and evaluation and very little space is left for institutional self-expression. There is a need to facilitate a space for such innovations to take place so that the policy can draw from them.

In spite of these constraining conditions, there are and have been a number of initiatives that could be drawn from. A case in point is the four-year integrated Bachelor of Elementary Education (B.El. Ed.) programme for the preparation of elementary school teachers offered by select affiliated colleges of the University of Delhi. NCERT's experiments with the four-year integrated programme leading to the degree of B. Sc. Ed., two-year B. Ed. programme and integrated M.Sc. Ed. are other examples. Similar innovations are also being tried out in other institutions across the country. Several initiatives for providing academic support to in-service teachers include the setting up of resource centres. Programmes and activities of such centres include organization of workshops, provision of research fellowships and study sessions.

1.11 Open and Distance Learning (ODL) in Teacher Education

Open Education as a concept, coupled with modalities associated with Distance Education, does not stand as an exclusive transactional modality. There are several aspects of ODL which will get meaningfully translated only if the boundaries between direct human engagement and ODL tend to get diffused to the extent possible and perhaps, desirable. A modular approach to the development of teacher education curriculum along with a focus on independent study and on-line offering involving interactive modes of learning and the consequent modification in the approaches to assessment



Open University for Professional Education in the United Kingdom (UK) Press, 2000, p. 100.

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Ethical Standards in Pain Management and Research

I. General

Know the basic ethical standards in pain management and research (United Nations Office of the High Commissioner for Human Rights 1948; International Association for the Study of Pain 1993, 1995; American Medical Association, Council on Ethical and Judicial Affairs 2001; National Comprehensive Cancer Network 2001; Council for International Organizations of Medical Sciences 2002; Institute of Medicine 2002; World Medical Association 2001).

A. Philosophical concepts

1. Understand the concepts of subjective experience of pain and objective assessment of pain, and ways these assessments have contributed to problems in research and practice (Venetian 1989; Rollin 1990; Mac 1992; Cunningham 1993; Rich 2000).
2. Understand the distinction between the concepts of pain and suffering, and ways this distinction may or may not give scientific and moral status to the emotional component of pain (Roy 1992; Shapiro 1995).
3. Be aware of ways in which scientific and clinical attention to individual and group differences in the intensity and meaning of pain may conflict with the scientific ideal of generalizable, universal causes and markers of pain (Venetian 1989; Rich 2000).

B. Ethical obligations

1. Be aware of the importance of individual cultures, basic human rights, and responsibilities, and the need for constant review of current practices (Council for International Organizations of Medical Sciences 2002).
2. Understand that witnesses to patients' suffering of unnecessary pain have a moral responsibility to those patients, even if the witnesses are not clinically responsible for that pain (Hilberg 1992). Understand the potential moral difficulties associated with professionals' development of emotional distance from patients in pain (Shapiro and Fromm 1992; Cunningham 2001; Shapiro 1995; Rich 2000).
3. Understand that any pain above moderate levels can be physically and psychologically harmful. Preventing or alleviating such pain is not merely a matter of charity or doing good (beneficence), but carries a duty to prevent harm (non-maleficence) (Melnick 1988; Carr 1993; Walker et al. 1996).
4. Be aware that patients in pain may be at great risk for injury to their dignity, as well as to their autonomy; patients whose pain has been ignored, especially in chronic pain, may experience their pain in the same way as do victims of torture (Bardach and Lutz 1991). International declarations prohibit torture or other degrading treatment (United Nations Office of the High Commissioner for Human Rights 1948).
5. Understand the principle of justice as it may apply to all individuals and groups of patients in areas of pain prevention, assessment, and treatment (Foley 1995). Dedicating certain patients merely by posing as historical or current standard practice may be a form of false justice (Cunningham 1993; Walker et al. 1994; International Association for the Study of Pain 1995).

II. Clinical care

A. Professional power and responsibility

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