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Henk A.M.J. ten Have *Editor*

Bioethics Education in a Global Perspective

Challenges in global bioethics

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In memory of Edmund Pellegrino (1920–2013)
and Stuart Spicker (1937–2013)

Preface

This book is one of the results of the first international conference of the International Association for Education in Ethics (IAEE) that took place in Pittsburgh, USA, in May 2012. The legal establishment of IAEE in April 2011 has created a scholarly platform for expert interested and involved in ethics teaching. There is a substantial number of professionals who are teaching ethics in various types of programs and schools, and in different areas of applied ethics. Their professional effort and engagement should be better recognized; experiences and models of teaching should be exchanged, so that ethics education can be further enhanced and expanded. The IAEE offers the opportunities for international exchange, functioning as global centre of contact for experts in ethics education. The first conference attracted approximately 200 participants from a wide range of countries. The best of many presentations were elaborated into contributions for this book.

The incorporation of IAEE as well as the first conference has been generously supported by the Administration of Duquesne University. Specific appreciation is due to President Charles Dougherty of Duquesne University, a bioethicist by profession, for his continuous encouragement and support. Thanks are also owed to James Swindal, dean of McAnulty College and Graduate School of Liberal Arts, and philosopher by profession, for his enthusiasm and generosity. I owe a special debt to my colleagues in the Center for Healthcare Ethics. Gerard Magill energetically provided feedback and ideas, while Glory Smith mobilized all our doctorate students in the successful planning and proceeding of the conference. Finally, special thanks go to my research assistant Gary Edwards whose sharp eye, clear brain, language skills and ethical competence substantially facilitated the editing of this book.

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Chapter 1
Globalization of Bioethics Education

Henk A.M.J. ten Have

1.1 Introduction

This collection of essays is a sequel of the Inaugural International Conference on Education in Ethics, organized by the International Association for Education in Ethics (IAEE), which took place in Pittsburgh, U.S.A. in May 2012. More than 200 scholars from 33 different countries participated in this conference. Since many of the presentations specifically highlighted the global development of bioethics education, an initiative was taken to elaborate several aspects of this development into chapters for this book.

1.2 The Development of Bioethics Education

One of the remarkable phenomena in the development of sciences is the rapid expansion of the new discipline of bioethics in the last few decades. Van Rensselaer Potter, who was the first to introduce and elaborate the notion of bioethics in subsequent publications from 1970, was surprised to note how quickly and widely the term became used in scholarly debates (Potter 1975). Potter, however, also lamented that the meaning of the term has deviated from the broader vision he had proposed. Bioethics had become redefined and restricted to 'medical bioethics,' focusing on ethical issues concerning individuals and relations between individuals, and neglecting ecological, population, and social problems. In this narrow vision, bioethics debates are addressing short-term issues rather than the continued existence of the human species. It therefore continues examining the old problems such as abortion and euthanasia instead of analyzing problems that really matter for the survival of humankind. In Potter's assessment, bioethics has in fact become a new name for medical ethics.

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The number of ethics teaching programs rapidly grew in the early 1970s, first of all in medical schools in the United States. In a relatively short period of time, almost all medical schools introduced ethics education. Currently, these schools are required to include bioethics in their curricula in order to be accredited. Other countries followed this pattern of dissemination. Since then, the scope of bioethics education has significantly widened. Ethics teaching came to be offered not only in the undergraduate programs but also in graduate, specialization and postgraduate education, and especially in clinical settings. Bioethics teaching was furthermore introduced in the professional training programs of other health professions such as nursing and scientific disciplines such as biology, genetics, and life sciences. Finally, bioethics education has become relevant outside of the professional training context as a resource for experienced practitioners, members of ethics committees, and also policy-makers, journalists, and interested parties in public debate (ten Have 2013a). This growth of bioethics education is in line with the wider notion of bioethics as a new discipline that combines scientific knowledge with philosophy and ethics in order to analyze and comprehend the contemporary challenges of science and technology for health, life, and care.

1.3 Global Bioethics

Potter has argued that bioethics is not merely a short-term ethics of individuals but should have a wider perspective. In order to better articulate this perspective he introduced the term *global bioethics* (Potter 1988). This concept of global bioethics is attracting more attention nowadays than 2 decades ago when Warren Reich could only identify a modest legacy for Potter (Reich 1994, p. 322). Today there is an increased interest in and retrieval of Potter's original interest in global bioethics. His work has received more recognition especially outside the United States, particularly in Latin America and Europe. In 2000, 1 year before his death, Potter was awarded the first Bioethics Prize of the International Society of Bioethics (convening in Gijon, Spain). More importantly, the idea that bioethics should broaden its mission seems to gain support. There is a growing number of publications that demonstrate how bioethics has disseminated throughout the world and how it is developing in many resource-poor countries (Myser 2011; ten Have and Gordijn 2013). But there is also a lot more attention to global issues such as global health, global justice, poverty, inequality, and vulnerability. More scholars are arguing that medical, social, and ecological issues are closely connected, for example in the phenomena of climate change and environmental degradation, so that bioethics will necessarily include environmental ethics and social ethics, as advocated by Potter (Dwyer 2009; Gruen and Ruddick 2009). Potter has also noticed that the search for a global scope for ethics was undertaken by world religions, especially through the activities of Hans Küng (Potter 1994). In 1993 hundreds of leaders from more than 40 religious and spiritual traditions agreed on a statement declaring that all traditions share common values such as respect for life, solidarity, tolerance, and equal rights (Parliament of the World's Religions 1993).

1.4 Global Dimensions of Bioethics Education

The term *global* in connection to bioethics has two distinct meanings: worldwide and comprehensive. Both meanings are reflected in the current process of the globalization of bioethics education.

1.4.1 Worldwide Scope

For bioethics education there are at least six reasons to address global dimensions.

The first is that international exchanges between medical schools and health professional training programs have enormously increased. The International Federation of Medical Students' Associations claims that annually 10,000 medical students around the world participate in exchanges (IFMSA 2013). The European student exchange program started in 1987 with 3,244 students studying abroad and in the academic year 2010–2011 more than 230,000 students participated. It is estimated that more than 4% of European students will participate in international exchange at some stage of their higher education studies. The overall average duration of studies abroad was 6 months. (European Commission 2012). Although student mobility in the area of health and welfare is relatively low (with only 10,781 students in 2010–2011) it nonetheless means that bioethics teaching programs involve a growing number of students from other countries. The same is true for teaching staff. In Europe, over 42,000 staff exchanges toke place in the above academic year with teaching assignments or training periods abroad.

The second reason is international migration of health professionals. For decades, approximately 25% of physicians practicing in the U.S. have been trained abroad. In New Zealand, Ireland, and the United Kingdom more than a third of all doctors are educated in other countries. The majority are coming from developing countries, notably India for doctors and the Philippines for nurses. More than 50% of medical professionals educated in countries such as Liberia, Angola, and Tanzania have migrated to developed countries (OECD 2010). In today's healthcare practice and education there is a mix of practitioners from various cultural and religious traditions. The assumption that a shared moral context or a common framework of values exists for health professionals may no longer hold; such common context and professional morality need to be created or reinforced through bioethics education.

The third reason is the new phenomenon of health tourism. Traditionally, wealthy patients from the developing world are used to seek sophisticated medical treatment in developed countries. But currently, patients from more developed countries are travelling to receive treatment in less developed countries. Thailand and Turkey, for example, are actively promoting medical interventions for visitors, ranging from cardiac surgery to hair implants. There are also specialized forms of tourism such as transplantation tourism to China and reproductive tourism to India. In most cases, people only visit for a few days, and then return to the healthcare system in their own country. It may, for example, imply that interventions that are ethically

problematic at home are performed elsewhere. The fact that health professionals will face a growing numbers of patients treated abroad within a different medical and ethical context is another reason to broaden the scope of bioethics education.

The fourth reason is the growing international cooperation in research and healthcare. One of the striking features of globalization is the rapid expansion of medical research across the world. Particularly clinical trials have become a global industry, increasingly outsourced and off-shored to developing countries. It is estimated that currently between 40 and 65% of clinical trials are conducted outside the United States (Levinson 2010). Also in the field of healthcare, the number of partnerships between institutions in different countries has steadily increased (Jones et al. 2013).

A further reason, related to the above, is that health resources such as drugs and devices are increasingly produced elsewhere, like most goods in the global era. This brings not only uncertainty concerning safety and quality assurance but can also lead to misjudgments, mistakes, and even fraud. An example is the scandal that broke in 2010 concerning silicone breast implants produced by a French company. Although the FDA had introduced a moratorium in 2000, implants were massively used in Europe and Latin America until it became clear that they had a unusually high rupture rate causing infection, and possibly cancer and death because substandard gel had been used (Chrisafis 2013). Professional competency therefore requires knowledge of where and how devices are produced, and whether they are reliable.

Finally, the sixth reason to address the global dimension in bioethics education is related to the nature of contemporary bioethics problems. Bioethics nowadays does not only examine the traditional topics such as abortion, end-of-life care, reproductive technologies, and transplantation medicine. The main ethical challenge of these topics is related to the power of science and technology: how are individual patients and citizens empowered to choose treatments and interventions that will benefit them or at least not harm them? Today, however, there is a plethora of new issues on the agenda that fundamentally have a global nature. Examples are pandemics, organ trafficking, climate change, hunger, malnutrition and obesity, corruption, bioterrorism, disasters and humanitarian relief, bio-piracy and loss of biodiversity, and degradation of the biosphere (ten Have 2013b). These topics are not the result of scientific and technological advancement but rather the consequences of processes of globalization. They present new challenges to bioethics and bioethics education in particular.

1.4.2 Comprehensive Approach

Global bioethics is increasingly using an encompassing and unified approach, incorporating various viewpoints and methods. Nowadays it is combining traditional professional ethics with environmental concerns and the larger problems of society, economy, and politics. This means that the focus of ethics is widening from relations between individuals, to relations between individuals and society, and ultimately to relations between human beings and their environment. However, the fact that there

are similar bioethical problems in many countries does not entail that the same ethical approach exist everywhere. It is clear that approaches are different, that cultures and religions have different values, and that similar ethical principles are applied in heterogeneous ways in various cultures. The global dimensions therefore invite us to rethink the usual approaches and ethical frameworks. On the one hand, they make us aware of the *locality* of moral views, while on the other hand, they encourage the search for moral views that are shared globally. In this bifurcation between universality and particularity, global bioethics is increasingly connected with international law, particularly human rights law.

A major step in the development of global bioethics has been the adoption in 2005 by the Member States of the United Nations Scientific, Educational and Cultural Organisation (UNESCO) of the *Universal Declaration on Bioethics and Human Rights.* This Declaration presents a framework of ethical principles for global bioethics. It goes beyond the four principles formulated by Beauchamp and Childress (2013) that is characteristic for the Western individualistic perspective of traditional bioethics. The UNESCO Declaration not only is the first political statement of a global framework, but it also reflects Potter's idea of global bioethics, covering concerns for health care, for the biosphere and future generations, as well as for social justice (ten Have and Jean 2009). The Declaration assumes the existence of a global moral community in which citizens of the world are increasingly connecting and relating due to processes of globalization but also sharing global values and responsibilities. This global community generates certain common principles, for instance the principle of protecting future generations, the principle of benefit sharing, and the principle of social responsibility. Various ethical systems are converging into a single normative framework for all citizens of the world (Veatch 2012).

1.5 Challenges of Bioethics Education

Bioethics education, particularly at the global level is confronted with several challenges. As indicated earlier, bioethics teaching programs have mushroomed in the 1970s and 1980s in the U.S. and European countries. The situation has stabilized since then and in many countries all medical schools now have ethics teaching programs (Eckles et al. 2005). But it is not clear that this situation will not deteriorate under economic and political pressures on universities replacing experienced staff with temporary adjuncts and online courses. Ethics teaching is also regarded by policy-makers as a curious type of palliative remedy. Every time when professionals infringe on important ethical norms, the need for ethics teaching is re-emphasized as the antidote. In response to a repeated cycle of cases of scientific misconduct and ethical problems concerning financial conflicts of interest, the National Institutes of Health and the National Science Foundation in the U.S. have required as of January 2010 that researchers funded by their grants must have received ethics education focused on promoting research integrity. Education in ethics is seen as a remedy against deficiencies in professional behavior. But it is obvious that the impact of

bioethics education is limited if the systemic and structural causes of such misconduct are not addressed. Also hardly any provisions and regulations are provided for ethics education so that a 1 day online course can be sufficient to meet the requirements. The almost general agreement that bioethics education is very important for healthcare professionals therefore is not translated into efficient practical arrangements. Although bioethics teaching is done, in most countries it is not very impressive in terms of volume, time, and commitment. Persad et al. (2008) point out that in the U.S. bioethics education, although required, comprises only 1 %of the medical school curriculum. Many educational activities are sporadic and occasional. In Europe most hospitals have only short-term educational initiatives instead of longer courses and programs, while nobody seems to take responsibility for the activities (Pegoraro and Putoto 2007). Moreover, there is a serious lack of qualified teachers. Not even half of the bioethics instructors in the U.S. have published a single article in bioethics (Persad et al. 2008). For many teachers of bioethics this is not their primary academic focus. A survey in 2004 showed that 20 % of medical schools in the U.S. and Canada did not even fund teaching in ethics (Lehmann et al. 2004). The first challenge therefore is that the professed importance of bioethics education should not blind us for the frail and anemic status of programs in many settings.

Another challenge is related to bioethics education itself. It is exemplified in the enormous heterogeneity of the field, as also shown in this volume. Within the same country, different types of programs are offered, didactic approaches and methods differ, the number of teaching hours has a wide range, and ethics courses are not scheduled in the same phases of the curriculum. Major controversies exist concerning the objectives, methods, content, and evaluation of teaching activities (ten Have and Gordijn 2012, 2013a). However, this diversity does not imply that there is no consensus. Over the last few decades scholars have come to agree that certain approaches of teaching are preferable, for example, that there is a need for longitudinal and integrated programs, making ethics not an isolated, one-time event but part of daily care routine; there is a need for team teaching with close cooperation between ethicists and clinicians. Also a student-centered approach in bioethics education focused on active learning is preferable since it encourages critical thinking and reflection. Furthermore, there is agreement on the need for comparative studies. Developing teaching programs is often not informed by experiences elsewhere. In many cases the wheel is re-invented since there are few descriptive and analytic studies of specific programs published. Finally more efforts are undertaken to define a common core for bioethics education, for example the core proposal in the United Kingdom, and the core curriculum launched by UNESCO (Stirrat et al. 2010; ten Have 2008).

1.6 A broader Philosophy of Bioethics Education

The mentioned heterogeneity reflects two diverging views of bioethics education. The question of what is good education requires a prior answer to the more fundamental question: why do we educate at all? Responding to this query one can

observe two different philosophies of bioethics education. One pragmatic view regards ethics teaching as a way of learning skills for analyzing and resolving the ethical dilemmas that will confront health professionals in their future practices. The role of bioethics education therefore is limited. It should focus on what is practical and measurable. In this modest educational philosophy it is not realistic to expect that ethics education can create morally better physicians and scientists. After all, how can a limited number of courses bring about a change in behavior or character of health professionals? The primary objective therefore is to teach skills so that it will ultimately lead to better professional decisions. The other view is broader and bolder. In this philosophy, bioethics education is not merely focused on skills to improve decision-making but is basically a long-term effort to create better health professionals and scientists. It is aimed at character formation, integrity, and professional virtues. Rather than enhancing professional skills it aims to improve the professional. Only in this way can bioethics teaching contribute to enhancing the quality of patient care. This broader philosophy is motivated by the fact that bioethics education was introduced and promoted to counteract dehumanizing and objectifying tendencies in contemporary medicine and health care. It is not just there to facilitate medical decision-making, but it should contribute to making medicine more humane. For this reason, bioethics education has a broader focus on the humanities, liberal arts, social sciences, and philosophy, so that medical activity is located in a wider human context.

It seems that the philosophy of bioethics education is increasingly moving towards this broader conception. While the focus on identifying and analyzing ethical issues has been characteristic for the early stages of bioethics education, at present there is more emphasis on how to influence students' attitudes, behaviors, and characters, emphasizing that the ultimate goal of bioethics education is to produce good health professionals and scientists (Goldie 2000). Good medical practice requires more than knowledge and skills. We expect health professionals to demonstrate good conduct and action. This is what education should train and nourish (Gelhaus 2012). The focus of bioethics education should therefore move beyond problem-solving and applying principles.

1.7 The Challenge to Global Bioethics

The need for a broader focus of bioethics education is even more necessary given the emergence of global bioethics as a consequence of processes of globalization. Nowadays, globalization is a major source of bioethical problems. While there are different interpretations of globalization, the common core of these interpretations has been identified as "the operation of a dominant market-driven logic" (Kirby 2006, p. 80). In other words, it is the specific neoliberal market ideology driving globalization that is generating bioethical problems. This ideology is shifting policies away from maximization of public welfare to the promotion of enterprise, innovation, and profitability. It also favors competition instead of cooperation. This

logic changed the nature of state regulation, "prioritizing the well-being of market actors over the well-being of citizens" (Kirby 2006, p. 94). Rules and regulations protecting society and the environment are weakened in order to promote global market expansion. A new social hierarchy emerged worldwide with the integrated at the top (those who are essential to the maintenance of the economic system), the precarious in the middle (those are not essential to the system and thus disposable), and the excluded at the bottom (the permanently unemployed). Increasing vulnerability, precariousness, inequality, and exclusion are characteristics of this new social order of globalization. Due to increasing risks and lower resilience, people all around the world but especially in developing countries have diminishing abilities to cope with threats and challenges. Neoliberal market ideology is seriously damaging health and healthcare at the global level, creating many of the global problems mentioned before. Thus, the same source that has produced global bioethics is also generating the relevant global problems of today (ten Have and Gordijn 2013).

This context clarifies the main mission of bioethics education nowadays and in the near future: bioethics should be a critical discourse that analyses and scrutinizes the current value systems pervasive in neoliberal globalization. If many ethical issues arise because of these value systems, bioethics cannot simply reproduce this ideological context but should take a critical stance towards it and present alternatives. This is the double bind of global bioethics. It has to critically review the context of globalization in which it has originated as well as the economical forces that are driving these processes of globalization. Because it has emerged in the context of globalization, the moral discourse seems already captured and determined with a preconceived value framework. Global bioethics therefore has to emancipate from its sources and should adopt the Socratic task of being a gadfly or the Kantian role of philosophy as critical thinking rather than merely explaining and justifying current situations. Otherwise it will merely serve to soften and humanize the neoliberal ideology that determines current globalization. This critical stance requires that global bioethics goes beyond the focus of traditional bioethics on individual autonomy and issues of science and technology and critically analyses the social, political, and economic context of healthcare and science. This critical refocusing is particularly important for bioethics education, now that in many countries education itself is significantly transformed into a commercial industry, remaking universities into businesses, students into customers, and academic research into an economic asset (Collini 2013). In the logic of marketization and quantification, the sole purpose of education is to provide graduates with capabilities that are demanded in the economy. If bioethics education accepts this logic it will be anointing neoliberal ideology; but if it is not, it will be in serious jeopardy.

Criticizing neoliberal market ideology requires a broader framework than the usual emphasis on individual autonomy. This emphasis is convenient for the neoliberal perspective since it regards human beings first of all as individual rational decision-makers and consumers. What they need is information so that they can choose what they value or desire. But a human being alone, as Charles Taylor has argued, is "an impossibility" (Taylor 1985, p. 8). Even economists nowadays argue that this conception of individual autonomy is an "anthropological monster"

(Cohen 2012 p. 34). Regarding human beings as self-interested, self-determining subjects disregards the basic importance of cooperation, the interconnectedness of human beings, and the interrelations between human beings and the environment.

1.8 International Exchange and Cooperation

The interconnected nature of ethical problems today requires international cooperation. For example, in order to address the proper conduct of international clinical trials, regulation at the level of the nation-state is no longer sufficient. The same trend is reflected in bioethics education; it is moving from a localized and individual effort towards more cooperative and interactive endeavors with exchange of information and harmonization of methodology and contents. A major event in this regard has been the establishment in 2011 of the International Association for Education in Ethics (IAEE), a non-profit organization with the aims (a) to enhance and expand the teaching of ethics at national, regional, and international levels, (b) to exchange and analyze experiences with the teaching of ethics in various educational settings, (c) to promote the development of knowledge and methods of ethics education, and (d) to function as a global center of contact for experts in this field, and to promote contact between the members from countries around the world. The establishment of IAEE was in fact a logical outcome of the Ethics Education Program of UNESCO, launched in 2004 (ten Have 2008). This program has identified and described ethics teaching programs, initially in Central and Eastern Europe, the Arab region, the Mediterranean region, and Africa. In order to analyze the programs in sometimes very different educational settings, UNESCO organized regional meetings of the instructors of those programs. Currently, 235 teaching programs have been validated and entered into the UNESCO Global Ethics Observatory database, covering 43 countries. The Global Ethics Observatory provides detailed information (concerning for example, for each teaching program the location, objectives, number of teaching hours, study materials, syllabus topics, teaching methodology and student evaluation) and the data is available in comparative format (UNESCO 2013).

Governmental policy-makers, administrators in universities, academies of science, and even bioethics experts themselves do not often have adequate information about what exist and what is lacking in the field of bioethics education. It is therefore necessary to provide and exchange accurate information about existing ethics programs so that the substance and structure of each program can be examined and various programs analyzed and compared. In many settings ethics teaching programs are vulnerable. They are taught by enthusiastic and motivated teachers but a firm institutional basis is lacking so that there is no guarantee that programs will continue when the teachers leave or the curriculum is revised. In many countries there is no systematic effort to create a future generation of bioethics teachers. Bioethics teachers often do not communicate with each other. They have no idea what their colleagues in the same and neighboring countries are teaching. Everybody apparently is inventing the wheel anew. The idea that something can be learned

from experiences elsewhere is not widespread. These weaknesses can possibly be addressed if there is a more scholarly perspective of bioethics education, regarding it as an activity that requires research, analysis, evidence, and creativity. The first step in this direction has been the establishment of a global platform for ethics education. Such a platform may facilitate the exchange of educational experiences, may bring colleagues from around the world in contact, and in the end may promote the quality of ethics teaching. Against this backdrop the IAEE International Association for Education in Ethics was founded. This volume is a first result of international cooperation.

1.9 Ethics Teaching Experiences Around the Globe

The first part of the book presents experiences with bioethics education in a selection of six countries. In Brazil, as explained by William Saad Hossne and Leo Pessini, bioethics has been practiced during the last 2 decades. The first bioethics journal was created in 1993. The Brazilian Bioethics Society was established in 1995. Its biennial conferences are major events with over one thousand, mostly young participants and a very diverse program. Bioethics in Brazil is also firmly institutionalized, following the enforcement of ethical guidelines for research with human beings in 1996. Bioethics education not only takes place within existing undergraduate and graduate curricula but has also resulted in specific post-graduate programs at master and doctorate levels, so that professional bioethicists are trained. It is interesting that deliberate efforts are undertaken in these programs to address a range of issues and problems that are specifically important within the Brazilian context of social and political inequalities, injustices, poverty, and violence. In the second chapter, Vina and Ravi Vaswani discuss the situation of bioethics teaching in India. In this vast and populated country bioethics is characterized by a religious as well as traditional context. Religions, particularly Hinduism and Buddhism, but also ancient health care systems such as Ayurveda have emphasized moral education since many centuries. Bioethics education, however, is rather recent and compared to Brazil, very slowly developing. There have been a few institutional achievements, such as the establishment of a professional journal, a national bioethics association, and several university centers for bioethics. But educational programs at university level are scarce; there is also lack of experts and research projects in bioethics. The chapter describes interesting initiatives to enhance this situation. Significant challenges are identified at the institutional and policy level giving the impression that bioethics education in India is mainly driven by enthusiastic and motivated individuals. It seems that in India, in distinction to Brazil, bioethics is less supported by medical and scientific institutions. There also seems to be less policy-makers who are convinced of the importance of bioethics education. This is also different from Japan as argued in Chap. 3 by Toshitaka Adachi. Although the term *bioethics* was introduced in the 1980s, Adachi argues that bioethics education has been quickly and firmly embedded in Japanese health professionals' curricula.

One reason is that there already was a tradition of teaching medical philosophy and history in the overwhelming majority of medical schools so that ethics could easily be added and introduced—a situation comparable to that in Germany. The other reason is that political and policy-making bodies requested the integration of ethics in the undergraduate medical curriculum and proposed a model core curriculum. The national medical examination now includes questions about bioethical concepts and issues. However, like in India, most teachers in bioethics do not have any educational background in bioethics themselves. Adachi also discusses the situation in nursing schools where most schools provide bioethics education, and most teachers have a background in nursing. Chapter 4 addresses the teaching of bioethics in Nigeria, Africa's most populous nation. Limited access to bioethics education existed until the decade 2000–2010 when bioethics education received a major boost in development through funding and training opportunities provided mainly by the American National Institutes of Health (NIH). The NIH funded training programs resulted in rapid increase in the number of bioethicists in the country. The availability of this group of professionals has contributed to the development of a national code to regulate the conduct of health research in Nigeria and the establishment of a postgraduate training program on bioethics in the country's premier university. In addition, NIH trained professionals have contributed to the improvement of the expertise for members of Ethics Review Committees in the country. Ademola Ajuwon argues that these improvements have led to the growing recognition of the importance of bioethics as a discipline and its role in ensuring the rights, safety and integrity of persons who participate in research. However, bioethics education seems to focus primarily on research ethics and does not have a wider scope. This is a drawback in a country characterized by a context of poverty and corruption.

A different perspective is in Chap. 5 by Nada Eltaiba who is reporting on her experiences with ethics teaching to social work students in Qatar. Bioethics education is very relevant since social work entails ethical values, in particular in relation to human rights and social justice. In Qatar this is a recent educational activity without much literature in the Arabic language. Eltaiba discusses problems that students encounter because of the specific cultural and religious context of their work. She also shows how the methods of teaching can be adapted to accommodate these problems and to teach students how to effectively cope with ethical issues. Hongqi Wang and Xin Wang in the last chapter in this section present the situation of bioethics education in China. Like in India, there is a long tradition of medical ethics teaching in China, but bioethics education is relatively new because western medicine only became popular since the last century. With the support of international agencies and organizations, bioethics started to develop in the 1980s with the founding of specialized journals and educational programs. Wang and Wang show that there are different academic schools interpreting bioethics as a universal approach or as a more specific Chinese approach, based on the country's tradition and history or based on communist ideology. The interactions between these different schools focus particularly on specific issues such as the tension between individual and collective rights. This tension is clear in the public health policies regarding epidemic diseases such as SARS, HIV/AIDS, and avian flu. The conclusion of the chapter

is that the development of bioethics education is still in its early stages. Although bioethics has been born and is showing signs of promising growth, given the size of the country, its population and the challenges of globalization, it will still take time before bioethics education will have reached a mature stage, benefitting every health professional.

1.10 Ethics Education for Professionals

Bioethics education for professionals is the subject of the second part of the book. The chapters in this part all focus on professional education but within the very different contexts of social philosophy, religion, and commercialism. Paul Ndebele (in Chap. 7) discusses the goals of ethics education for professionals in Botswana. Like in other African countries, society in Botswana is characterized by a specific social philosophy, Ubuntu (or Botho as it is called in the country). It was officially adopted by the Government of Botswana in 1997 as one of the guiding principles for national development and the University supports the national vision by teaching students on the ethics of Botho. It emphasizes that the individual person is intrinsically part of community. Rather than individual autonomy, the basic moral notions are community and shared humanity. This philosophy determines the goals and content of ethics education at the University of Botswana. The university itself is the result of public commitment, established with donations of cattle by the citizens. Educating professionals therefore serves a social purpose. Communal instead of commercial interests are driving professional education. The philosophy of Ubuntu also ensures that ethics education is diachronic, following subsequent stages of the education system, as well as synchronic, articulating the social philosophy of the country. Professionals are trained in regard to moral sensitivity, judgment, motivation and character that is typical for their profession as well as their society. In Chap. 8, Bahaa Darwish who has teaching experiences in the Arab region in the fields of business ethics, bioethics, and science ethics discusses the goals of ethics education against the background of religious traditions, particularly Islam. He distinguishes five goals of ethics education: identifying ethical issues, analyzing ethical issues, applying ethical analysis, moral reasoning, and moral conduct. These goals assume that ethics education can improve the behavior of students. But the results of education programs are different and mixed. It is often argued that in the Arab world religious observance is more important than ethics education. But Darwish rejects this conclusion. He argues that religious students, at least in his part of the world, need to learn ethics more than other students. Moral reasoning for example can make religious practice more consistent. It also provides justifications for religious convictions and it fosters tolerance for other views. Rosemary Donley examines the teaching of ethics to nurses in Chap. 9. Although nursing has a strong ethical tradition, it struggles to conceptualize and teach ethics to students of nursing. This difficulty occurs even with strong endorsement for the importance of ethics in nursing practice from nursing associations.

Not only in the U.S. but in many other countries, nursing education has changed dramatically. While ethics for a long time has been an inherent component of the nursing curriculum, the context has changed because healthcare is nowadays regarded as a business driven by profits. The economic model of healthcare produces problems of social justice, exclusion, and vulnerability, so that ethics teaching is often regarded as a remedy. This different context, however, also generates perplexities concerning the modalities of professional ethics education. Donley discusses queries regarding the content of such education, the framework guiding education, and the qualifications of persons teaching ethics. She concludes that it is imperative to train competent professionals, nurse ethicists, who can really incorporate ethics into nursing practice.

1.11 Educating Bioethics in Resource-Poor Countries

Many countries only have a limited infrastructure in bioethics, lacking expertise, educational programs, bioethics committees, public debate, and legal frameworks. The global nature of science and technology implies the need for a global approach to bioethics. But this presupposes, of course, that countries are able to apply such an approach in practice.

For example, international clinical trials require that research proposals are also reviewed in the host countries. These countries therefore need to establish functional ethics committees and also to develop a legislative framework for bioethical issues. Without the existence of a national bioethics committee that can make recommendations to policy makers, such frameworks will not develop. At the same time, efforts in ethics education are necessary to make scientists and health care professionals aware of the moral dimension of their activities, and to raise awareness among the public of the moral rights and responsibilities that should prevail in health care and scientific research. But in order to effectively implement bioethics teaching certain preconditions in building capacity must be fulfilled before educational programs can be set up (Mills and Rorty 2010). The challenges facing bioethics education in resource-poor countries are highlighted in the third part of this volume. In Chap. 10, Claude Vergès argues that the developing world has many differences. On the one hand are extremely poor countries with few professionals. They are dependent on cooperation. Bioethics education must first of all address the basic needs of the population since access to basic services is virtually absent. On the other hand are economically emergent countries like the ones discussed in part one. They have a sufficient number of professionals and are able to develop policies. The main bioethical problems are social inequality, lack of democracy, violence, and corruption. Especially in Latin America, social problems and social injustice are on top of the agenda for bioethical debate. Citizens in general do not trust institutions, and access to healthcare is very unequal. Bioethics education in these conditions is facing many challenges. As Vergès shows from her experiences in Panama, bioethics education is not well developed; it has to compete with the

professional culture that is characterized by paternalism and hierarchical relations between physicians and patients. One challenge is that students are not used to moral reasoning and critical reflection. They have to learn how to formulate their own thinking and reasoning. But they also have to make the case for the importance of bioethical principles in practice. Within a social context of injustice, physicians need to demonstrate respect for individual patients, and they should be able to argue why this attitude of respect is necessary. According to Vergès, neoliberal ideology is particularly influential in some countries in Latin America so that students are more concerned with public appearance, assuming that a wealthy doctor must be a good doctor. Countering such an assumption requires a different methodology in bioethics education with strong emphasis on active participation and discussion. Chapter 11 presents another perspective. Leonardo de Castro and Sarah Jane Toledano first of all reject the expression *resource-poor countries* since even the poorest countries have other resources. For example, their native country, the Philippines is rich in human resources, providing many other countries with nurses and doctors. The major problem they raise concerns the adaptation of bioethics to the local context. Developing countries are dependent on foreign funding for the initiation and expansion of bioethics. But this funding has a price in the sense that it often furthers the interests of the funding agency. But in bioethics, there also seems to be ideological dependency since the type of bioethics introduced is often alien to the domestic culture and tradition. In the Philippines, scholars trained in Georgetown University enthusiastically spread the Georgetown principles when they returned to the country. Part of De Castro's and Toledano's chapter reads as a eulogy of Fogarty International Center's bioethics education programs. Indeed, together with UNESCO, this NIH Center has been a major stimulus to promoting bioethics education in developing countries. But, different from UNESCO, the Center's efforts have an ideological price. They are primarily focused on research ethics. Educating bioethics can encourage future members of ethics review committees to use a similar ethical framework as Institutional Review Boards in the U.S., which will greatly facilitate the outsourcing and off shoring of clinical trials for the pharmaceutical industry. Adapting bioethical approaches to Filipino values and principles is not excluded but will require considerable emancipation from the funding sources. The same is true for areas of bioethics beyond the sponsored realm of research ethics. Clinical ethics and public health ethics can be developed without foreign funding, if there is a trained body of bioethicists, assuming that people will evolve and change. But within a context of poverty and corruption this will not be an easy task. In fact, De Castro and Toledano make a plea for such emancipation. Accepting the foreign funding as a way to create expertise in bioethics, it should then be widened into a "bioethics from below" that itself defines what problems and issues are relevant in the country, and that develops educational methods, approaches, and resources that are typical for the social and cultural environment in which they occur.

1.12 Can Bioethics Education Be Improved?

The last part of the book addresses the possibilities for improvement of bioethics education. In Chap. 12 Berna Arda elaborates the pedagogic and didactic principles of a good educational program. She examines the various steps that should be taken in order to plan, design, and develop a program that maximally motivates the learning process of students. She then applies these principles on ethics education in medical school, emphasizing that integrated and interactive learning experiences will create a positive educational environment in which the humane dimension of medicine can best be nourished. This is of primary importance since contemporary healthcare has become a bureaucratic, profit-oriented enterprise. One of the key goals of teaching ethics is moral improvement. However, the question of whether, and if yes, how ethics education can achieve this goal, is not easily answered. Bert Gordijn in Chap. 13 addresses this question by reviewing three different philosophical views on how to achieve moral improvement and the role of education. Gordijn analyzes first the epistemological view that knowledge is a condition for moral behavior. He then discusses the psychological view that knowledge is not sufficient and that character development is necessary for moral behavior. The third, more contemporary view is biological. It argues that education and legislation are not sufficient but moral improvement can only be achieved through biological-technological enhancement. Gordijn subsequently assesses these perspectives and looks at the implications for contemporary ethics education. He draws two interesting conclusions. First, bioethics education should more clearly emphasize the goal of moral improvement. This emphasis has implications for teaching methods, particularly encouragement of reflection and debate. Second, alternative methods of education should be developed, for example using literature and art to enhance moral imagination. The following chapter introduces another approach to improve bioethics education, especially in countries where bioethics is recently evolving. This is based on the bioethics core curriculum developed by UNESCO. With the adoption of the *Universal Declaration on Bioethics and Human Rights* a general framework of bioethical principles was available that could be used as the basis for a model course. An expert group from across the world drafted such a course, assuming that the 15 principles of the Declaration provide the basic structure of a minimum program. Each principle is considered a modular unit and further elaborated in learning objectives, learning materials, relevant topics and cases, as well as a teacher manual (ten Have 2008, 2013a). The underlying idea is that global consensus exists (at least exemplified in the adopted Declaration) on the general principles; at the same time, the application and implementation of each principle will be determined by the social, cultural, and religious context in which they operate. A trans-cultural effort is therefore required to make the core curriculum model at work in a specific country. This is exactly the issue discussed in Chap. 14. Volnei Garrafa, Natan Monsore, and Claudio Lorenzo show how in the Brazilian landscape, full of challenges and contradictions—and discussed in the first chapter of this book—bioethics education can be promoted. They demonstrate how the teaching programs at the University

of Brasilia have benefitted from the UNESCO model. But, the contrast between economic development, scientific-technological advances and quality of life of the Brazilian population also requested significant adaptations and modifications in the application of the model. Especially the content of the course was modified in order to focus on the cultural plurality and historical peculiarities of the Brazilian reality. Similar experiences have been described by Susanna Davtyan who introduced the UNESCO core curriculum in the Yerevan State Medical University in Armenia (Davtyan 2012). The core course replaced the existing teaching based on the Georgetown principles, and thus provides a broader approach to bioethics, more adapted to the Armenian value context. Interestingly, she also points out how new methods have been used to encourage the interests of students, for example requesting them to read certain plays and to watch theatre. This introduces the main focus of the final chapter. Jan Helge Solbakk examines the use of theatre and cinema in bioethics education. His aim is to discuss how teachers of ethics should proceed didactically to make students benefit morally from their teaching. He demonstrates how bits and parts of theatre plays and movies may be used didactically to promote a kind of moral learning that is not confined to providing students with knowledge about ethical theories and principles, but engages their moral appetites, beliefs, emotions, and desires as well. He also clarifies how relevant bits and parts of theatre plays and movies can be selected. Finally, he suggests a methodological framework of cathartic analysis and learning of emotional narratives in order to make moral discourse more engaging and productive.

1.13 Conclusion

Bioethics is not like other disciplines contributing to healthcare education: it is an intrinsic part of healthcare itself as a moral enterprise. It is focused on understanding and transmitting the basic values of the healthcare professions. This transmission is continuous and not the result of an incidental or supplementary educational intervention. Healthcare education is a process of socialization, of moral enculturation, transmitting a distinctive morality (Hafferty and Franks 1994). Bioethics education therefore never takes place in a vacuum. The increasing interest in professionalism in healthcare education, in particular professional identity formation, can be an important mechanism for teaching ethics. But if ethics is considered as an intrinsic element of medicine, nursing, or social work, some common expectations concerning bioethics education need to be redefined:

- it cannot be a one shot approach. Ethics is not a matter of a few courses; repetition is indispensable and there should be sufficient time for reflection;
- the impact is not cumulative. Although there is progress in developing moral behavior, at the same time there are many failures and near-misses; there is moral distress and moral injury;
- the educational mission is never accomplished; instead virtues require life long learning;

- moral behavior is more than personal; moral virtues are not only necessary at the individual level but also at the institutional level; virtue ethics is more than an individualistic enterprise but also matter of collective agency and communities that sustain virtues (Pellegrino 1995, 2002).

Redefining these expectations of bioethics education, and taking it seriously, formulates an almost infeasible and unrealistic program. It will remain unrealistic as long as we do not address crucial questions as what is good education and why do we educate. The purpose of education is not, or at least not primarily, economic. We do not have education to create jobs or prepare young people for jobs. The ultimate aim of education is transformative. The goal is "to effect beneficial changes in humans, not just in what they know and can do but, more important, in their character and personality, in the kind of persons they become" (Jackson 2012, p. 94). Education is fundamentally a moral enterprise. It is, what John Dewey has called, the manifestation of humankind's responsibility to conserve, transmit, rectify, and expand "the heritage of values we have received" (Dewey 1934, p. 87). Education is the cultivation of humanity; fostering the capacity for critical examination of oneself and one's traditions and to see ourselves bound to all other human beings by ties of recognition and concern (Nussbaum 1997). But that is perhaps not a humble ambition at all. Bioethics education, as this volume demonstrates, has a similar mission at a global scale. It invites students to participate in a specific professional community, grasping and shaping what is valuable in being a professional. It is not a remedy against unethical behavior. It helps to construct professional identities and shaping character. In building and reinforcing these professional identities, knowledge and practice are intrinsically linked. This makes a global perspective inescapable since sharing of expertise and experiences is the only way forward.

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Part I
Ethics Teaching Experiences Around the Globe

Chapter 2
Bioethics Education in Brazil

William Saad Hossne and Leo Pessini

2.1 Introduction

This chapter starts with presenting some historical facts that helped to develop bioethics in Brazil. Over the last 42 years, since the birth of the bioethics movement, the points of reference are usually the historical facts in the USA at the beginning of the 1970s (Van Rensselaer Potter and the Georgetown principlist paradigm); in Brazil we have only begun to talk about bioethics during the last two decades (Pessini et al. 2010a).

In the 1990s and in Brazil, three historical facts have fostered the growth of the bioethics movement. First, the involvement of physicians in the field through the Federal Council of Medicine (CFM) with the publication of the first journal of bioethics in the country, entitled *Bioethics*. The first issue of this publication came to light in 1993. Second, the birth of the Brazilian Society of Bioethics in 1995. This society initiated various activities in education and published materials on bioethics, and it also organized eight national conferences of Bioethics so far, with the presence of many renown bioethicists from abroad invited to give presentations in these conferences. Third, at the Federal Government level (specifically the Ministry of Health) one has witnessed the creation of the National Commission for Ethics of Research Involving Human Beings and the enforcement of the *Ethical Guidelines for Research Involving Human Beings* in 1996 drawn by an *ad hoc* commission appointed by the Minister of Health and formed with a spirit of interdisciplinary cooperation.[1] These three key events encouraged the formation of the Brazilian bioethics movement in its early stages.

In our effort to present the state of the art of education in bioethics in Brazil, we take into account this context as a starting point (Sect. 2.1). We go forward

[1] The Resolution n. 196/96 was abrogated by Resolution no. 466 on Research of Human Beings of December 12th, 2012, that was enforced on June 13, 2013, when was published in the Diário Oficial da União.

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exploring some data from the literature concerning the field of education and teaching in bioethics (Sect. 2.2), and define our understanding of the relevant terms: moral, ethics, and bioethics (Sect. 2.3). Then, we explore the birth of the first courses of post-graduation education *lato sensu* (courses of specialization) and courses *stricto sensu* (postgraduate courses) in bioethics, comparatively master and doctorate degree courses, with the length of 2 and 4 years respectively (Sect. 2.4). We then discuss bioethics as a discipline in the undergraduate and graduate programs in the health care field of some Brazilian universities (Sect. 2.5). Next, the role of research ethics committees in bioethics education is discussed (Sect. 2.6), as well as major publications, journals, and books in bioethics as sources for education in bioethics in Brazil (Sect. 2.7). Finally, we conclude by identifying some challenges in the area of bioethics education that are coming in the near future.

2.2 The Brazilian Context: Preliminary Considerations

Bioethics in Brazil began to take its shape as a cultural movement in the 1990s when three events took place in the Brazilian academy and society. First was the launch of the journal *Bioethics* by the Federal Council of Medicine (CFM) in 1993, with an editorial board representing professionals of the various domains of health care and humanities. This year (2013) completes its 20th anniversary of uninterrupted publication. Second was the foundation of the Brazilian Society of Bioethics in 1995, taking many initiatives in bioethics, especially publications and the organizing and sponsoring of national and international conferences in bioethics (Pessini et al. 2012; Anjos and Siqueira 2007). And third, the creation of the National Commission of Ethics of Research Involving Human Beings by the federal government in the Ministry of Health and the enforcement of the *Ethical Guidelines for Research Involving Human Beings* (1996) with the process of creating ethics committees for research with human beings all over the country (Pessini et al. 2010b; Pessini and Barchifontaine 2012).

The characteristics of each one of these initiatives, though specific, had in common Potter's concept of *bridge bioethics*. That is, a specific field of knowledge, pluralist, multi-, inter- and trans-disciplinary, working inside the sciences of life, of health and the environment, so not restricted to biomedicine (Potter 1971). This idea of Potter was endorsed in Brazil from that time on. The challenge, however, was how to put together in a dialogue these two different cultures: science on the one hand and humanities on the other. From its inception, professionals considered this union of two cultures and its pluralist character as one of the great legacies of this concept of bioethics. Quickly, it became important that bioethics should include not only ethical questions arising from the advancements of technical-scientific progress, especially biotechnology, but also ethical problems already existent (persistent and lasting), especially in the biomedical, social, and also from the political fields. Within this expanded vision, from that time on, the effort was to characterize bioethics not as a sub-discipline, or an interdisciplinary science, in order to avoid

confusion. From this context emerged the proposal of bioethics as "a specific field of knowledge" (Hossne 2006).

The expression *bioethics* appeared as a neologism, and soon it took roots and expanded, since it was born already having a deep meaning. Recent research in the field discovered the European roots of the term *bioethics*. We must go back in time, more precisely to 1927 and find Fritz Jahr, in Germany, a professor and pastor that coined the term *bioethics* (in German) for the first time (Muzur and Sass 2012). In addition to that and, perhaps, at least in part, for that very reason, in the international literature several adjectives appeared giving specific meanings to bioethics according to the kind of work and/or work field (for example prescriptive bioethics, interventionist bioethics, social bioethics, and personalist bioethics) or even related to some specific principle (for example, bioethics of precaution, bioethics of responsibility, and bioethics of care).

This phenomenon also took place in Brazil. It had even became a title of publications and of discussion in seminars, such as *Bioethics or Many Bioethics?*. This is evidence of a pluralistic vision of bioethics. To a certain extent, this phenomenon contributed, in Brazil, to the dissemination of bioethics, but, on the other side, it neglected the process of conceptual structuring of bioethics that was in the pre-paradigmatic stage, continuously seeking the consolidation of its paradigms (Siqueira et al. 2007).

The first phase of the Brazilian process of bioethics was a critical analysis of the principlist paradigm derived from the principles of autonomy, nonmaleficence, beneficence, and justice. In Brazil as a whole, the different groups of bioethicists agree that such a principled approach is important and necessary, but insufficient for adequately defining bioethics in the Brazilian context. It is understood that such principles have been proposed by the national commission issuing the *Belmont Report* (1978), created by the USA Government in 1974, "to identify the principles that should guide research in human beings"—and not specifically for bioethics.

As argued above, the neologism *bioethics* was born with a deep meaning that secured its survival and evolution, but without an elaborated ethical conceptual structure. The incorporation of the four principles approach into the field of medical ethics reached bioethics. By the way, it is worth noting that the so-called principles were already identified centuries ago. For instance, the principles of nonmaleficence, beneficence, and justice are known from to the times of Hippocrates and Socrates, and the principle of respect for autonomy is known from the seventeenth century at the time of democratic revolutions and from philosophers like Kant, Spinoza, and Locke. Thus, in Brazil, the various groups of people that started to work with bioethics in the universities, in general, respected the principlist approach, though with some restrictions in adopting the principles regarding them as elements for the evaluation of the different themes and subjects of bioethics. These principles certainly are useful and necessary, but not sufficient, as was said earlier in this text (Siqueira et al. 2007).

In the decade since 2000, in Brazil, many professionals from the health care field began to question whether the principles were not more properly to be considered as rights (and/or obligations) or even virtues instead of principles. For this reason,

Table 2.1. Number of publications on *Bioethics and Education* (in the title)

	Period			
Source	1970–1990	1991–2011	Total	2012
Pubmed	3	47	50	3
Lilacs	–	48	48	2
Philosopher's index	–	13	13	–
Total	3	108	111	5

among others, one of us proposed in 2006 to replace the expression *principles* with *ethical references* (Hossne 2006).

An important source for education in bioethics in Brazil during these years was the opportunity to participate in National and International Conferences of Bioethics promoted by the Brazilian Society of Bioethics. Brazil (Brasilia, October 30–November 3rd, 2002) was the host for the *VI World Congress of Bioethics* that dealt with the theme: *Bioethics: Power and Injustice* (Garrafa and Pessini 2003). More recently, St. Camillus University Center/Program of Bioethics in Sao Paulo, together with a network of other universities and health care institutions, organized the eighth International Conference on Clinical Ethics & Consultation (São Paulo, May 16–19, 2011) with the theme *Clinical Bioethics in Diversity* (Pessini et al. 2012).

2.3 Education and the Teaching of Bioethics

These considerations allow us to understand why the literature linked to *Bioethics and Education* shows deep gaps since its beginnings and in its basic concepts. Many authors and thinkers in bioethics in the USA note that, after 40 years, the question of education in bioethics is still not well established. There are many gaps and divergences that need more research, discussion and understanding. Despite these deficiencies, almost all recognize the importance of the theme *Bioethics and Education* as evidenced by the literature about several experiences in several countries, adopted, at the right time, by UNESCO. One recognizes, in surveying the literature, the urgent necessity of reflection on the subject due in part to the fact that bioethics is now recognized as an important subject in many fields, especially in the health sciences. Therefore, it has become more pressing to train bioethicists within a structured educational process. A search for abstracts of papers related to bioethics education starting from 1970 in the databases Pubmed, Lilacs, and Philosopher's Index in English and other languages has produced the following results (Table 2.1).

The literature data demonstrate the importance of the critical thought, rationality, and the skills of argumentation (Chowning et al. 2012) to building a bridge between the humanities and life sciences (Magalhães et al. 2011) and to the importance of training in small groups (Yang et al. 2010). There is a growing interest in introducing and/or enhancing education and the teaching of bioethics in different courses within the health care field (Harrison and Laxer 2000; May 2001; Salerno 2008; Kelly and Nisker 2009).

Table 2.2 Number of publications on *Bioethics and Teaching* (in the title)

	Period			
Source	1970–1990	1991–2011	Total	2012
Pubmed	5	40	45	1
Lilacs	–	41	41	1
Philosopher's index	–	10	10	–
Total	5	91	96	2

Table 2.3 Number of publications on *Ethics and Education* (in the title)

	Period			
Source	1970–1990	1991–2011	Total	2012
Pubmed	8	27	35	1
Lilacs	2	33	35	–
Philosopher's index	50	213	263	5
Total	60	273	333	6

It is interesting to note that one of the first publications on the subject of bioethics education refers to a judgment based on a real case with the participation of professional actors, a medical body, and judges, as a teaching-learning process. The most interesting thing, in our opinion, is that the question discussed concerns informed consent in a clinical setting which is not linked to research. The publication is from Canada (Langford 1970) and it comes 34 years after the Code of Nuremberg and 26 years after the Declaration of Helsinki.

In the same way, Fulton (1977) already warned about the question of bioethics and education in the health care field, considering the situation predicted by G. Rattray Taylor and his book entitled *The Biological Team Bomb*, published in 1968, i.e. a few years before the emergence of the neologism *bioethics*. These are suggestive examples of the latent and always present concern about education in bioethics.

The Brazilian contribution to the subject of education in bioethics is more obvious in the database Lilacs with publications mostly in Spanish and Portuguese (42 % of the publications). Together, Brazilian publications show a concern with interdisciplinary studies (Zacanato 2005) and the importance of bioethics in the training of health professionals (Segre 2005; Siqueira 2005; Barreto et al. 2007; Bonis and Costa 2009; Mascarenhas and Santa Rosa 2010).

Although the expression bioethics has appeared in the beginning of the 1970s, only 20 years later can one notice interest for the subjects *Bioethics and Education and Bioethics and Teaching* (Tables 2.1 and 2.2). Using three main data bases (Pubmed, Lilacs and Philosopher's Index) as sources, we noticed that from 108 publications in which bioethics and education appear in the title, 98 % of the publications take place after 1990. In the case of bioethics and teaching, the same phenomenon is observed, since 95 % of the articles were published after 1990.

When we analyze the publications referring to ethics and education (Table 2.3) we see that 82 % of the publications took place after 1990. It is necessary to point out that nearly 20 % (18 %) was published in the period from 1970 to 1990 and are

Table 2.4 Number of publications on *Ethics and Teaching* (in the title)

	Period			
Source	1970–1990	1991–2011	Total	2012
Pubmed	165	295	460	14
Lilacs	7	45	52	–
Philosopher's index	80	594	674	14
Total	252	934	1186	28

indexed specially in the database Philosopher's Index. Analyzing data referring to ethics and teaching (Table 2.4), we see that 21 % was indexed in the period 1970–1990. When we compare Tables 2.1–2.4, we notice that the Philosopher's Index registers a predominance of papers on ethics over those on bioethics. With this context in mind, it seems valid to note two points: (1) we observe various interpretations of the concept of bioethics that can lead to different and incomplete understanding of bioethics in its content; and (2) for that same reason, it is clear that the proposals and the reflections on education in bioethics must be preceded by a clear concept of what bioethics means. Without this clarification, we believe, it is difficult, in the process of teaching bioethics, to reach goals and objectives as well as to structure a system of education.

2.4 Defining Basic Concepts: Morals, Ethics, and Bioethics

First of all, we endorse the line of thought that clearly distinguishes the meaning and the understanding of morals and ethics, although these concepts are intertwined. Both concepts deal with what we call generically values. In the case of *morals*, the so-called moral values (*mores*, from Latin, meaning customs) are a consequence of uses and customs of a society; they may vary from society to society and also in the same society through time. Moral values (which are relative) are thus elected by a specific society. These are the values every citizen must adopt and respect. *Ethics* (*ethos*—from Greek meaning customs, uses, habits and *ethos*, character, a person's way of being) refers to reflexive analysis and critical judgment on values that may be even in conflict. Ethics as reflection and critical judgment ultimately leads to a valuable choice done by each one of us. Every one of us, in ethics, analyzes, reflects, judges, deliberates critically, and finally makes a choice.

There are interesting corollaries arising from this ethical perspective. When we choose, each one of us mobilizes our genetic inheritance, emotions, convictions, reason, and also moral values. It is a deep immersion inside of each one of us. It is important to note that, on the whole, the act of choosing may produce a deep anguish (different from the once called neurosis of Freudian anguish) to such a point that human beings may want to have their choice made by others (moral code, legal prescriptions), so that they do not have to feel the anguish, nor the guilt of

conscience. But the most important thing to remember is that there can only exist an option when there is an intrinsic condition that bioethics cherishes: freedom. This is mostly interpreted as freedom for allowing an adequate choice with the consequent responsibility. So, the exercise of ethics and, *ipso facto*, of bioethics presupposes freedom, being incompatible with ethical mechanistic theory and/or processes of violent restriction, coercion, constraint, and/or fraud.

Ethical and bioethical reflection presupposes, thus, the possibility of the presence of a *healthy existential anguish*. We must not escape from it, though many people prefer escaping to the point of rejecting freedom. This vision requires preparation in order to elaborate, and this is a task of education on bioethics. This anguish preparation is the climax of bioethical reflection. Together with freedom, we think that the reflective exercise of ethics and bioethics presupposes other conditions: (1) *Non-prejudice*—it is essential that when examining any ethical question that the individual be completely free from any type of prejudice; (2) *Be humble* enough so as to respect all and any divergent point of view; (3) *An internal attitude of openness for change* (greatness of soul) in case the first option seems mistaken (Hossne 2006). Non-prejudice, humility, greatness, freedom—these are excellent qualities for the development of each one of us, and they are excellent values that must be made manifest in the process of education and teaching in bioethics. So far, we have only talked about morality and ethics. What about bioethics?

Bioethics is first of all an ethics, and so it is a part of philosophy (*philia*—friendship, *sophia*—knowledge, wisdom). It is an ethics directed toward the field of the sciences of life, health and the environment, although we must remember that one of the characteristics of bioethics is the interface between the following three fields: (1) bioethical questions emerging for example from the health care field must be examined in interaction with the (2) sciences of life and the environment without forgetting the (3) social and political context.

What is also characteristic of bioethics, as an essential element of its identity, is pluralism; that is, the participation of all the disciplines, respective protagonists and actors in the ethical discussion. So, for example, in the Brazilian guidelines for research on human beings the committee analyzing a research project, in addition to its multidisciplinary characteristic, must have at least a representative from the researched population (usually vulnerable groups of people) as one of its effective members. These characteristics must be taken into account in the education process in bioethics (Pessini et al. 2010a).

We must distinguish clearly bioethics from deontology. This last area is restricted to rights and obligations, shaping a code of norms, establishing what is prohibited or is allowed. This does not fit with bioethics because it restricts the freedom of choice. In our view, in bioethics, what is prohibited or is allowed is to be established beginning with the ethical analysis of the values that are in conflict and concludes with a critical ethical judgment. Deontology, the codes and the legal guidelines must be based on bioethics. It is not possible to expect—and this needs to be clearly stated in the education process—that bioethics, although being the major inspiration, does not give magic formulas to be applied in every single situation. Bioethics helps us to deliberate ethically and proposes that the one who has the duty or the power to make decisions is acting wisely in making decisions and is responsible for it.

We are speaking about the importance of choice in bioethics. But how do we choose? How do we take that into account in the education process? It is worth emphasizing that choosing requires first of all to know the alternatives. So, there is an initial and extremely important cognitive moment: the person must be cognitively educated to identify and/or diagnose the ethical facts, using medical terminology. The critical reflection must begin by considering the existing alternatives. It is not necessary to find the dilemma as a starting point, although it could become the conclusion. We must take into account this perspective in the process of bioethical education.

When the alternatives have been diagnosed and analyzed, we come to the choice, which, is generally based in the perspective of principlism. However, in Brazil, several groups of bioethicists have been looking for a more comprehensive view of the understanding of bioethics by adding other ethical elements. This background and context must be taken into account for the appropriate structuring of a program of education in bioethics.

2.5 Education in Bioethics in Brazil: Some Notes of a Brief and Recent History

At the end of the 1990s, there was already a great interest in bioethics in the country especially in universities and professional health care that attracted teachers and biomedical professionals. Contributing to this interest were the events mentioned earlier: the start of a journal, the establishment of a society, and the issuing of ethical guidelines for research.

Professionals from health care and also the humanities created groups for the development and discussion of bioethical themes related to the problems and ethical challenges of their professions. These *bioethicists* (experts with professional training in their respective fields and an interest in bioethics) were trying to respond to educational concerns. Although it was clear that there is a need for training and education in bioethics, the main challenge was to have a critical evaluative group within the university of colleagues of the other disciplines needed for the development of the activities of education in bioethics.

To respond to this demand one of the new initiatives was the creation of postgraduate courses called *lato sensu* (specialization), with the duration of 1 year, with 360 h of class time plus 120 h for the written concluding paper of the course (dissertation) with invited professors. Nevertheless, the necessity for a more profound level of academic training in bioethics was more and more felt and requested by many people involved in the committees for ethics of research with human beings. This included the following: physicians and nurses serving in special ethics committees in the health care field and lawyers called to make official judgments in front new public policies that emerged in the country related with biosafety, genetically modified foods, embryonic stem cells, anencephaly and abortion, and so on. In Brazil there are 18 postgraduate courses (*lato sensu*) in bioethics. Out of 18, 7 are

located in the southeast of the country, 6 in the South, 3 in the Center-West and 2 in the Northeast Region. Many of the students that frequented these courses are now seeking masters or doctorate degrees in bioethics. In this context, the initiative was taken to establish a program (*stricto sensu*) of education in bioethics, with masters guidelines of at least 2 years of length with 1440 h of classes and orientation for the dissertation and doctorate guideline of approximately 4 years with 2,880 h of classes and orientation.

It was important to note that bioethics was on the edge of leaving the pre-paradigmatic phase and reaching the paradigmatic one which takes place when the new knowledge in the field is introduced and implemented in its graduate course programs. This developed education in bioethics and, in turn, created and developed a community as well as institutionalized research in the specific field.

In 2004 the Saint Camillus University Center in São Paulo initiated legally (approved by the Ministry of Education of Brazil) the first post-graduate course (*stricto sensu*) in bioethics (2 years of duration) in the country; the doctorate degree in 2008 (4 years of duration); and in 2012 the post-doctorate program in the field of bioethics. So far this University Center trained 117 masters and 3 doctors in bioethics (as of September 2013). The University Center started in 1997 a postgraduate course (*lato sensu*) in bioethics and health care directed primarily on clergy, seminarians, and people of the Catholic and Protestant Churches. So far 276 students completed this course as specialists in bioethics. The total amount of classes is 360 h plus 120 h for elaboration of the final paper.

The University of Brasilia was the second institution in the country to have approved in 2008 the masters and doctorate degree in bioethics. Until now this program has trained 29 masters and 5 doctors in bioethics. The third program of education in bioethics is located in Rio de Janeiro (RJ) and is a consortium among of three Institutions: Fundação Oswaldo Cruz (National School of Public Health), State University of Rio de Janeiro (UERJ), and the Federal University Fluminense. This program was inaugurated in 2010, and so far no one has concluded the training; it has following title: *Bioethics—Applied Ethics and Public Health*. Recently (September 2012) the Ministry of Education approved the fourth program of bioethics: the *strict sensu* master's degree in the Pontifical Catholic University of Paraná (Curitiba).

At the Saint Camillus University Center, the program of bioethics is also responsible for the publication of the scientific journal *Revista Bioethikos*, in the seventh year of existence, published four times per year. In this same University Center, the main objective of the educational bioethics program is related to the improvement of the intellectual abilities that gives to the students the capability of sound reasoning and human virtues that facilitate the relationship with others in a context of moral pluralism. The objectives of the University Center are as follows: (a) *Cognitive competence*—it's our mental capacity to make an accurate analysis and diagnosis of the bioethical characteristics of a scientific fact or situation that is in conflict with our personal and/or social values; (b) *Capacity of critical reflection* (with good cultural and philosophical formation)—the student should be capable of critical thinking (capacity of listening), open to dialogue with the other diverse and

different, able to work in a multi-, inter- and trans-disciplinary setting; (c) *Capacity of elaborate the healthy existential anguish* in the option for values in conflictive contexts and situations; (d) *Competence and capacity of articulation among the various ethical referentials*, classifying them in accordance with a specific situation, with the objective of making the most adequate choice. Among the ethical referentials beyond the classic four principles we highlight: vulnerability, altruism, care, solidarity and justice/equity; (e) *Character, emotional equilibrium, humility* in order to accept the opinion and the critic reflection of the other. The wisdom to change his or her choice, when there is evidence that it is equivocated; (f) *Freedom and flexibility* in not to identify him/herself in a rigid way, *a priori*, to any kind of ideology that may instrumentalize bioethics; (g) *Maturity and equilibrium* in sharing the responsibility of deliberate collectively with other protagonists; (h) *Serenity in taking responsibility for conduct*, recognizing the right and the duty of whom has the task of the decision; (i) *Good Character*, disposition for learning, for reviewing concepts, acts, attitudes, lines of thinking, and a deep respect for the other, whomever it may be (Hossne 2006; Pessini et al. 2012).

The program of bioethics (master and doctorate degree) at Saint Camillus University Center has three lines of research: Bioethics history and theories, Bioethics and research with living beings, and Bioethics in clinical settings (Clinical ethics). The curriculum includes the following disciplines: (1) foundations of bioethics—history of its beginnings, development, key bioethical issues, present and future perspectives including the different theories and paradigms of bioethics; (2) ethics and the various currents of philosophies and philosophers; (3) bioethics and anthropology; (4) bioethics and the code of ethics of the various professions in the health care field; (5) scientific methodology; (6) methodology of the higher education. All these disciplines are mandatory for those who wish to be trained in bioethics. The students can choose among the following disciplines: (1) bioethics and rehabilitation; (2) bioethics in clinical settings (clinical ethics); (3) bioethics and research with human beings and animals; (4) bioethics and the beginning of human life; (5) bioethics and end of life issues; (6) bioethics and law (biolaw); (7) bioethics and the environment (sustainable development); (8) bioethics, science, and technology; (9) bioethics and forensic medicine; (10) bioethics and religions; (11) bioethics and the humanized care in the health care field; (12) bioethics and sociology; and (13) bioethics and human rights.

It is worthwhile to mention two activities introduced in the postgraduate program in São Paulo. One is an extracurricular activity in high schools. The other concerns conversations on Citizenship: Ethics and Bioethics and is sponsored by the City Hall of Sao Paulo. This is open to a general audience, but it is directed mainly at parliamentarians and politicians. Another initiative is a joint project, aiming at cultural exchange, with the General Office of Human Rights of the City Hall of Sao Paulo. This agenda of bioethics and human rights is very important in Brazil because of the huge social and political inequities and injustices such as narcotrafficking and violence.

2.6 Bioethics as a Discipline in Undergraduate and Graduate Programs

In many Brazilian universities, private and public, particularly in the health care field, such as medical and nursing schools, bioethics exist as a discipline in the curriculum of undergraduate courses. In other educational institutions, bioethics is taught together with medical ethics and/or forensic medicine.

The *Commission of Medical Teaching of the Ministry of Health* has been recommending the inclusion of bioethics in the entire medical curriculum, in interaction with topics of the field of application, involving faculty members. For example, while discussing the question of the use of animals, courses must bring together faculty of the field of animal experimentation (physiology, pharmacology) to interact with students in the learning process. Also one must discuss from a bioethical point of view the question of abortion during obstetrics classes with obstetrics professors. Few courses have succeeded up to now in introducing this system, although it is recognized by almost all schools as the ideal one.

In spite of the efforts of the Commission, the Curricular Directives of the course of Medicine of the *National Council of Education* hardly quote bioethics. The only time it does is on Art. 4º. II, which establishes that "the professionals must carry out its services inside the highest standard of quality and according of the principles of ethics/bioethics…" (Brasil 2001). Anyway, there is a growing interest of students for bioethical debates, at least in the courses in which the subjects are discussed in an interactive way instead of as professorial classes. There is also an effort, still incipient, for including bioethics in medical residence programs.

It is necessary to recognize that in spite of all efforts, it is not possible to characterize the activities in undergraduate courses as being of education in bioethics in the sense here presented. They are, in fact, activities of initiation, directed more to information than to formation.

2.7 Bioethics Education: The Role of Research Ethics Committees

As education centers in bioethics, although less formal, it is also necessary to mention Research Ethics Committees (CEP). In accordance with the Brazilian standards (Resolution 196/96) from the Ministry of Health no research project involving human beings, in any field of knowledge, may begin without the approval of the CEP (Brasil 1996).

In accordance with this resolution (elaborated in a bioethical perspective, conception, content, implementation and control), the CEP is endowed with a legal status as an autonomous, independent collegiate body and an inter- and multidisciplinary bioethical body. As such, no more than half of its members may belong to the same profession, which guarantees the participation and the integration of

techno-scientific fields with human sciences fields. Today, in Brazil, there are more than 600 research ethics committees with the mission of social control of the research with humans done in the country including nearly 20,000 persons who meet at least once in a month to analyze, discuss, and approve or reject research protocols. In light of bioethical consideration, they can also ask for reformulations of research projects involving human beings. In addition, CEPs are charged with the task of developing educational activities concerning issues of ethics and bioethics of research. Thus, CEPs are places of information, formation, and education in bioethics, and, at the same time, they are potential sources for candidates for the post graduate programs (*stricto sensu*) in bioethics.

2.8 Publications of Journals and Books in Bioethics: Sources for Education

In Brazil there are three journals of bioethics: *Bioethics*, published every 3 months by the Federal Council of Medicine since 1993, the *Journal of the Brazilian Society of Bioethics*, published four times a year since 2005, and *Revista Bioethikos*, published every 3 months by the program of bioethics of the St. Camillus University Center since 2007. The last journal has a permanent section for teachers and students named *Bioethics—What are we going to do now?* used as a pedagogic resource.[2] The scientific journal *O Mundo da Saúde* (*World's Health Journal*) was the first Brazilian journal to publish papers linked to bioethics.[3] The first article goes back to 1987. The publishing standards of the three journals comply with international standards. They are pluralistic and open to all critical scholars.

The first book on bioethics published in Brazil was in 1991, by Loyola Press, authored by Léo Pessini and Christian de Paul de Barchifontaine. Its title is *Problemas Atuais de Bioética* [*Current Issues on Bioethics*], that presently is in its 10th edition—actualized and expanded—with more than 50,000 copies published so far (Pessini and Barchifontaine 2012). This original Portuguese publication was initially a handbook for education in ethics and bioethics for health care professionals. Nowadays, it is the text book for many undergraduate courses in the health care field. The publication of textbooks in bioethics, both translated and written originally in Portuguese, is growing progressively. The publishing market, in a certain way, reflects the views of bioethics in the country. It is worth mentioning Loyola Press (Edições Loyola), a publishing house with more than 75 titles in bioethics with about half of them translated. As an illustration, one of the great Sao Paulo bookstores (Livraria Cultura) offers 300 titles with bioethics in the title. The publishing boom took place after the 2000, since 70% of the publications dates from 2000 to 2010.

[2] Cf. http://www.saocamilo-sp.br/novo/publicacoes/publicacoes.php and www.revistabioethikos.com.br.

[3] Cf. http://www.revistamundodasaude.com.br.

2.9 Conclusion: Bioethics Education in the Community and Towards the Future

Looking to the future, it is imperative that many other universities establish academic programs of education in bioethics. They also should collaborate in producing publications (journals and books), in organizing conferences, seminars and congresses, and developing research projects to facilitate the exchange between students in bioethics within the country and abroad.

There is also the need to open space in the universities for young trained professors in bioethics. Right now many people trained in bioethics are second-career experts because teaching bioethics is still considered a new field of knowledge. The professionalization process is running faster now. It is necessary to recognize the existence and necessity of a new professional, at least in the health care field with so many challenges that need first of all ethical discernment for the best choice to be made. We are talking now of the professional in bioethics, the *bioethicist,* whose identity and values are recognized in the academic setting because of his or her competence and wisdom to operate within this context of fragmented knowledge. Confronted with the techno-scientific imperative, the existence of the bioethical imperative has become an urgent necessity (Anjos and Siqueira 2007).

Bioethics in its beginnings was seen as a bridge to the future (Potter 1971; Ten Have 2012), but it must also be a bridge towards the society and a special instrument for the conquest of citizens, mainly among the vulnerable ones in an unjust society. Education in bioethics in this perspective is the key issue and a huge challenge ahead of us that defies our hope in being agents of social transformation beyond any kind of personal conversion. For this task to be accomplished successfully, Potter (1971) would say that it is necessary to nurture our humility with responsibility that has to do with human wisdom in the midst of all scientific knowledge.

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Chapter 3
Bioethics Education in India

Vina Vaswani and Ravi Vaswani

3.1 Introduction

Bioethics (and the ethics of interconnectedness) can be linked to the religions existing in India. Bioethics education in India has however languished for lack of proper vision, infrastructure, and trained personnel. This chapter is laid out in four distinct sections: the first section recounts a brief overview of religions in India and describes the philosophies of the various religions within the context of ethics; the second section describes bioethics education in the ancient health care systems of *ayurveda* (*Charakha samhita* and *Sushrutha samhita*) and *siddha* systems of medicine; the third section deals with the status of bioethics education today, in the forms of unstructured, semi-structured, and well-structured ethics education programs; and the last section discusses the challenges to bringing ethics into the mainstream of conscious thought in higher education in India, at various levels—individual, institutional, and policy.

3.2 Religions in India

In this section, the reader will be given an overview of the different religions that co-exist in India, within the context of ethics. We will see how the religions gave rise to the earliest ethics in codified forms.

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3.2.1 Understanding Hinduism

To get a comprehensive picture of bioethics in the Indian context, it is essential to have a glimpse of Hinduism as a religion. The Hindu scriptures are made up of *Vedas*, *Purānas*, and *Upanishads*. These form the backbone of the Hindu religious philosophy. The *Vedas* are believed to be the earliest (about 5000 BCE). They are a compilation of four volumes (*Rigveda*, *Yajurveda*, *Samaveda*, & *Atharvaveda*) and are believed to be divine in origin (not through human agency). A famous sage, Vyāsa was the first to classify and compile the oral version into written text, and it has largely remained unchanged since then.

The word *purāna* is derived from two words: *pura* meaning old or ancient; and *ana* meaning narration. The *purānas* were written in the form of stories. Even though they are ancient scripts, they are widely perceived as being applicable today. The common feature in these scriptures is the description of myriad gods, goddesses, humans, demons, animals, plants, and seas where no one is described as perfect. Even the faults and imperfections of the Gods are pointed out thus reinforcing the value of righteousness and justice. The essence of these scriptures can be seized by the following verse:

> Ashtadasha purāneshu; Vyāsya vachana hayam
> Paropakārāya punyāya; Pāpāya para peedanam

"Benevolence is the highest order of sacredness and to hurt someone is the worst of sins in the world" (Paliwal 2008). This embodies the philosophy of Hinduism where virtues such as compassion and benevolence are deep rooted.

Upanishads are the distilled version of the *Vedas* and are also described as *Vedānta* (the end of the *Vedas*) implying that these are to be read at the end of the Vedas, or as an appendix to the Vedas. Some of the principles enunciated in these scriptures are ageless and are true even today. Bomhoff (2011) during his interaction with natives of Kerala (a southern state) in India refers to a *shloka* (short verse) that is often recited about human dignity and *good death*:

> Anāyāsena maranam; vinā dainenya jeevana
> To lead a life without pity, and court death without pain

The earliest reference to *ahimsa* (non-violence) as an ethical discipline has been found in *Chandogya Upanishad* where it is bracketed with truth (Harshananda 2008). Every living being (*ātman*) is a reflection of God (*paramātman*), which calls for observance of ahimsa and also to exhibit compassion towards one's fellow living beings. Even though in the ancient times animals were sacrificed at the altar, it is *ātman* that was believed to be directly reaching the *paramatman*. Moreover, the animals were rendered unconscious before killing, so that the final event would be painless.

3.2.2 Jainism

Jainsim is a religion found mainly in India, and is attributed to the first *teerthankara* (enlightened soul) Rishabha, though many Jains contest this saying that Jainism has no beginning and no end. Mahaveera is the most well-known of the *teerthankaras*. Jains believe there is no one creator of the universe, and that the latter always existed. Souls have the job of finding their way back to the ultimate place (heaven) through personal toil and self-realization. Jains believe that all living beings in the cosmos live in a complex interconnected web where each life is intricately linked with each and every other. Thus the core beliefs are right vision, right knowledge, and right conduct. Jains follow a five-point ethical code: *ahimsa* (non-violence), *satya* (truthfulness), *asteya* (non-thieving), *brahmacharya* (celibacy), and *aparigraha* (detachment from materialism) (Harshananda 2008).

3.2.3 Buddhism

Buddhism as a religion was brought into existence somewhere near the sixth century BCE and is based on the teachings of the founder Siddartha (or Gautam Buddha). Similar to Jainism is the codified ethical conduct for every person embracing this faith. The ethical code (also known as the five precepts) includes prohibitions against killing, stealing, lying, sexual misconduct, and intoxication. Along the lines of Jainism but with less vigor, Buddhism also proscribes to *ahimsa* (non-violence) against all living creatures however primitive or advanced in the evolutionary stage. Buddhism also teaches that it is not merely the action that is good or bad but the intention and thought that makes it so (Dhammananda 2002). Nalanda University developed by Emperor Asoka in the third century BCE is one of the earliest educational institutions recorded. It went on to become the first monastic university in India, so it flourished until it was destroyed in the thirteenth century. In the second century CE, the proponent of Mahayana Buddhism, Nagarjuna, taught in this university. (Loizzo 2009).

3.2.4 Christianity and Islam

Christianity came to the Indian shores in the first century AD, when the apostle St. Thomas landed in the erstwhile Cranganore. (Neill 2004) By this time, small pockets of Jews were already in existence in Bombay and Cochin, who had migrated to India even before the destruction of the Second Temple of Jerusalem. Around about the fourth century AD, a large number of Christians families landed in Malabar region, having sailed in from Persia and Mesopotamia. From then on the Christian communities grew from strength to strength and effectively blended into the local societies and customs to become one of the main religions in the country in modern times. According to Neill, due to lack of credible evidence it is more likely to assume that Greek monism and India monism developed independent of each other,

and that neither had a significant impact on the other. The Christian philosophy and the ethics that emerged from this, such as respect for life, care of the sick and love for the fellow human being has remained essentially the same as that in the rest of the world.

Islam made a bimodal entry into India—the first in seventh century CE when traders landed along the Malabar Coast (now the state of Kerala) and then in the twelfth century through Mughal invasions from the north. There are three main settlements: immigrant settlers from the north-west (Sindh and Punjab), descendants of the Mughal dynasties (Central India) and people of Arab descent who came by sea and settled along the west coast of India (Arnold 1913). Since then, Islam has grown to become the second largest religion in the subcontinent. Islamic ethics are based on the teachings of the holy book, the Quran. These tenets include monotheistic worship; virtues such as humility, honor, and compassion; wise use of moneys; avoidance of wanton killings, abhorring adultery; and providing care for the needy.

3.2.5 Sikhism

The Sikh religion is a monotheistic religion founded in the fifteenth century CE. The founder was a learned scholar Guru Nanak (Harshananda 2008). The ethics of Sikhism has more to do with daily living than with the preaching of specified virtues or values. Human life is the most precious thing and therefore Sikhism discourages abortion, euthanasia, and suicide but is not against using contraception or organ donation.

3.3 Ethics Education in Ancient India

In this section the reader will be introduced to ethics education as taught in the ancient systems of medicine that until today have sizeable populations of believers.

3.3.1 Gurukul

A schooling system called *Gurukul* unique to India was being practiced in the ancient times. *Guru* means one who dispels darkness and *Kula* means family. Like an extended family, the pupil lived in the house of the guru with other students and learned from the Guru, not just the core subjects, but even life's skills of managing oneself. There was no monetary exchange between guru and pupil. This system was exclusive to India. Besides the medical subjects students were taught were grammar, moral science, logic, ethics, martial arts, and astrology.

3.3.2 *Ayurveda*

Ayurveda can be literally translated as the science of life (*ayu* = life span; *veda* = understanding). *Ayurveda* is a sort of distillation from one of the primary *Vedas*, the *Atharva Veda* (1500 BCE), which describes detailed methods in the approach to health, encompassing physical, mental, and spiritual aspects of health in the context of human interaction with the environment (Harshananda 2008). *Ayurveda* origins are attributed to the time Dhanvantri was sent to earth from heaven to propagate the practice of healthy living. It was later made more widely known by two famous practitioners: Charaka (a physician) and Sushrutha (a surgeon). Even though controversy surrounds the Aryan invasion and the bringing of their texts, the *Vedas*, the fact remains that ancient India has been the recorded birth place of this traditional system of medicine.

Ethics was taught to students of *Ayurveda*, and they were exhorted to practice ethically as shown by the following text in the *Charaka samhita*: "He who practices medicine out of compassion for all creatures rather than for gain or for gratification of the senses surpasses all. No benefactor, moral or material, compares to the physician who by severing the noose of death in the form of fierce diseases, brings back to life those being dragged towards death's abode, because there is no other gift greater than the gift of life.… He who practices medicine while holding compassion for all creatures as the highest religion is a man who has fulfilled his mission. He obtains supreme happiness." (Pandya 2000).

3.3.3 *Siddha*

Before the Aryan dominance in the sub-Himalayan regions, there existed a system of medicine focusing on sanitation and treatment of diseases. This was the *Siddha* system of medicine. Unlike *Ayurveda*, the *Siddha* system relied heavily on metal and mineral preparations (Narayanaswami 1975). The *Siddha* system of medicine originated in South India (Tamil Nadu) believed to be founded by sage Agasthya.

3.4 Bioethics Education in India in the Present Day

This section describes the status of bioethics education as it is today. In a nutshell it can be said that ethical issues in biomedical research has come into the limelight due to the increasing number of clinical trials conducted by an increasing number of contract research organizations (CROs). While functioning of ethics committees (review boards) and ethical issues in biomedical research have been receiving greater attention since the last decade, bioethics education in general has languished. Structured and institutional academic courses with established curricula are few

(Azariah 2009), nevertheless, a start has been made and things can only get better from here.

Bioethics education in India can be discussed from the point of view of its structure and divided into three areas:

- awareness and sensitization to bioethical issues through the print media,
- semi-structured education in conferences and seminars organized by associations for ethics, bioethics, humanities, and
- structured courses in institutions and universities.

3.4.1 Awareness and Sensitization Through Journals and Print Media

The most significant contribution is from the *Indian Journal of Medical Ethics* (IJME) (formerly known as *Issues in Medical Ethics*). In 1993, the Forum for Medical Ethics Society (FMES), a registered body was formed by like-minded health care professionals, researchers, and ethics activists (IJME 2012). The *Indian Journal of Medical Ethics* is the brain child of FMES that started off as a quarterly journal on ethical issues in health care, sensitizing doctors and the lay public alike. Dr. Amar Jesani, founder of the Society and the founder-editor of the journal, is the most visible face of the Society, and is renowned as an ethics activist, both nationally and internationally. Since then, the IJME has been the sole dedicated platform for discussions and debates on ethical issues in the country with in-depth analysis from the Indian perspective. The *National Medical Journal of India* does also publish articles on ethics, but is more of a general medical journal yet adds significantly to growth of ethics in India.

3.4.2 Conferences and Seminars Organized by Associations

Indian Council for Medical Research (ICMR) is the regulatory body in the country for formulation, coordination, and promotion of medical research. The ICMR conducts training in bioethics and research ethics sporadically. It has a bioethics cell that is in the process of preparing a bioethics curriculum. The ICMR has conducted national and international workshops culminating in the production of guidelines for ethics committees, for human subject participation, and animal ethics committees (ICMR 2012). Besides this the ICMR also collaborates with premier institutions across the country to conduct 1-day or short training courses in biomedical research ethics. It sponsors bioethics conferences and training programs through funding.

All India Bioethics Association (AIBA) based in Chennai was established in 1997 and held the first international seminar in bioethics. The significant awareness amongst the teacher fraternity in bioethics in the southern state of Tamil Nadu was the joint efforts of Jayapaul Azariah and Darryl Macer (UNESCO Bangkok).

This seminar titled Bioethical Management on Biogeo-resources was conducted in Chennai in 1997, following which the conference organizers published a book *Bioethics in India* (Azariah et al. 1998). In the editorial preface, the authors' recommendations included the teaching of bioethics, encouraging forums for publication in bioethics, and formation of a national level bioethics society.

Similarly, the Centre for Studies in Ethics and Rights (CSER), created through the formation of a non-governmental organization called Anusandhan Trust has since 2005 been developing training programs in ethics and human rights for students and professionals from different disciplines including counselors and lawyers. They also take students as research fellows and guide them in research projects on ethics. This has resulted in an increase in bioethics research and publication.

The National Bioethics Conference (NBC) is a biennial event conducted by the *Indian Journal of Medical Ethics* since 2005 with the objective of bringing all stakeholders involved in bioethics in the country onto a common platform to share their experiences, innovations, and vision. The inaugural conference met with instant success and many institutions are now active co-organizers of the event, and presently this is the biggest bioethics event in the country.

Since 2011, the Centre for Ethics at Yenepoya University conducts an annual continuing medical education (CME) program in bioethics. The first 2 years saw the Indo-German CME on Clinical Ethics Consultation. Both of these 1-day CMEs were conducted in collaboration with the Johannes Gutenberg University, Mainz, Germany, with Prof. Dr. Norbert W. Paul as the chief resource person. The objectives were to sensitize health care professionals to the practice and models of clinical ethics consultations in the developed countries and to make them aware of a need for initiating a similar consultation process in our hospitals. In 2013, the Centre organized an international CME on public health ethics—the first of its kind in India. Prof. Angus Dawson of University of Birmingham, Birmingham, UK and Dr. Amar Jesani, Anusandhan Trust, Mumbai, India were the chief resource persons.

3.4.3 Structured Courses in Universities and Higher Education Institutions

The medical curriculum in India has been prescribed by the Medical Council of India (MCI) ever since it was created as an act of parliament in 1956. The curriculum across medical schools in India has essentially remained unchanged since then. Medical ethics, as it is called, merits a mere 6–8 h of didactic lectures, at a stage when the medical student has rudimentary clinical experience. The curriculum has always stressed codified ethics: the do and do nots for a doctor and how to avoid medical negligence. Theories of ethics and ethical concepts such as justice, human dignity, and personhood receive no mention.

Some of the reasons for the backburner status for bioethics, especially in medical schools, are the lack of research in ethics, lack of trained personnel to teach, and lack of main stream courses in bioethics at the masters degree level. This again can

be explained by the rigid stand taken by the MCI which lays down fixed faculty strength, fixed number of hours of teaching, and leaves little space for individual institutions to be flexible and innovative. Until 2010, even in the diploma or post-graduate diploma courses offered by a few institutions, ethics was embedded in medical law, and other law related courses, and a dedicated bioethics curriculum was singularly lacking.

3.4.4 Current State of Bioethics Education

The Federation Internationale des Associations Medical Catholique (FIAMC) established its Biomedical Ethics Centre (FBMEC) in Mumbai, India in 1981. Since 2003 it conducts a certificate course in health care ethics. This once-a-month eight capsules (half-day sessions) program covers topics of interest such as the ethics of abortion, transplantation, HIV, and other clinically relevant topics.

For many years, St. John's National Academy of Health Sciences, Bengaluru, India has been teaching ethics to undergraduate students. In the first phase, the focus has been on values in the second principles of bioethics and the final phase on clinical ethics. Also, there is an interns' forum for ethical case reviews. The Christian Medical College, Vellore, India has a similar semi-structured approach to medical ethics while keeping in mind the guidelines laid down by the MCI.

Besides these, there are several law institutions that offer a postgraduate diploma in medical law and ethics (The Institute of Law and Ethics in Medicine, a subsidiary of the National Law School of India University, Bengaluru; James Lind Institute, Hyderabad), but these are oriented more to the subject of law rather than bioethics.

In January 2011, Yenepoya University, Mangalore, started the first formal, structured academic course in bioethics. This is the Postgraduate Diploma in Bioethics & Medical Ethics (abbreviated to PGDBEME). The course runs for 1 year and has six contact programs on weekends of alternate months. The curriculum was designed by one of the authors upon her successful return after completion of a Masters in Bioethics (under the European Union's Erasmus Mundus Initiative) and drew extensively from the United Nations Educational, Scientific and Cultural Organization (UNESCO) Bioethics core curriculum proposal with modifications to suit the national requirements.

Participants have to attend all six contact programs. The coursework relies heavily on self-directed learning using group discussions, role-plays, reflective sessions, and online forum discussions (using the university's e-portal YENGAGE). Students have to submit six assignments online and complete one project which is presented during the oral test. Summative assessment is done by conducting an essay-type theory paper. Dr. Sridevi Seetharaman (an Erasmus Mundus Bioethics Alumnus) of the Swami Vivekananda Youth Movement, Saragur, Karnataka, India serves as an external examiner. She is one among a panel of the handful of qualified bioethicists in the country.

In the same year, in November 2011, in collaboration with the Department of History, Philosophy & Ethics in Medicine, Johannes Gutenberg University, Mainz,

Germany, the Centre for Ethics, Yenepoya University started the Certificate Course in Clinical Ethics Consultation (CCCEC). This is a 6-month course (two 5-day contact programs) with the objective of familiarizing the Indian health care providers with the concept of clinical ethics consultation as it is practiced across the globe while keeping local requirements in mind. The Indian scenario is covered by senior faculty (practicing bioethicist-clinicians) drawn from across the country and the clinical ethics consultation model is covered by Dr. Norbert Paul from the Johannes Gutenberg University. Participants have to submit online assignments that are evaluated and at the end, the participant makes a presentation of a project/research paper to a panel of experts. Since 2013 this certificate course has been upgraded to a 1-year Postgraduate Diploma in Clinical Ethics (PGDCE).

There is a need to develop and strengthen healthcare ethics educational and training programs in India. There is also a need to facilitate exchange of international PhD scholars so as to give a boost to trans-cultural research activities. Taking the first step in this direction, a memorandum of understanding (an agreement on collaboration) was signed in May 2011, by the Centre for Ethics, Yenepoya University with Center for Healthcare Ethics, Duquesne University, Pittsburgh, USA. Prof. Dr. Henk ten Have (Duquesne University) and Prof. Dr. Vina Vaswani (Yenepoya University) are the coordinators for the collaboration.

In June 2011 (the funding was approved in 2008; the course began 2011), the Indian Council of Medical Research (ICMR) launched its postgraduate diploma in Bioethics under the project Centrally Co-ordinated Bioethics Education for India. This is a joint venture of the ICMR and the Indira Gandhi National Open University (IGNOU) funded by the Fogarty International Center, National Institute of Health, Bethesda, Maryland, USA. The program implementation is done through the National Institute of Epidemiology, Chennai which is an arm of the ICMR. Dr Nandini Kumar, former Deputy Director General of ICMR and herself an alumnus of Fogarty's International Program is the main force behind this activity. The eight modules are entirely covered online.

Since May 2012, the Centre for Ethics, Yenepoya University has started a 5-day Short Intensive Course on Ethical Issues in Biomedical Research with the objective of training existing and potential members of institutional ethics committees and also health care professionals who are actively engaged in clinical trials. This is an annual (once-a-year) course. The faculty is drawn from the Harvard School of Public Health, Boston, USA, Centre for Studies in Ethics & Rights, Mumbai, India and other premier institutions across the country, including a senior faculty from the corporate sector involved in clinical trials. A former deputy director of the ICMR is also on board as a faculty member.

3.4.5 Future Plans

Going by the Vision 2015 document of the MCI (MCI Vision Document 2015, 2011), the prescribing authority for standards in medical education, there is little scope for institutions to take a lead in starting new courses in bioethics. Alternately,

it is left to the leadership of the forward looking autonomous educational institutions to take the lead and make a difference. The Centre for Ethics, Yenepoya University has plans to start a masters degree in bioethics by 2014 and a doctoral degree by 2015. Several other institutions are also planning to make a bid for a masters in bioethics, with international collaboration and funding from National Institute of Health (NIH), Bethesda, USA.

3.5 Challenges Faced Going Forward

So far we have seen how the Hindu religion, its offshoots, and other imported religions created ethical codes that dictated how the people of the region lived their lives and received education about ethics through religion. We have also observed how the winds of change have brought in a few, albeit significant, developments in the form of structured bioethics teaching at the national and international level. The goal is far from achieved. What are some of the challenges faced by bioethics educators in India? This section attempts to analyze the challenges to the development of bioethics education in India at individual, institutional, and policy levels.

3.5.1 Individual Resistance to Change

There are two ways in which medicine (at least the allopathic version) is practiced. One relies heavily on scientific rigor obtained from print media (called evidence-based medicine in its new avatar). The other relies on intuition, experience, and feelings (what is referred to in a lighter vein as eminence-based medicine). Irrespective of the way of practice, both schools arise from a common traditional teaching-learning model that stresses a doctor-centered approach and largely ignores patient values, emotions, and the importance of human interaction.

The humanities have been neglected in India by medical scientists, because of its perceived non-scientificness. Resurgent ethics and other humanities related subjects threaten to break the paradigm and give the patient her proper place at the center of health care. Increasing patient autonomy is seen as eating into the physician's freedom to choose on behalf of the patient. Hence subjects like ethics are not very popular. Individual doctors, nurses, and other health care stakeholders need to change the lens from which they view their professional world. Only then will the widespread resistance give way to broad acceptance of bioethics as a mainstream subject in health education.

Most medical college faculty members in India are familiar with quantitative scientific inquiry which differs from that of ethical inquiry, which tends to be more qualitative in nature. The former is based on traditional controlled environments, measurable events, and hard statistics, whereas the latter is less controlled as often themes are not quantifiable and depend more on reflections. These educators are

uncomfortable dealing with research based on qualitative processes. Moreover, the idea of art (and thereby the humanities) intermingling with the medical sciences is relatively new in our country, and not widely accepted.

Medical ethics in most medical colleges is taught by forensic medicine faculty members whom, being comfortable with the jurisprudence lens, are unable to separate the legal layers from the ethical. They bring in the experiential legal angle from court rooms and in the end emphasize outcomes rather than the processes of ethical deliberations. All of the 6–8 h of medical ethics teaching is didactic. Moreover, forensic medicine is regarded as a non-clinical subject giving students the impression that ethics is not clinically relevant. Since the first author taught forensic medicine for 15 years before training in bioethics, she knows that most ethical discussions begin with ethical questions but get derailed by legal and procedural ramifications with conclusions coming from evidence of the law and not from ethical deliberations. India needs more educators trained in bioethics and only then can we expect more structured programs that will meet the needs of the healthcare professionals. Not only that, we also need more clinician-educators trained in bioethics, since nowhere else is role-modeling so crucial as in ethics education.

The words of Mahatma Gandhi ring very true in this context: "We have to be the change we wish to see." The process is bound to be slow and frustrating. Repeated stoning of a thick glass will produce no visible change. Nevertheless, the cumulative effect of increasing numbers of invisible cracks will at some point cause the entire glass sheet to shatter. Analogous to this, a start has been made by at least a few institutions that are relooking at bioethics courses. It is only a matter of time before the tide swells.

3.5.2 Institutional Resistance to Change

An important goal of teaching, especially medical education, is to get students to critically evaluate the issues. Modern education in India is more focused on rote memorization of content than reflection on values and therefore, is unable to orient students toward positive values (Jothi Rajan et al. 2008). The values and personality of the teacher rather than the system become crucial to the success of the educational goals.

Ethics education in India has been nurtured on a curriculum that is archaic, with just about 6–8 h in the entire medical curriculum of 5 years. It has remained largely unchanged even after India gained independence in 1947. The curriculum content addresses codified ethics, duties of a doctor and defensive practice, and largely ignores ethical theories, hermeneutics, ethics of research, and ethical issues at the beginning and end of life. The Medical Council of India (MCI) attempted to overhaul the curriculum across medical schools in India through the publication of its document—Vision 2015. The attempt at revision is laudable, since such an exercise has not been contemplated for several decades. Nevertheless, even this future-looking document falls short in giving bioethics its due place in the undergraduate

curriculum. The word *bioethics* does not appear even once in the entire document. The words ethics or medical ethics are mentioned in five places.

If we analyze the Vision 2015 document of the MCI, we find the following. The concepts rooted in the minds of the architects are still embedded in the duties of a doctor and doctor-patient relationship. It does not put the patient in the center of the health care scenario (patient autonomy and personhood). The Vision mentions about new masters degrees in courses such as Family Medicine and Hospital Administration but does not talk about starting of masters in bioethics. The need of the hour is to develop a pool of ethics educators trained in bioethics. The vision document missed a good opportunity to realize this.

The work is cut out for the present-day ethics educators to convince the MCI to revise its stand on bioethics education. The MCI has to produce revised regulations making it mandatory to teach bioethics in all perspectives, and not just duty-based deontologic ethics. The graduate curriculum for bioethics needs to be strengthened by more hours, more interactive teaching, and more integration across disciplines (including clinical departments). The new bioethics curriculum, if it has to be meaningful and achieve the objective of extensive application of bioethics in medical practice must address reflective processes, value clarifications, and value analysis. Newer teaching technology and methodology need to be introduced to understand experiential learning and promote non-threatening arguments. If the MCI does this, it will ensure that modern bioethics education in India will be uniform and at a minimum standard.

For this to be successful there should be extensive curriculum building workshops followed by training of the bioethics educators. This will ensure minimum standards in the teaching-learning process. Mere allotment of enhanced hours for medical ethics teaching, as has been suggested in the Vision 2015 document, has the peril of reducing it to a notional exercise.

The role played in disseminating bioethics to a huge number through (1) the Indian Journal of Medical Ethics, (2) the ICMR with policies and training programs, (3) the advocacy by groups like SAMA (Delhi), CEHAT (Mumbai), (4) institutional leadership of St. John's (Bengaluru), Christian Medical College (Vellore), and (5) Yenepoya University (Mangalore) are praiseworthy. The current need is to establish more centers, departments, and the starting of graduate degree programs (masters and PhD) in bioethics. Only then will bioethics education and research be taken to greater heights and the knowledge thus created can be applied in clinical settings.

3.5.3 Resistance at Policy Level

Bioethics teaching does not happen in a policy vacuum and like everything else requires processes in place. Many countries have a president's Bioethics Council which advises the president on issues affecting and impacting national policies from an ethical dimension. This is lacking in India. In the days to come, in a country mired in scams and corrupt practices, the change has to come from the top, and this can happen through greater transparency and ethical counsel.

3.5.4 Global Networking

Some changes happen fast especially those related to technology and to market economies. Clinical trials, many conducted by multi-national companies, have made a foray into developing countries which have succumbed to the market forces. This has forced research ethics and review committees into the forefront in some countries, including India. At the same time, bioethics as a subject does not enjoy that kind of patronage without a market driving force. India, and other developing countries, need to lean more on countries with strong bioethics education, and these in turn need to provide more support, both in terms of expertise and curriculum development. UNESCO is already supporting developing countries in a big way, but the way forward should also include institutions in ethics-resource-rich countries to actively engage in the teaching-learning process. The Erasmus Mundus mobility program of the European Union, Wellcome Trust (UK), University of Toronto (Canada), Fogarty International Center (NIH, USA), and Kennedy Institute for Ethics (USA) are some of the institutions that have been doing notable work in creating a niche for bioethics in developing countries by providing education, training, or research support opportunities.

3.6 Conclusion

Bioethics is an old and hoary tradition in India and was taught in the ancient universities like Nalanda. In modern times, however, bioethics education has not received due recognition and development in higher educational institutions of any discipline or field. Structured courses are conspicuous by their absence. Quality research, even though happening due to awareness created by ICMR, CSER, and few other NGOs, is not being translated into policies. Policy makers have shown a systematic lack of vision.

The first need is for institutions (especially universities) to create formal, structured academic courses in bioethics. Next, we need more ethics educators trained in bioethics with greater emphasis on curriculum development and institutional support. Hopefully the starting of new courses will provide the substrate for this to happen. Especially in health care education, the policy makers have to make huge changes in their approach to ethics. The focus has to shift from duty-based medical ethics to the broader aspect of bioethics that will include areas like patient autonomy, appreciation of human dignity, ethical decision-making at start-of-life and end-of-life, ethics in biomedical research, and concepts of ethical theories. Finally, there is need for a firm commitment at all levels to encourage and support ethics education. Unless provision is made for this through set goals and objectives, then consistent, sustainable change towards ethical educational leadership may remain a distant vision. The way forward is the ethics way.

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Chapter 4
Bioethics Education in Japan: Ethics Education for Medical and Nursing Students

Toshitaka Adachi

4.1 Introduction

Since the term *bioethics* was introduced into Japan in the 1980s, the subject has been taught at different educational levels and in various professional contexts. For this reason, and also because everyone must inevitably confront the issues of *inochi* or *seimei* (*life* in Japanese) and *shi* (*death*), nobody can now doubt the significance of bioethics education for people in general, regardless of their interests or jobs. This is especially true in situations where people interface with the life sciences, including broad areas like medical science, nature, and human nature.

In today's Japan, bioethics as a course subject or area of study has an established place at various levels of the educational curriculum from primary to postgraduate. In terms of recipients, bioethics education can be classified into two broad categories: one addresses non-professionals and the general public, including primary and secondary school students and university students on non-healthcare related courses such as law, economics, engineering, and agriculture; the other is aimed at healthcare professionals, including medical residents and university students as prospective professionals in medicine, dentistry, nursing, pharmacy, and so on.

Limitations of space mean that this chapter will focus primarily on bioethics education for prospective healthcare professionals (medical and nursing students); it will deal with the subject in terms of its character, history, and existing programs, as well as making suggestions for future improvement. First, though, it may be helpful if we briefly describe the development at various levels of bioethics education designed to meet the needs of those who are not, or do not intend to become, healthcare professionals.

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4.2 Bioethics Education for Non-healthcare Professionals and the General Public

4.2.1 At Primary School Level

In the entry for Bioethics Education in the *Encyclopedia of Bioethics* (revised and third editions, 1995 and 2004 respectively) there are no sections on primary schools, non-health related professionals, or the general public (Reich 1995; Post 2004). This and this reflects the fact that bioethics scholars have not generally considered these aspects of the subject to be of much importance. Primary schools in Japan have in fact, though, attempted to provide pupils with educational opportunities to think about human life, and these can be classified as forms of bioethics education. In 2008 the Ministry of Education, Culture, Sports, Science and Technology (MEXT) revised the curriculum guidelines for primary schools and added new objectives such as teaching respect for life, including human life and nature, and the preservation of the natural environment. Given these objectives, classes in moral education or integrated studies are possible occasions for the discussion of topics like *life* and *life and death* and hence can be opportunities to cultivate character or moral virtues in students as they learn about current social issues in Japan.

In terms of this kind of educational opportunity, much attention has been paid in Japanese society to life education and death education in the last decade. Some atrocious and life threatening crimes were committed by very young children; for example, in July 2003 a 12 year-old boy kidnaped and killed a 4 year-old boy, and in June 2004 an 11 year-old girl killed her classmates in their classroom. Such events shocked Japanese society

Why do such crimes occur? One possible reason is that children who become too immersed in computer games sometimes lose the ability to distinguish between the real and the virtual worlds. As a result, they can easily kill their friends in the belief they can be revived after death. Such a misunderstanding of life blinds them to the moral prohibition against killing others. To address such problems, core notions of bioethics like the study of life and death also need to be the province of primary schools, where educators must teach pupils to take human life (their own and that of others) seriously.

4.2.2 At Secondary School Level

Teachers of biology and social studies have been assigned the responsibility for instructing high school students in bioethics education (Macer et al. 1996; Asada et al. 1996). Since its formation in 1996 the Network of Bioethics Education in Schools, a collaboration between university professors and high school teachers, has played a major role in developing the subject in high schools by suggesting how it should

or can be delivered. Focusing on the objects, content, methodologies, and materials of bioethics education, the Network has produced publications like *The Education of Life* (2000), a book that includes actual case studies on the themes of bioethics education in high schools; these include the nature of life, issues concerned with human birth, sexuality, the body and the mind, cross-cultural understanding, disease, illness, and aging. Many current social studies textbooks for high school students (which must be approved by MEXT) include a section on *seimei-rinri* (bioethics) introducing this key term and a variety of relevant issues for discussion.

4.2.3 At University Level

Bioethics education for university students majoring in non-healthcare subjects has developed in various ways. The program at Kyushu University, for example, currently requires all students regardless of their major to take a bioethics or biomedical ethics course with the theme of life and body to promote a deeper understanding of the human essence. In this course, the following biomedical ethical issues concerning birth, the end of life, and informed consent, as well as other topics of interest to students such as euthanasia and designer babies have been taken and discussed. The aim of this course is to help students understand the humanistic aspects of medicine and medical practice.

There have been other unique projects in bioethics education in Japan, including *Seimeigaku* (Life Studies) advocated by Professor Masahiro Morioka, *Seizongaku* (Arts Vivendi) at Ritsumeikan University, and *Shiseigaku* (Death and Life Studies) at the University of Tokyo; all of these actively promote thinking about issues surrounding humans or bioethical issues among university students as well as the general public in terms of philosophical, sociological, and religious or spiritual viewpoints.

4.3 Bioethics Education for Healthcare Professionals

The main target of bioethics education, though, has been healthcare related professionals or prospective ones, including university students training to become medical doctors, dentists, nurses, pharmacists, social workers, care workers, and so on (Ban and Fujino 2012). This section focuses on medical students and nursing students as examples of such prospective healthcare professionals, and treats education programs in ethics, medical ethics, and nursing ethics as part of bioethics education as a whole.

4.3.1 Ethics Education for Medical Students

4.3.1.1 The Outline of Medicine

Before the introduction in the late 1980s of the area of study we now call bioethics as first formulated in the United States, bioethics education for medical students was in fact already available in Japan in the shape of *Igaku-gairon* (The Outline of Medicine): a very unique discipline related to bioethics that was created by Hisayuki Omodaka (1904–1995) whose expertise lay not in medicine but in French philosophy. He began to teach his new discipline to medical students at Osaka University in 1941 by framing and defining it as the philosophy of medicine and introducing the study of the nature of medicine, its mission, and the kind of discipline that it really is (Omodaka 1967). In so doing he sought to encourage medical students to reflect on themselves and their future careers as they prepared to enter the medical profession, and so engender in them what we now call professional ethics or professionalism.

Yonezo Nakagawa (1926–1997), a physician greatly influenced by Omodaka, inherited and developed the new discipline by organizing it into three main subdisciplines: the philosophy of medicine, the history of medicine, and medical sociology (Nakagawa 1964). Medical students were able to learn about the nature of medicine, about the essential quality of the medical profession, and about how to create good doctor/patient relationships. The objectives of Nakagawa's teaching were to get medical students to reflect on and reconfirm their own values as they prepared to become professional physicians. The educational focus here appears to have been on medical students' motivation, attitudes, and behavior, which is why the Outline of Medicine seems to have constituted moral education for future physicians and an education in professionalism.

Almost four decades ago, the Outline of Medicine had developed into a very popular discipline in Japanese medical schools; Omodaka notes that it was offered in over 90% of medical schools of Japan in 1971 (Omodaka 1987), and it has survived in the curricula of some medical schools even into the twenty-first century, with one survey showing that it is the third most popular course in liberal arts and medical humanities education in terms of cultivating the humanity of students (Association of Japanese Medical Colleges 2008). It emphasizes medical ethics and professionalism as vitally important disciplines for those wishing to become humane physicians. In the curricula of some schools today, it is also a core subject for the enhancement of human nature or humanity and the fostering of good relations with others (Association of Japanese Medical Colleges 2011). It has also been a major subject in liberal arts and medical humanities education in Japanese medical schools.

4.3.2 Medical Ethics

4.3.2.1 History

Since 1990, Japanese medical education has undergone significant changes, with some medical schools implementing integrated curricula, problem-based learning tutorials, and clinical clerkships (Kozu 2006). These changes have influenced liberal arts and medical humanities education.

One of the landmark events that changed medical humanities education was the innovative 1991 University Chartering Standards Law, which triggered changes in liberal arts education in all universities and colleges in Japan, including medical schools. With respect to medical education, these changes included: (1) the widespread abolition of departments of general or liberal arts education; (2) expanded offerings of specialty subjects; and (3) an increase in early exposure programs.

Three major challenges confront medical education in Japan today when it considers its future: (1) how to teach alternative ways of thinking about medical-related subjects, including the medical sciences; (2) how to create an educational system that takes account of recent changes in the lives of young people; and (3) how to establish divisions that can organize and supervise general or liberal arts education comprehensively (Fujisaki and Nakamura 1998).

Even though the University Chartering Standards Law in 1991 mandated the reduction of general or liberal arts education, various reports and official documents on medical education recommended that general or liberal arts education should form an essential part of the educational curricula for prospective doctors and accorded proper respect (Goto 2006). These documents included the Report of the Council of Universities, *A Vision of Japanese Universities in the twenty-first Century and Principles of Future Reform* (1998); *The Fourth Report of the twenty first Century Medical Meeting* (1999); the Central Education Council, *On Liberal Arts Education in the New Era* (2000); and *A Model Core Curriculum for Medical Education* (2001), prepared by the Research Council on Medical and Dental Education, and supervised and issued by MEXT. The latest version of *A Model Core Curriculum for Medical Education* has been promulgated in 2010 but the basic framework has not been changed.

The last-named of these, *A Model Core Curriculum for Medical Education* (2001), outlined a core structure for undergraduate education in medical and dental schools. It was divided into seven sections: (A) Introduction to medicine; (B) Medicine in general; (C) Normal structure, function, pathophysiology, diagnosis, and management for each of the body's systems; (D) Systematic physiological reaction, pathophysiology, diagnosis and management; (E). Basic clinical examination; (F) Medicine and society; and (G) Clinical practicum.

It also outlined some objectives related to bioethical matters or those relating to medical ethics. For example, section A (Introduction to medicine) had four subsections: (1) Principles of Medicine; (2) Safety in Medical Practice and Risk Manage-

ment; (3) Communication and Team Care; and (4) Task Analysis, Problem Solving, and Logical Thinking. The first of these (Principles of Medicine) states that students must learn: (1) Medical Ethics and Bioethics; (2) Patients' Rights; (3) A Physician's Duties and Responsibilities, and (4) Informed Consent, all of which are usually considered as topics for bioethics or medical ethics. The third subsection (Communication and Team Care) deals with how medical practitioners communicate with others, including patients and their families, and build good relationships with patients and their families, topics that might also be seen as part of bioethics education in Japan.

In addition, section D (Systematic physiological reaction, pathophysiology, diagnosis and management) had a subsection on human death requiring medical students to learn about death from a societal as well as a medical point of view, reflecting a belief that medical students needed to understand human death holistically and should also study topics like the difference between death with human dignity and euthanasia, and grief care for family members. Issues relating to end of life care have become increasingly serious in Japan and prospective physicians are now required to learn about them.

All medical schools in Japan were expected to utilize 70% of the above model core curriculum, with the remaining 30% available for school-specific curriculum goals (Kozu 2006). As this officially promulgated model core curriculum recognized the significance of bioethical or medical ethics education, it could also be viewed as a core discipline for liberal arts or medical humanities education in medical schools. This is why Japanese medical educators came to think that the ethical aspects of medical practice or ethics education itself should have an important place in the medical humanities education provided by medical schools.

In one national survey of medical education, over 77% of respondents (representing 59 out of 76 schools) said that teaching ethics as part of a liberal arts education is important because medical students must develop a sense of human dignity and ethical sensitivity in medical practice (Association of Japanese Medical Colleges 2008). Here bioethics or medical ethics were considered to constitute a fundamental principle of medicine showing that medical educators recognized their significance. However, nobody knows how many schools teach bioethics or other related subjects; according to the first national survey to focus specifically on bioethical or medical ethics education in Japanese medical schools, 79 out of the total of 80 that responded offered bioethics or medical ethics as a teaching subject in their school curricula (Kodama et al. 2009). Given that bioethics or other ethics related subjects are being taught in Japanese medical schools, probably all prospective physicians have opportunities to learn about bioethics or medical ethics in general.

In terms of the educational system, bioethics seems to have become a popular disciple in medical humanities education in medical schools in Japan today for two reasons. The first is that, as noted above, bioethics or medical ethics was mandated in the *Model Core Curriculum for Medical Education* giving medical educators an incentive to recognize the importance of bioethics education and reserve for it a place in their curricula. The second reason is that questions about the bioethical

concepts and issues that medical students might confront in their future careers began appearing in the national examination for a physician's license. For example, required questions were set on important topics such as medical ethics and patient's rights, and society and medicine. With the former, students could be asked about the professionalism or social responsibility of a physician, or about patient rights, patient autonomy, informed consent, confidentiality and disclosure, and respect for patients' opinions. In relation to society and medicine, questions could appear on guidelines for research ethics, including human genome and genetic studies, epidemiological studies, and so forth, as well as on ethical issues related to clinical trials. As well as such required questions, general questions could be set on matters connected to the end of life, including the concept of death, death with dignity, euthanasia, and living wills. So, interested or not, students now had to study medical ethics or research ethics to pass this examination.

4.3.2.2 Course Contents

How has bioethics or medical ethics been taught in Japanese medical schools in terms of timing and content? Information is mainly drawn here from the above-mentioned national survey conducted by Kodama et al. in 2008 (hereafter referred to as *Kodama's survey*), supplemented by data from a more recent version of the national survey, *A White Paper on the Medical Schools in Japan 2010* (hereafter the *White Paper 2010*) and other sources.

First, then, when and how is medical ethics taught in medical schools? Kodama's survey revealed that medical ethics was most likely to be taught in the first year of a program (60.8% of medical schools reported teaching medical ethics to first year students), and much less likely in the final years, with only 11.4% of schools offering it to fifth and sixth year students (Kodama et al. 2009). Regarding the teaching format, 79 schools offered a lecture format, and 27 a tutorial one; some schools did, though, use other formats, including case studies, debates, small group discussions, clinical ethics workshops, role playing in lectures, and so on (Association of Japanese Medical Colleges 2011).

Second, what topics are taught in medical ethics courses? According to Kodama's survey, the 10 most highly rated topics were: informed consent (95.0%); terminal care (86.7%); euthanasia and death with dignity (85.0%); an overview of bioethics and medical ethics (80.0%); advanced medical technology (78.3%); medical ethics and law (65.0%); basic ethical theory (65.0%); the ethics of medical research (61.7%); the issue of privacy (58.3%); and clinical ethics (55.0%). References to landmark bioethical cases in the United States (including the Tuskegee Syphilis Experiment, that of Karen Ann Quinlan, and Tarasoff *vs*. the Regents of the University of California) and in Japan (such as the 1995 euthanasia case involving Tokai University Hospital, and that of 2000 concerning the refusal of blood transfusions by Jehovah's Witnesses) were made in the course of various lectures (Kodama et al. 2009).

With regard to clinical ethics education, the survey showed that 55.0% of medical schools taught topics related to this in a lecture format, while 47.0% invited practicing clinicians to give lectures and engage in discussion with students. In addition, 21.7% offered bioethics or medical ethics teaching as part of the clinical clerkship or other clinical practicums. The survey reported lecturers in bioethics or medical ethics as saying that the aspects of their course that provided most satisfaction to students were: using real, specific cases from everyday practice; putting the study of bioethics to practical use in the clinical clerkship or on other clinical occasions; and collaboration with clinicians. For bioethics educators, then, it was important to relate bioethics or medical ethics to specific examples of actual clinical practice (Kodama et al. 2009). The *White Paper 2010* revealed how they were also concerned to promote the teaching of clinical ethics in bioethics education via relationships with clinical staff or clinical facilities, with 28 schools teaching bioethics as part of their internal clinical practicum, and 11 doing so as part of a clinical clerkship or other related clinical practicum in affiliate clinical facilities such as hospitals (Association of Japanese Medical Colleges 2011).

Thirdly, what are the qualifications of those teaching medical ethics? Kodama's survey showed that 70% of lecturers teaching bioethics or medical ethics were nationally licensed physicians in Japan, while 20.0% had an educational background in bioethics and 18.3% in philosophy. However, 73.3% had no special educational background in bioethics or other ethics related disciplines, and only 10% of those with no educational background in bioethics or medical ethics had had special training in bioethics in foreign countries (Kodama et al. 2009). The conclusion from the evidence of this survey is that the majority of lecturers teaching bioethics or medical ethics in Japanese medical schools were not professional bioethics educators.

This situation has improved recently, since according to the *White Paper 2010*, in 80 medical schools there were 29 professors in charge of bioethics education with an educational background either in bioethics, medical ethics, the philosophy of medicine, philosophy, or ethics (Association of Japanese Medical Colleges 2011). So educators in the humanities are involved in bioethics or medical ethics education in medical schools.

4.3.3 Ethics Education for Nursing Students

4.3.3.1 History

Three educational routes are open to those wishing to become registered nurses in Japan: one can graduate from a university type of nursing school (*Daigaku*), or from a junior college type (*Tanki Daigaku*), or from a training college type (*Senmon gakkou*). While the first of these requires nursing students to complete a 4-year curriculum to be eligible to take the national nursing examination, the other two types require only 3 years of study. Regardless of the length of the course, however, since 1949 nursing education (including ethics education) has been based on the Rules for Schools of Public Health Nurses, Midwives, and Nurses, which have been revised

several times in accordance with changing social circumstances over the past half century with the latest revision having been promulgated in 2011.

The 1951 revision of the Rules stipulated that nursing ethics for nursing students should be included as an independent teaching subject in the curricula of nursing schools. The educational content here included how nurses learn about and develop their own moral character and virtues such as tenderness towards patients, self-sacrifice, obedience or courtesy to physicians, and a volunteer spirit; the main purpose seeming to be the improvement of individual character and of attitudes to others, such as patients and physicians, in order to become an ideal nurse (Sakuraba 1990). At the time, though, in the eyes of medical society, ideal nurses were not expected to think for themselves, to take action on their own responsibility, or to be autonomous or professional, but to work for physicians and obey their orders as a dependent being. Japanese society considered the decision maker in medical practice not to be the nurse but to be the physician. Autonomy of nurses was therefore unnecessary. Since autonomy is one of the necessary conditions for a professional, nursing was not viewed as a profession at that time in Japan. On this view, nursing ethics was a type of moral or character education that produced appropriate nurses who would work entirely under the supervision of physicians (Miyawaki 2012).

As new nursing theories and systems were introduced into Japan from abroad (especially the United States) in the 1960's, the world of Japanese nursing seemed to have its conventional model of nursing shaken. The new theories and systems of nursing, which emphasized its status as a profession, produced a new ideal of the nurse, and so changes to the teaching of nursing ethics became unavoidable. But while adjustments based on the new ideal of the professional nurse were needed, nursing educators and policy makers did not come to grips with the rapid change in the ideal of nursing. So in the 1967 revision of the Rules, nursing ethics as a teaching subject within ethics education was eliminated, and since that time ethics education has not been included in curricula for nursing students (Kojima 1991).

In the late 1980's, new concepts in bioethics and medical ethics, including informed consent, the ethical principle of respect for patient autonomy, patient rights and so on, were introduced into Japan, and since then medical circumstances in the country have gradually changed. One such change involved taking the concepts of patient-centered and team-based medical care seriously. The traditional structure of the medical world in Japan was rigidly hierarchical and vertical, extending from the physician at the very top to the patient at the very bottom with nurses generally being placed beneath physicians and required to follow their orders. The idea of placing the patient at the center, with medical care being delivered by a team, was unthinkable. But as the notion of the team developed, it became possible to conceive of members of different professions being equals in status, and nurses now began to be considered as belonging to a profession and so were expected to play a professional role in team-based care. The requirements of such societal change meant that the new identity of nurses as members of a profession had to be promoted, and so the teaching of nursing ethics had to accommodate this new model of nursing as a profession.

As a result of all of this, the 1996 revision of the Rules declared that ethics education should be implemented in such a way that nurses should "be able to recognize the diverse values of others, to do nursing practice based on professional attitudes and ethics, and to cultivate the basic competence of the continuous self-learning of new knowledge and skills" (Miyawaki 2012, p. 9). The Rules thus clearly stated that ethics education should aim at training an ethically professional nurse.

4.3.3.2 Content

After the 1996 revision of the Rules went into effect, most nursing schools, regardless of their type, gave ethics related teaching subjects a place in their curricula (Ohinata and Inaba 2009). How have these subjects been taught in nursing schools? Two national surveys of ethics teaching for nursing students in Japan help to answer this question.

The first survey, carried out in 1999, covered the 3-year training college type of nursing school (*senmon gakko*), with 293 out of the 494 *senmon gakko* in Japan responding (a rate of 59.3%). The results showed that 147 out of 280 schools had an independent ethics related subject on their curricula; 79 had ethics as a subject, 73 had bioethics, and 24 had nursing ethics. Ethics was taught in the first year in 46 schools (58.2%), with 83.5% of the educators teaching it being part time or adjunct lecturers in ethics or other related disciplines. Bioethics was taught in the first year in 30 schools (41.1%) and 41.1% of the educators here were part time or adjunct. Nursing ethics, on the other hand and taught in the third year in 15 schools (62.5%), with 79.2% of the educators here being licensed nurses.

In terms of the contents of these ethics courses, the survey asked nursing schools to report on the following topics taught: death with dignity and euthanasia, informed consent, brain death and organ transplantation, truth telling, abortion, the code of ethics for nurses in the Japanese Nursing Association, end of life care, gene therapy, conflicts between nursing principles and medical ones, and patient discrimination. The survey showed that the three most common bioethical topics were death with dignity and euthanasia (94.1%), informed consent (91.6%), and brain death and organ transplantation (88.8%). This may well reflect social issues that were prominent at that time. Regarding teaching methods, most schools used a lecture format, making the teaching of knowledge apparently the main purpose of ethics education; group discussions and case studies were used relatively rarely. Although informed consent and truth-telling are ethical issues arising from clinical practice, little ethics teaching was done in the clinical practicum (Yamada et al. 1999).

A second survey, carried out in 2011, covered 4-year university nursing schools (Tsuruwaka and Kawakami 2013). It analyzed the syllabi of 193 nursing schools identified via their websites as of August 2011. Independent ethics related subjects were taught in the curricula of these schools under a variety of names such as bioethics, nursing ethics, medical ethics, and ethics. It was found that 100 schools (52%) taught bioethics, 81 (42%) nursing ethics, and 88 (46%) other ethics related subjects including ethics, medical ethics, and philosophy. Additionally, 38 of the

193 schools (20%) taught both bioethics and nursing ethics, and only eight had no ethics related subjects in their curricula, meaning that the vast majority of these nursing schools made some provision for ethics related subjects. So at present the teaching of ethics, under whatever name, seems to be prevalent in Japanese institutions of nursing education. Let us examine in more detail the teaching of bioethics and nursing ethics, the two most common forms of ethics education courses in these 4-year university nursing schools.

Bioethics was a required course in 57 of these schools and an elective in 24 others. Fifty schools classified it as a liberal arts education subject, and 35 as part of basic nursing education. In a majority of cases, it was taught in the first 2 years: 49 of these nursing schools offered it in the first year and 23 in the second. In terms of the staff qualifications, in 71 out of the 106 schools offering bioethics as part of their curricula, the specialty of the professors teaching it lay not in nursing but in other disciplines, especially subjects in the humanities such as bioethics, ethics, philosophy, literature, sociology, law, and religion. As for the content of these courses, the 2011 survey revealed the following facts: 92% of the schools offering such courses included a variety of bioethical topics such as ethical issues related to advances in medical technology, including assisted reproductive technology, genetic technology, organ transplantation, regenerative medical technology, and end of life care. Ninety percent of schools provided an overview of bioethics, covering topics such as its history, its relationship to the law, bioethical principles, and some methodologies; 38% of schools included basic ethics within the subject of bioethics; and 22 schools (25%) taught nursing ethics under the name of bioethics, even though seven of these also offered nursing ethics as a separate subject in their curricula. This would suggest that these seven schools viewed bioethics and nursing as different subjects, even though there may have been overlapping content.

Turning now to nursing ethics courses, the 2011 survey found that 84 out of 193 nursing schools offered these as part of their curricula, they being a requirement in 67 schools and an elective in the eight others. Such courses were offered relatively rarely in the first 2 years (16% in the first year and 30% in the second), whereas 24% of schools offered them in the third and 26% are in the fourth years; some in fact spread them across both the third and fourth years, and others across the 3 years from the second to the fourth. Over 75% of schools that categorized nursing ethics as ethics teaching did so as an element of specialized nursing and not of liberal arts education. Nearly 80% of the professors responsible for teaching nursing ethics courses were licensed nurses. The content of such courses included the methodology and some models of nursing ethics, the foundation of nursing ethics, the ethical code for nurses, basic ethics including ethical theories and principles, ethical issues arising from nursing practice in specific areas, clinical case studies including typical ethical cases as well as particular ones experienced in the clinical practicum, bioethics, and so on (Tsuruwaka and Kawakami 2013).

Some differences between the teaching of bioethics and nursing ethics were revealed quite clearly by the survey. The first concerned timing; whereas bioethics tended to be offered in the first 2 years of a course, nursing ethics was more often taught in the final two. A second difference involved the teachers; while the major-

ity of educators teaching bioethics had backgrounds in the humanities or social sciences (including bioethics, ethics, philosophy, sociology, and so on), those teaching nursing ethics had backgrounds in nursing.

These differences can be linked to the way the two subjects are categorized. Bioethics can be treated as liberal arts subjects in nursing curricula, and these subjects are taught in the first 2 years in most nursing schools. So professors of humanities or social sciences who are in charge of liberal arts education find themselves mainly involved in bioethics education, since delivering a wide range of knowledge and information to liberate students from their own narrow world of thinking by opening up new perspectives is one of the main purposes of liberal arts education. This also explains why bioethics education is mainly delivered in a lecture format.

Nursing ethics, on the other hand, can be categorized as a specialized nursing subject, and such subjects are taught in most 4-year university type nursing schools in the final 2 years, and mainly by professors of nursing, regardless of their specific area of nursing expertise. The educational purposes of nursing ethics, namely to provide students with a basic knowledge of the subject, to enhance their ethical sensitivity as nurses, to explore ethical decision-making in nursing practice, and so on (Tsuruwaka and Kawakami 2013), explain why nursing ethics can be considered to be a specialized subject. Given that it covers issues related to a specific area of nursing and the acquisition of professionalism in nursing, it can be understood why professors of nursing are so often involved here.

Nursing educators seem able, then, to distinguish clearly between bioethics and nursing ethics. However, the Tsuruwaka's survey found that some nursing schools with both subjects on their curricula were teaching bioethics content in nursing ethics classes and nursing ethics content in bioethics classes. What explains this overlap? It may be that some schools intentionally allow it to give students the chance to understand the topic more deeply. But my belief is that in most of these schools educators in different subject areas do not discuss what they teach with their colleagues. So when consideration is given to where ethics related subjects are to be placed in a curriculum, discussion and planning need to occur if a systematic ethics education program is to be established. In addition, educators from different specialist backgrounds should cooperate with one another to enrich the content of what they teach in their respective areas of responsibility.

4.4 Conclusion

The significance of liberal arts education (or what we now term medical humanities education) in the curricula of schools that train future healthcare professionals has been widely recognized in Japan. Bioethics and other ethics related subjects, such as medical ethics and nursing ethics, have been treated as core courses in the medical humanities programs of such schools. When educational institutions view bioethics or similar ethics courses in this light, they are inclined to schedule them to be taught to first and second year students.

But bioethics and other closely related ethics subjects have also been viewed as belonging to specialized education, the more clinically oriented sphere that is of great importance to future healthcare professionals. This approach has meant that bioethics and its relatives have tended to be taught to students their final years (the fourth or fifth in medical schools, and the third or fourth in nursing ones, i.e. during or after the clinical clerkship or practicum). However, a review of the current situation here suggests that the objectives of ethics education have not yet been firmly established and that perspectives seem to be confused in some school curricula.

Steven Smiles et al. describe the premises of proper medical ethics education as follows: "ethics education should (1) be conceptually coherent, (2) be vertically and horizontally integrated through preclinical and clinical training, (3) be multidisciplinary, (4) be academically rigorous, and (5) demonstrate humane and value-conscious medical practice" (Smiles et al. 1989, p. 707). Let us examine the situation in Japan in the light of their first two premises.

In terms of conceptual coherence, ethics education for healthcare professionals in Japan has its flaws. Ethics education course subjects, like bioethics, medical ethics, nursing ethics and so forth, suffer from confusion and overlap in some school curricula. In the case of bioethics and medical ethics in medical curricula, and in that of bioethics and nursing ethics in nursing curricula, it seems that educators have not discussed the content of what they teach with others responsible for closely related subjects in the same school. Ethics educators need to cooperate to establish a shared concept of ethics education and implement their own teaching as part of it.

With regard to the second premise (integration), ethics education for prospective healthcare professionals in Japan seems well integrated in a vertical sense. Ethics education is seen as part of liberal arts education in the early years of the student curriculum; but it is also viewed as specialized education in the later years, and here it needs to be implemented on a clinical basis with ethics educators, regardless of their particular healthcare or non-healthcare background. Ethics educators should cooperate with members of the clinical educator or staff.

However, such collaboration between ethics educators and clinical educators might still not be enough to solve all the problems of ethics education for students in their final years. Here, then, ethics education for prospective healthcare professions needs more integration in a horizontal sense, which I think must mean greater cooperation at all levels with other professors regardless of their particular expertise. It is very important to promote cooperation between everyone involved in ethics education: those whose expertise lies in non-healthcare areas like the humanities and social sciences, those who are health care specialists (in medicine and nursing for example), and members of staff in clinical institutions. A push for integration in both the vertical and horizontal senses can only help to establish a more systematic ethics education experience for prospective healthcare professionals.

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Chapter 5
Access to Bioethics Education in Nigeria: Past History, Current Situation, and Opportunities for the Future

Ademola J. Ajuwon

5.1 Introduction

Bioethics encompasses the principles, standards, norms, and guidelines that regulate the design, implementation, and dissemination of findings from scientific inquiries (Jeffers 2002). The primary role of ethics in research is to protect the rights, integrity, and safety of research participants. There are several ethical codes, norms, and guidelines designed to protect the safety of individuals who participate in research. Some of the best known guidelines are the Nuremberg Code of 1948, Helsinki Declaration of 1964, *The Belmont Report* of 1974, and the Council for International Organizations for Medical Sciences (CIOMS) guidelines of 1982. A major component of the application of these guidelines is an Ethical Review Committee (ERC) whose responsibilities are to review, approve, and monitor studies involving human participants. The purpose of the ERC review is to assure, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of research participants (USA-CFR 2002). However, the availability of international codes of ethics and institutional ERCs has not eradicated the incidence of abuse of research participants in both the developing and developed countries (Jeffers 2002; Chima 2006; Eyelade et al. 2011).

Bioethics education is the process of learning about all principles, regulations, norms, and practices relating to responsible conduct in research. Education on ethics can be delivered using different approaches including didactic teaching, experiential learning through placement at an ERC, and analysis of case studies. The goal of education in ethics is to empower trainees with knowledge and skills for critical thinking and problem solving. Bioethics education has three roles to play in ensuring the protection, safety, and integrity of research participants.

a. Formal and educational updates in research ethics is an excellent method of increasing a professional's knowledge and sensitivity to existing and evolving

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ethical concerns in the conduct of research. For example, initial and continuing education sensitizes scientists to the ethical issues arising from the rapid advances in medicine and biotechnology such as research into genome, stem cells, multi-country field trials, and experimentations involving human vulnerable populations (CIOMS 2002).

b. Education has been shown to be effective in providing scientists with skills for dealing with the ethical dilemmas they encounter in their own research. For example, in a training program for surgical residents, Pollock and colleagues found that ethics in research trainees were better able than non-participants to deal with problems relating to how to proceed if they lacked sufficient quantity of a reagent critical for experimental data replication, had problems with discordant or outlier experimental data, and were prepared to seek a third party input for resolving a dilemma involving their own work (Pollock et al. 1995). The study by Brown and Kalichman (1998) among graduate students in experimental sciences also showed that training resulted in improved reports of knowing what to do if faced with an ethical dilemma. Thus, the training raised awareness and understanding of the pressures leading to unethical behavior and how to ethically deal with them.
c. Finally, training in research ethics affords scientists, especially those from the developing countries, the opportunity to contribute to the ever increasing international debate on ethical issues and to analyze and articulate the ethical concerns most relevant to their local context (Guenter et al. 2000). This debate is especially required given the increase in the number of clinical trials taking place in African countries where high levels of poverty and limited access to basic health care increase the risk of exploitation of vulnerable populations (Kilama 2003). This chapter describes the history of and the current status of access to bioethics education while offering a projection for the future of bioethics education in Nigeria.

5.2 The Context

With a population of approximately 140 million, Nigeria is Africa's most populous nation but also one of its poorest. Democratic governance and rule of law were established in 1999 after military dictatorship of about 30 years. The health sector is characterized by wide disparities with respect to distribution of health facilities with the majority of health facilities located in urban centers even though the majority of the citizens live in rural communities. Agriculture used to be the mainstay of Nigeria's local economy until petroleum was discovered in the 1970s. Despite the availability of oil and growth in the national economy during the last decade, the majority of Nigerians still live in poverty. For example, the percentage of Nigerians living in absolute poverty rose from 28% at independence in 1960 to 49% in 1998 (UNDP 2000). Despite official claims by successive administrations to tackle corruption, it permeates all sectors of governance and is one of the major obstacles

to development in Nigeria. Although substantial improvement has occurred in the legislature and judiciary since the restoration of democracy in 1999, the Nigerian state is substantially unable to fully provide safety and protection for the vulnerable segments of the population.

5.3 History of Access to Bioethics Education

Prior to the decade starting from year 2000, there were extremely few opportunities for bioethics education in Nigeria. The available opportunity for bioethics education consisted of short courses organized by mostly international non-governmental organizations who taught ethics to the staff of their project as a component of the requirements of funding agencies. Another key feature of this period is the fact that ERCs were either non-existent or too weak to perform oversight functions required to promote responsible conduct in research and guarantee safety of research participants (Ajuwon and Kass 2008). For example, until 2001 there was no functional ERC in the oldest medical institution in the country (Ajuwon and Kass 2008). Although a national ERC had been in existence on paper at the Federal Ministry of Health since the 1980s, it remained *dormant* (Federal Ministry of Health 2007) because it did not provide leadership or oversight functions in setting ethical standards for the conduct of research in the country. In addition, research ethics was not available as a formal course of teaching in Nigerian universities. However, students learned about responsible conduct in research through mentoring. This scenario, characterized by weak institutions, inadequate local regulation of biomedical research (Chima 2006), and military dictatorship was what favored the occurrence of the infamous scandalous drug trial conducted by Pfizer in Kano in 1997.

5.4 The Current Situation of Access to Bioethics Education

Opportunities for bioethics education in Nigeria increased tremendously during the decade starting from 2000. Some of the major sponsors of bioethics education programs in Nigeria are the Wellcome Trust, the European and Developing Countries Clinical Trials Partnership, the AIDS Prevention Initiative in Nigeria, Pan African Bioethics Initiatives, and the United States National Institute of Health (NIH). The training sponsored by these organizations consists mainly of short in-country training and development of infrastructure to improve ethics review. Of the available training programs, those sponsored by the NIH have been the most popular. There are five NIH sponsored bioethics education programs in which many Nigerian professionals have participated in the last decade. The first is the African Bioethics Training program offered by the Johns Hopkins School of Public Health, Baltimore, Maryland. This program consists of instruction on research ethics and required

attendance at ERC meetings, and the development of a practicum that trainees implement in their home countries. The training at the Case Western Reserve University in Cleveland, Ohio consists of instruction and practical experiences that leads to the award of a Masters of Arts degree in bioethics. The program at the University of Toronto consists of lectures and experiential learning leading to the award of the degree of Master of Health Sciences. The training offered on the South African Research Ethics Initiative program at the University of Kwazulu Natal leads to the award of diploma and master degrees in research ethics. The bioethics training program at the University of Ibadan began in 2008. Sponsored by the NIH, this postgraduate program aims to build capacity for the ethical review of health research and to strengthen the capacity of ethics committees in institutions throughout West Africa. The program consists of modular teaching, practicum, and research leading to the award of a Master of Science degree. It is one of the first-ever multidisciplinary degree program developed at Ibadan, involving faculty collaborators from clinical sciences, law, social sciences, arts, and public health.

The NIH sponsored bioethics education programs have had the greatest impact on bioethics education in Nigeria in terms of number of Nigerians trained (see Appendix), thus contributing to the growing number of the critical mass of trained bioethicists in the country. In addition, the activities of the trainees of these programs have created a multiplier effect on the development of bioethics education in the country. For example, the practicum project implemented by one trainee from the Johns Hopkins program resulted in implementation of capacity development on research ethics for 133 scientists from the premier university in the country (Ajuwon and Kass 2008). Other scholarly activities of trainees have led to a growing number of local ethics publications assessing and addressing different issues including the role of ERCs (Eyelade et al. 2011; Kass et al. 2007), prevalence of scientific misconduct (Adeleye and Adebamowo 2012), informed consent (Ogundiran and Adebamowo 2010; Taiwo and Kass 2009), decision-making and motivation to participate in research (Osamor and Kass 2012), and factors influencing use of childhood immunization services (Jegede 2006). With these publications, the views and contributions of Nigerian bioethicists are now being aired in the global space. This situation has in turn improved the status of the bioethics discipline in Nigeria.

In addition, in 2005, a trainee of the Hopkins program created a course entitled *Ethics of Public Health Research and Practice* for the postgraduate students in the Faculty of Public Health at the University of Ibadan. The goal of the course is to empower trainees with knowledge and skills for ethics reasoning and improve their capacity to conduct ethically acceptable research. The contents of the course are the foundations of research ethics: ethics review committees, informed consent, and research integrity. To date, approximately 400 students have attended the ethics course (Ajuwon 2012). A major contribution to these positive outcomes is the fact that all the NIH funded trainee programs have a high return home rate which strengthens the impact of their activities in Nigeria (Ali et al. 2012).

There are two other important events in recent history that have contributed to the rapid development and progress of bioethics education in Nigeria. The first is the controversy surrounding the trial of the drug Trovan among children with meningitis by Pfizer in Kano in 1997 (Chima 2006). Pfizer sponsored the study to

determine the effectiveness of Trovan in treating meningitis during an epidemic. A panel of investigation concluded that Pfizer did not obtain authorization from government nor received valid informed consent from all parents of the children enrolled into the study (Annals 2009).

The reports of the events by the local media and the public outrage that came afterwards opened the eyes of many Nigerians, including lay persons, to the significance and relevance of research ethics. These events now serve as a reference point for the teaching of responsible conduct in research and the need for oversight by regulating agencies and ERCs. In teaching the topic of scientific misconduct, Nigerian trainers no longer need to rely on foreign examples to emphasize the significance of responsible conduct in research. The event is also used as an advocacy tool to convince university administrators of the importance of creating functional ERCs and policy makers and government officials of the need for regulation and oversight as part of efforts to protect research participants from exploitation.

The second significant event which has accelerated bioethics education in Nigeria is the development of the National Guidelines in 2007. The code consists of 68 pages, has 10 sections that define research, formulate requirements for registration of an ERC, define the role of the ERC, responsibilities of researchers, requirements for conduct of ethical research, and sanctions for erring researchers (FMOH 2007). The development of the code is significant for four reasons. First, Nigeria can now count itself among other nations that have regulations which take into account the context of its social and cultural traditions and which offer clear guidance for professionals who conduct health research in the country. Second, the code provides trainers in bioethics with reference material from which educational contents as well as local and appropriate examples can be drawn. Thirdly, the code has proven to be useful reference material to guide the conduct and operation of the activities of the ERC members. For example, the code provides clear guidelines regarding the role of the committee and set standards for the creation and operations of such committees. Finally, the code creates the National Health Research Ethics Committee (NHREC) and designates it as the leading agency responsible for ensuring adherence to guidelines that govern ethical research practice in order to ensure the protection of human research participants in Nigeria (FMOH 2007).

Despite the availability of this code, its impact remains limited primarily because it is yet to be officially passed into law by the National Assembly. In addition, many Nigerian scientists claim that they are not aware of its existence, and hence, they do not abide by the regulations contained in it. The situation was considered a major limitation of the practice of ethics of health research in Nigeria since violators of the code cannot be prosecuted (COPEH-WCA 2012).

5.5 Conclusion and Projection for the Future

Although access to bioethics education has increased substantially in Nigeria during the last decade, some challenges remain. To the best of my knowledge, only the University of Ibadan has a formal postgraduate training program on bioethics

education. This is inadequate given the fact that enrollment for postgraduate training continues to increase every year. There is need for more Nigerian universities to create training programs to increase the number of trained bioethicists in the country. There is also need for training on research ethics for the faculty at various Nigerian universities. Lack of access to formal training on ethics is acute for staff from Nigerian universities because there is neither a formal training for newly recruited lecturers nor a continuing education program on research ethics for academics already on staff. In addition, Nigerian universities need to develop clear policies on the conduct of research, authorship, and responsible conduct. The University of Ibadan set a good example in 2010 when the institution launched its Ethics Policy (University of Ibadan 2010) and a policy on scholarly publications (University of Ibadan 2013).

There is an urgent need to pass into law the Nigerian code for health research in line with international best practice. This will require greater levels of advocacy targeting policy makers at all levels of governance in the country. The NHREC should work harder to create greater visibility for itself as the body in charge of setting and enforcing standards for the conduct of research in the country. While the country has made some progress in increasing access to bioethics education affecting research involving humans, there are few initiatives relating to development of a code of ethics on research and use of animals. There is therefore the need for the development of clear guidelines for the conduct of research with animals in line with international best practices.

Appendix

Table A.1 Bioethics Education Training programs & Nigerians who participated in them (2000–2012)

NIH sponsored programs	Number of attendees
African Training Program at the Johns Hopkins School of Public Health	4
University of Toronto	4
Case Western Reserve University	3
Training of Bioethics at the University of Ibadan	12
South African Research Ethics Training at University of Kwazulu Natal	15
Total	38

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Chapter 6
Teaching Ethics to Social Work Students in Qatar: A Vibrant Challenge

Nada Eltaiba

6.1 Introduction

In this chapter, I reflect on my experiences as an educator teaching ethics in the social work program at Qatar University. Challenges related to teaching ethics to social work students in non-western societies, specifically those at Qatar University, will be explored. So too will some of the methods used to enhance teaching, in particular the reflective approach which, in social work, is a popular means of obtaining knowledge and insight.

6.2 Ethics in an International Context

Social work is an international profession. It originated as a western-based profession in Europe and the USA, and was then established in other traditional, non-western countries. More than 84 countries are members of the International Federation of Social Workers (Hugman 2010).

The social work profession strives to improve the wellbeing of individuals, families, communities, and societies. The profession is interdisciplinary and responds to injustices and to complex social problems within societies and throughout the world. In order to achieve these aims, social workers are expected to use assessment and intervention processes which draw on a range of knowledge, skills, and values. The International Federation of Social Workers describes social work as follows:

> The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being using theories

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> of human behavior and social systems. Social work intervenes at the points where people interact with their environment. Principles of human rights and social justice are fundamental to social work.

This description of social work, particularly its emphasis of the principles of human rights and social justice, clearly indicates that social work is an ethical practice (Hugman 2008a).

Social work has always been values-based. Values and ethics are influenced by social, cultural, spiritual, religious, and personal values—all of which influence social workers' professional decisions. Understanding the ethics of social work is highly important for social work practitioners and scholars. Social work ethics refers to: "… [the] specialist area of professional ethics comprising the study of the norms of right action, good qualities of character and values in relation to the nature of the good life that are aspired to, espoused and enacted by social workers in the context of their work" (Banks 2008, p. 18). As an indication of its growing importance, the literature on social work's values and ethics has increased significantly in the last 20 years.

There is, however, growing concern among social workers about having one general statement of professional ethics that is applied internationally. Indeed, some suggest that a single statement cannot be applied to all cultures. In particular, the various statements within the code are based predominantly on western concepts and paradigms (Hugman 2010; Ross 2008) and, as such, have limited applicability to non-western cultures. In response to this, the importance of developing ethics that suit social work practices in different cultures is being increasingly acknowledged.

6.3 Teaching Ethics in Social Work

Learning about ethics is an essential element of a satisfactory education in social work. Early on, the importance of teaching students about the challenges related to ethics and values was emphasized by social work practitioners (Congress 2002). Even further, a case can be made that teaching ethics is one of *the main aspects* of social work education. Ethics is identified as the main competency in the field of social work, a competency that comprises knowledge, skills, and values. The International Association of Schools of Social Work and the International Federation of Social Workers (IASSW/IFSW 2005) affirm that while there are general guidelines for what is required to be taught, there is also a consideration that the curriculums of social work programs will be oriented to students' academic needs. To be specific, the aim of social work programs is to prepare competent practitioners whom take morality seriously and whom are aware of their professional role in the local and global context.

Social work programs aim to equip students to respond to challenging ethical problems in a professional, unbiased fashion (Sanders and Hoffman 2010). The purpose of curricula is to assist students to develop an awareness of any potential

assumptions or biases they may have, and to be able to consciously apply ethical decision-making. Furthermore, it is to equip them with critical thinking and reasoning skills for dealing with complex ethical situations.

6.4 A Particular Context: Teaching Ethics in Qatar

Social work has been recognized as a formal activity in Qatar since the 1970s. The social work program at Qatar University was, however, stopped for more than 10 years only to re-commence in 2009. The first new group of graduates will complete their course in 2013, with almost 16 students expected to graduate and take up work in agencies in health, child protection, schools, aged care, and so on.

The majority of these students are from Qatari backgrounds, and a few are from other Arabic Middle Eastern countries. The cultural background of the students is predominantly Islamic and Arabic. Although these students take a variety of courses to equip them to work with individuals, groups, and communities, there is no course specifically designed to teach ethics. Rather, teaching ethics is embedded throughout the curriculum. Some of the particular challenges encountered in teaching ethics to social work students at Qatar University are outlined below.

6.4.1 Lack of Literature

While there has been an increase in the literature addressing social work ethics and values (Reamer 2006; Hugman 2008b; Banks 2006), the field is still developing in comparison to other disciplines. The literature in social work ethics is comparatively small (Banks 2008), and in particular, the literature on social work ethics in the Arabic and Islamic worlds is scant. Hardly any such research exists and few papers have been published in the area. Likewise, there are no textbooks written in Arabic about the ethics of social work or specifically about the ethics of social work in Arabic or Islamic cultures. Students observe that most of the literature available in Arabic is old or does not reflect the recent advances in ethics research.

6.4.2 Language and Professional Language

There are also challenges related to using professional language in social work. The language of instruction is both Arabic and English. Some of the classes are taught in Arabic while others are taught in English. Those teaching ethics in Arabic face the problem of a lack of professional terminology. For example, some of the terms are inconsistently translated, while others lack a clear translation. Though most students have a sound command of English, others face difficulties following the meaning of some of the concepts expressed in English. Together, the absence of

Arabic expressions for some professional terms, the ambiguous meaning of some of the terms that have been translated into Arabic, and the difficulties some students have understanding English-only expressions, make using professional language during class discussions a significant challenge.

6.4.3 Code of Ethics

In most professions, ethics is associated with a code of ethics. Social work's code of ethics comprises statements of purpose and lists of values, principles, standards, rules, and guidelines for how these are to be practiced. As such, the code assists in directing social work practice. It also contains values and principles that are important to ethical decision-making and responding to dilemmas within the field of social work (Banks 2008). One of the challenges experienced in teaching ethics is that there is no social work code of ethics specifically related to Arabic or Islamic cultures.

6.5 Examples of the Challenges Students Bring to Class

Students bring various ethical issues to class to discuss, some of which are general and others of which pertain to specific cultures. Students discuss what to do in these cases and ask questions about ways of dealing with such problems. Examples of the types of problems students discuss follow.

6.5.1 Working with a Client from the Same Family

One of the controversial ethical issues students most commonly discuss is that of working with clients from the same family or tribe. When working as a practitioner in such a close kinship society, social workers are highly likely to meet a relative from the same family or tribe. Even if the social worker does not know the client or family personally, they will worry about the family connection. The family members of the person seeing the social worker consider the social worker's familial or tribal connection to be a threat to confidentiality.

6.5.2 Confidentiality in the Classroom

Another important area is the need for confidentially among students and in the classroom. Students frequently disclose personal information or opinions about different issues. Also, some students in class are from similar kinship backgrounds.

While problems related to breaches of confidentiality among students have never been encountered, the importance of confidentiality in class and among class members needs to be emphasized—preferably at the start of course. Furthermore, while students need to feel safe to participate freely in class discussions, they must also be aware that confidentiality is to be respected in the class environment. This is especially so if issues of a moral or ethical nature are to be discussed openly.

6.5.3 Possible Other Challenges

Some students talk about the wearing of a veil. Some wear a veil because it is their personal wish to adopt this cultural habit. In class, they discuss how some clients might perceive their veil, and wonder whether they might be asked to take it off for more effective communication with their clients.

Other students have discussed ways to deal with clients who have a homosexual orientation or homosexual behaviors. Neither is viewed as being acceptable in Qatar's cultural and religious context. Concerning this issue, the students saw that being unbiased could be challenging. In particular, they felt that interacting with total acceptance might be a sign of not being true to oneself or of being a hypocrite.

6.6 Methods of Teaching

Certain teaching strategies can help students in non-western societies to explore the ethical dimensions of social work. These include: increasing students' awareness of relevant ethical issues, exposing them to ethical decision-making models and giving them opportunities to use these models, encouraging students to develop their analytical skills, and demonstrating the importance of reflective practice, particularly when faced with ethical dilemmas. Some of the strategies and methods to teaching used in the class are outlined below.

6.6.1 Raising Awareness

It is important for instructors to believe in their students' potential to grow. One way this belief can express itself is by highlighting to students the importance of understanding ethics. Such teaching may include making students aware of conflicting values, helping them to develop ethical sensitivity, which would include ways of classifying different moral aspects, and identifying the effects of their actions on clients, families, communities, and societies.

Case studies, scenarios, class discussions, and role play methods of instruction can be used to good effect. The aims of these activities are to teach students to explore ways of solving problems, and to gather as much information as possible to

develop an understanding of the situation and, further, to help clients to consider all potential options for reaching a decision and to be fully aware of the likely consequences associated with this decision (Gray and Gibbons 2007).

As previously mentioned, there is no code of ethics specifically designed for social work practices in Arabic societies. Notwithstanding this, students are taught about the IFSW's overall principles and guidelines. The areas of the IFSW guidelines that are covered include the development of competency and the appropriate implementation of skills, the performing of one's role with integrity, accountability, understanding boundaries, and the importance of self-care.

In addition, the notions of human rights and human dignity, and the responsibility of social workers to promote social justice, are discussed. Further, students are prompted to explore what it means to respect the rights of clients to self-determination and participation; to recognize the familial, environmental, and societal aspects of a person's life; and to identify the strengths and the resources within and around an individual. In relation to social justice, the importance of promoting integrity, acknowledging diversity, and encouraging harmony within society are stressed. Unfair policies and the negative effects of discrimination are also identified and explored.

As the students are from Muslim backgrounds and will practice social work in predominantly Muslim societies, Islamic ethical principles and value systems informed by religious philosophies and principles of justice are explored. These include, but are not limited to, the respect for human dignity and the right to autonomous decision-making. In short, all of the above mentioned values and principles are utilized to enable students to make informed ethical decisions.

6.6.2 Ethical Decision-Making

In class, students have the opportunity to explore ethical problems that are common in social work practice. These problems are presented as choices between options (Banks 2006), and several ethical decision-making models are discussed. Such models usually have some commonalities. For example, their aim is to provide practitioners with guidelines to make insightful decisions, as well as rationales and reasoning processes that lead to these decisions (Gray and Gibbons 2007). Chenoweth and McAuliffe (2005) explained that there are three constructed models for ethical decision-making: (a) process models, in which steps are clear and well identified, (b) reflective models, which emphasize self-reflection and the influence of power, and (c) cultural models, which draw attention to biases and inequalities. Some decision-making models considered include the Mattison model (Mattison 2000), the Inclusive Model of Ethical Decision Making (Chenoweth and McAuliffe 2005) and the DECIDE Model. Importantly, students are cautioned that decision-making models are not to be relied upon as simplified or surefire methods for arriving at and making a decision.

6.6.3 Enhancing Critical Thinking

The critical thinking process is a powerful technique (Vaughn 2010; Chenoweth and McAuliffe 2005) that enhances the skills of social workers to confront problems and to promote social justice and human rights. Critical thinking is important because it helps social workers to examine arguments and assumptions. It focuses not only on the results but on the process and the power of reasoning; that is, it emphasizes the logical connections between ideas. Further, critical thinking examines beliefs and the value of these beliefs. It provides evidence and different points of view, prompting students to adopt different perspectives in their thinking. In addition, the barriers to critical thinking are investigated, such as anger, biases, not being open to different views, and a lack of knowledge.

6.6.4 Fostering Reflective Approaches

Students are given the opportunity to reflect on their experiences, in particular, on their values, ethics, views, and emotions (Knott and Scragg 2010). Further, the uncertainties of making decisions are put before them (Swindell and Watson 2006). Examining their values, morals, and beliefs helps students to develop insight about their perceptions and the power inherent in the social worker's professional role. It also gives them opportunities to understand the possible effects of their personal views and experiences on making a decision (Gray and Gibbons 2007). Allowing in-class group discussions, reflecting on the ethical aspects of various case studies, and writing short essays to reflect on their own values are some of the ways students are stimulated to consider the ethical practice of social work.

6.7 Conclusion: Where to go from Here?

When teaching ethics to students from non-western cultures, it is important to emphasize the complexity of ethical and values-related issues. That is, there is no one solution for ethical problems. Rather, responses to these problems are the result of careful examination, dialogue, and thinking. Such a process should be built upon a strong base of knowledge and skills, which students can employ as they make decisions with their patients. In this *building process*, the role of the instructor continually changes from that of a facilitator (one who provides structure to discussions) to that of one who provides encouragement, feedback, and leadership.

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Chapter 7
Medical Ethics Education in China

Hongqi Wang and Xin Wang

7.1 Introduction

Medical ethics education has a long history in China. At the same time, it is also a new field of study, along with the introduction of western medicine to China in the past two centuries. Due to the different cultural traditions, different Chinese medical ethics scholars hold various viewpoints on medical ethics and bioethics research and practice. This paper is organized as follows: In the first section, a brief historical review of the overall development of Chinese medical ethics is presented. The next section presents three different schools of scholars in Chinese medical ethics and research. Then, Sect. 3 discusses the current popular research topics, which represent state of the art Chinese medical ethics research. The last section analyzes and evaluates the viewpoints from different schools and concluding remarks are offered.

7.2 Brief Historical Review

China is a country with a long history in education and research in medical ethics. Originating from *Da Yi Jing Cheng* (*On the Absolute Sincerity of Great Physicians*), which is also known as the Chinese Hippocratic Oath, by Sun Simiao (581–682) who is a famous traditional Chinese medicine doctor of the Sui and Tang dynasty, to *Wu Jie Shi Yao* (*Five Admonitions and Ten Maxims for Physicians*) by Chen Shigong (1555–1636) a great surgery doctor in Ming Dynasty, the traditional Chinese bioethics research contents focused on and emphasized doctors self-control and self-improvement on virtue of medical practice. Some of these works are still required reading for modern Chinese physicians. The following is a famous excerpt

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from *Da Yi Jing Cheng* by Sun Simiao: "A great physician should not pay attention to status, wealth or age; neither should he question whether the particular person is attractive or unattractive, whether he is an enemy or friend, whether he is a Chinese or a foreigner, or finally, whether he is uneducated or educated. He should meet everyone on equal grounds. He should always act as if he were thinking of his close relatives."

The traditional Chinese medical ethics emphasized heavily on physician's morality and set high standards for medical practice. To summarize the ideas in these historical works, the physicians must rescue every life without any preconditions. Physicians should not aim to obtain profit for themselves, but should devote themselves in medical research and strive to help patients. Physicians must be very conscientious in their medical practice, and treat all patients with respect, concern, sympathy, and equality. In Chen Shigong's famous work *Wu Jie Shi Yao*, he mentioned that "when making a visit to a sick married woman, widow, or a nun, the physician has to have a companion. Only then can he enter the room and undertake the examination." The most important philosophy of traditional Chinese medical ethics is that medicine is applied humaneness.

In Ming and Qing Dynasty, due to the influence of Christian missionaries, hospitals appeared in mainland China. The new hospital system is based on Christianity, western philosophy, and western cultural background. While traditional Chinese medicine, which is commonly referred to as Natural Medicine, is based on Yin Yang and Five Elements theory, Western Medicine were introduced to China from the western countries along with Christianity in the later Ming Dynasty. Western Medicine is commonly referred to as Allopathic Medicine and evolves from Hippocratic Medicine. Western Medicine differs from the traditional Chinese medicine in its approach to treatment, which relies heavily upon industrially produced medications and a strict adherence to the formal scientific process. In the year 1569, the first hospital was built by the Catholic Church in Macau (Macao), which may have been the first Christian hospital in China. Up to the year of 1937, there were more than 300 Christian hospitals (more than 21,000 beds all together) and more than 600 clinics burgeoned in Mainland China, most of which were attached to Christian churches in the early years.

Western Medicine has become more and more popular since the 1920s. From the establishment of the Republic of China in 1912 to the end of the World War II, hundreds of western medical colleges and nursing schools were established. Thousands of students were educated and graduated from those schools to become skillful doctors and nurses. Among them, the most prestigious institution is Peking Union Medical College established in 1906 by five Christian missionaries. Since 1915, supported by the Rockefeller Foundation, Peking Union Medical College has become the center of western biomedical science in China.

The earliest Chinese doctors of Western Medicine were educated or trained abroad and they brought back modern medical techniques to China. In 1926, the Chinese Medical Association (CMA) issued the Code of Medical Ethics (1926) in the *Journal of Chinese Medicine*. The western-trained physician Song Guobin (1893–1956) sought to integrate Western medical ethics with Confucianism, and

published his work *Ethics of Medical Practice* (1933, English version), which may be the first modern book on medical ethics in China.

Since the establishment of the People's Republic of China in 1949, medical ethics education has emphasized the following mission written by Chairman Mao Zedong in memory of Dr. Norman Bethune: "Heal the wounded, rescue the dying, and practice revolutionary humanitarianism," "serve the people heart and soul," and "utter devotion to others without any thought of self." These moralities of socialism and communism have been established and used to regulate doctors since the 1950s.

Since the Chinese Economic Reform in the 1980s, medical ethics research and education has stepped into a new era and achieved great improvements in China with the help of UNESCO, WHO, CIOMS, and other international organizations and institutions. In the 1980s, Chinese medical ethics studies began to show significant development. A large portion of Western medical ethics literature has been translated and introduced into China, including the Declaration of Helsinki and the biological-psychological-social medicine model. Ethics committees in hospitals, medical schools, Centers for Disease Control and Prevention, State Ministry of Public Health, and State Food and Drug Administration have been established. During this time, pioneer Chinese scholars, such as Prof. Ruicong Peng (Vice President of Beijing Medical University), Prof. Zhizheng Du (Editor-in-Chief of the Chinese journal *Medicine and Philosophy*), Prof. Renzong Qiu (Director of Philosophy, Institute of Chinese Academy of Social Sciences), and Prof. Dr. Qingli Hu (WHO Deputy Director General, Shanghai Jiaotong University) devoted a lot of effort to introducing medical ethics and bioethics. Meanwhile, they set up the corresponding educational agencies and sponsored many journals including *Medicine and Philosophy* (since 1980) and *Chinese Medical Ethics* (since 1988) as platforms for research studies and communications.

At the same time, Medical Ethics (or Professional Ethics Education) offered for medical college students and nursing students became a required or elective course (20–36 h). The course was categorized into the Marxist theory courses and ideological and political science courses educational system (so-called *two courses* for short). Bioethics has been typically offered to graduate students and doctoral candidates in many medical schools as an optional course (20–36 h). Many philosophy or ethics researchers and professors began to recruit PhD students in the field of bioethics, such as Prof. Renzong Qiu in the Philosophy Institute of the Chinese Academy of Social Science. Meanwhile, the four basic ethical principles (autonomy, justice, beneficence, and non-maleficence) were introduced by the instructors. The textbook *Principles of Biomedical Ethics* (Beauchamp and Childress 2001), the Belmont Report, and the Declaration of Helsinki have made great impacts and significantly influenced Chinese bioethics educators and researchers. The Harvard School of Public Health, the Kennedy Institute of Ethics at Georgetown University, the Hastings Center, the University of Wisconsin Medical School, FDA, NIH, UNESCO, WHO, and CIOMS have become more and more well-known to Chinese scholars.

In the year of 2007, Chinese President Hu proposed a "people oriented scientific outlook on development," which greatly improved the development of medical

ethics, bioethics research, education, and applications in China (Hu 2007). The Chinese government has been promoting sound and rapid development in medical ethics and bioethics. China is now in the stage of developing biomedical ethics with unique characteristics in the context of globalization.

7.3 Three Scholarly Schools in Chinese Medical Ethics

Since the 1990s, medical ethics and bioethics research and education in China has entered into a new age due to philosophical-social sciences' influences and many new technologies developing in the biomedical and bioscience fields. A series of Sino-US/Britain summer schools on philosophy and bioethics workshops have been held in major Chinese cities sponsored by the Philosophy Institute of the Chinese Academy of Social Science or by the Chinese Society for Philosophy of Nature, Science and Technology (the Chinese Society for Dialectics of Nature). Also, a great number of philosophy and bioethics books began to be introduced to China in translation. At the same time, Chinese scholars are more frequently taking part in international communications and collaborations. Due to the difference in background knowledge and experience, the scholars' viewpoints on academic characteristics of medical ethics and bioethics can be largely divided into the following three categories.

In the first category, scholars insist on introducing a universal medical ethics theory and new results of the bioethics and medical ethics studies into China. Scholars also focus on introducing the declarations, guidelines, criteria, and regulations from the WHO, CIOMS, and UNESCO to the Chinese professionals, doctors, and policy makers. They are also adamant about introducing state of the art international topics to China and trying to use the universal standard as the way to solve Chinese problems in medical ethics by leading toward prosperity for the people.

In the second category, scholars tend to study Chinese medical ethics resulting from studying the traditional and historical Chinese culture and context for future development. As it is known, the International Ethical Guidelines for Biomedical Research Involving Human Subjects (CIOMS/WHO 2002) has set up the three basic ethical principles for medical ethics and bioethics: respect for persons, beneficence/non-maleficence, and justice. There is a similar illustration in the Belmont Report. During the localization process in China, some Chinese scholars modified the three standards mentioned above as: respect and autonomy, do good things, and fairness. Other scholars among the second category even disapproved of these principles, and believed that fundamental ethical principles should come from traditional Chinese culture, in which they prefer the ancient Chinese Confucian saying by Dong Zhongshu (179–104 BC, a great Chinese philosopher in Western Han Dynasty): humaneness, righteousness, propriety, wisdom, and integrity. In his well-known work *Chun Qiu Fan Lu* (*Rich Dew in Spring and Autumn*) he summarized Confucius thoughts and proposed moral standards of the Three Cardinal Guides and Five Constant Virtues as specified in the feudal ethical codes. The Three Cardinal

Guides are the governor who guides his people, the father who guides his children, and the husband who guides his wives. The Five Constant Virtues are humaneness, righteousness, propriety, wisdom, and integrity, (as mentioned above). Humaneness can be defined by the concept of fraternity: "medical practice is technique of humaneness" (by Mengzi, about 372–289 BC, in Mengzi, Liang Hui Wang Shang: Do not harm, which means humaneness), and humaneness means love and care for persons (by Confucius, 551–479 BC, in Lunyu, Yan Yuan Pian). There, student Fanchi asked Confucius: "Teacher, what does Humaneness mean? Love the persons." Confucius answered, "What you don't want done to you, do not do to others," which can be the practical guidelines, just as Dr. Song Guobin had done 80 years ago in his textbook Ethics of Medical Practice (Jonsen 2008).

In the third category, the scholars try to learn to construct a "union of free individuals" from Karl Marx's The Communist Manifesto (1848), where "the free development of each individual is the condition of the free development of all," and to construct Chinese medical ethics and bioethics. Many theories include Chairman Mao Zedong's "heal the wounded, rescue the dying, and practice revolutionary humanitarianism" (July 15th, 1941, for Chinese Medical Universities in Yan'an) and "serving the people with whole heart and soul" (September 8th, 1944, a speech Serving the People in remembrance one of central guards regiment solders Zhang Side), "utter devotion to others without any thought of self" (December 21st, 1939, In Memory of Norman Bethune), and the current policy of a "people-oriented scientific development view." Collectivist and socialist medical ethics with Chinese characteristics are established in medical ethics research and education. Domestic medical ethics and bioethics have shown that diversified schools of studies flourish. Communications between different schools of studies have led the Chinese medical ethics and bioethics to prosperity.

In the twenty first century, different fields of medical ethics studies in China have been further developed, and have achieved more accomplishments. Several groups of studies with distinctive features have emerged. The representative societies of scholars are the following: the Society for Philosophy of Nature, Science and Technology (or: the Chinese Society for Dialectics of Nature) with its Bioethics Committee (focusing on universal bioethics, sponsored by Prof. Renzong Qiu and Prof. Xiaomei Zhai at Peking Union Medical College), the Medical Philosophy Committee (Chinese Encyclopedia School, led by Prof. Daqing Zhang, Peking University Medical Humanities, and by Editors-in-Chief Zhizheng Du and Prof. Mingjie Zhao of the journal of *Medicine and Philosophy*), and the Chinese Medical Association Medical Ethics Committee (hosted by medical university presidents or other officials, Red Cross Society, Chinese Medical Association officials). The representative education and research centers include: Peking Union Medical College Bioethics Research Center (directed by Prof. Renzong Qiu and his student Prof. Xiaomei Zhai, and in close collaboration with Harvard University, WHO, NIH, and UNESCO); Peking University Medical Humanities Center (directed by Yali Cong, from traditional Chinese Ethics to more broader international communications); Shandong University Bioethics Research Institute (directed by Prof. Yongfu Cao and his tutor Prof. Xiaoyang Chen focusing on Confucius ethics thought, and

in close collaboration with Prof. H. T. Engelhardt at Rice University, and with Prof. Ruiping Fan at City University of Hong Kong); Southeast University Medical Humanities Department (focusing on Christian bioethics and multi-culture research, directed by Prof. Muyi Sun, and in close collaboration with Prof. H. T. Engelhardt); and Guangzhou Medical College Medical Humanities School (focusing on Chinese medical ethics education). The most influential Chinese journals in this area are *Medicine and Philosophy* (sponsored by the Chinese Society for Philosophy of Nature, Science and Technology), and *Chinese Medical Ethics* (sponsored by the Chinese Ministry of Education, Xian Jiaotong University, and Chinese Medicine Association Medical Ethics Committee).

7.4 Current Popular Topics for Discussion in China

The authors have published similar views in *Chinese Medical Ethics* (Wang 2012) about the current topics in medical ethics research and education, including but not limited to the following viewpoints.

7.4.1 Tension Between Individual Rights and Collective Rights

Human rights and dignity are the inalienable fundamental privileges of every person, which are neither created nor can be abrogated. Personal rights and dignity should be protected and must not be infringed. Individual patients are often the subjects of medical research and treatment; therefore, clinical medicine should address individual human rights issues. Respect for persons should be emphasized, including patient autonomy, informed consent, patient confidentiality, and privacy protection. Beneficence/non-maleficence should be emphasized, including: *do no harm* as the minimum requirement and *do good things* or benefit the patient as the higher requirements. Justice should also be emphasized, including fair distribution of medical resources, revenue justice, and procedural fairness, which requires existing fairness not only in appearance but also in reality.

There are significant differences related to rights within clinical medicine and public health. Public health is the idea of protecting communities and keeping them healthy through educational services, promotion of healthy lifestyles, and researching disease prevention. Public health is mainly concerned with groups, communities, and society as a whole. Public health serves to emphasize the collective rights of the community and society. Clinical medicine is focused on protecting individual patient rights and dignity. Public health on the other hand is more concerned about protecting the rights of the general public. In some cases, conflicts exist between individual rights and collective rights.

For example during the SARS period, suspected SARS patients had to be quarantined in the interest of public health, which to some extent put a constraint on individual rights. This was a violation of individual patients' rights aimed at preventing

the spread of the virus to healthy people to avoid causing a larger epidemic. It can be asked why, then, similar methods cannot be adopted for other infectious diseases such as HIV/AIDS in order to prevent the spread of the virus by isolating infected patients with HIV/AIDS? Under what circumstances can isolated and infected patients be defended by humanitarian rights? Under normal circumstances, there is a certain tension between individual rights and collective rights. The balance of this tension needs to rely on the legal and moral power to regulate and restrict individual and collective rights.

Achieving individual human rights cannot and should not be achieved at the cost of impeding (or harming) the legitimate rights of others. It is based on this principle that persons who are infected with HIV/AIDS have the duty to inform their sexual partners of their infection. It is also based on the same principle that we require HIV/AIDS patients to not intentionally infect others through sexual activity or the use of intravenous drug injection needles. HIV/AIDS patients also have the obligation to explain their medical situation to their physician, surgeon, and dentist; at the same time those doctors cannot refuse treatment to these infected patients.

7.4.2 Contradiction Between Procedural Justice and Substantive Justice

John Rawls believes in justice as fairness; however, some scholars in China hold different viewpoints on how to follow it in practice. Individualism is different from traditional Chinese collectivism. Traditionally, the family is at the center of our society, the husband is the ruler over his wife, and different ranks and levels are the basic hierarchical structure of our society. The traditional family-based culture is now at a different position, so pluralistic viewpoints are necessary. Current studies about justice and fairness involve the overall reform of medical systems, including macro-level issues such as allocation of the health care resources, and the micro-level issues related to clinical practices.

The Chinese new rural cooperation (the new rural cooperative medical system), urban residents health insurance, serving medical insurance for working professionals, and some other commercial medical insurance problems, are all targeted for solving this problem. At the micro level, informed consent is required by the patient before any medical examinations or treatments will take place in hospitals. If a patient loses the capability to make rational choices and decisions, proxy consent is needed to carry on informed consent. This is a formal requirement and an important form of protection to procedural fairness.

However, there are also cases in which the informed consent form (ICF) is left unsigned sometimes due to cultural, economic, or psychological issues. If the patient or surrogate decision maker refuses to sign the informed consent form, then valuable treatment opportunities may be missed, possibly causing death, which could lead to medical litigation. This situation can cause doctors to experience moral distress, but their choices in this particular situation are limited. According to the regulation of no surgery should be performed without patient's or surrogate's

signatures, should the surgeon pursue a form of fairness and justice, or should the doctor consider what he or she believes to be the best interest of the patient and proceed with the treatment, despite a lack of informed consent?

The Lili Yun Accident is one of these cases, which occurred in West Beijing Branch of Beijing Chaoyang Hospital. On November 21, 2007, a 36-week pregnant woman, Lili Yun, who was experiencing a cough, yellow sputum, hemoptysis, fever, dyspnea, and orthopnea, was sent to the Beijing Chaoyang Hospital, West Beijing Branch by her husband, Zhijun Xiao. Faced with the critical condition of his pregnant wife, Zhijun Xiao refused to sign the proxy consent form for a necessary operation. According to Chinese law, without the signature, the hospital cannot perform the operation, essentially rendering the patient helpless. After 3 h of intense resuscitation efforts, the pregnant woman died. The public was astonished by the accident. There has been a heated debate among medical ethics education colleagues over this issue.

There are other cases in which patients may reject treatment plans proposed by doctors after informed consent. Due to religious reasons patients may refuse to have blood transfusions, or a patient may refuse to abort her unborn fetus despite the knowledge that it will have a serious genetic disease. The question then becomes: can the doctor, based on his own good intentions or the fundamental interests of others impose a blood transfusion or abortion upon these patients? There appears to be a contradiction between procedural justice and substantive impartiality, as well as a conflict between local/immediate interests and overall/fundamental interests.

Such conflicts of interests may also exist in pharmaceutical companies, research institutions, between the doctors as researchers and the patients as subjects, among the patients, insurance company and employing unit, or even between patients themselves and their family members. There may also be conflicts of interest within the doctor-patient relationship. Sometimes, the family members of a patient cannot afford the expensive medical costs, and reject medical treatment on behalf of the patient, therefore, there exists a conflict of interests between patient and his/her family members.

Conflict of interests may lead to very serious adverse consequences, and can even cause death in patients. For example, the above mentioned family members, due to economic conflict of interest, may make a decision on behalf of the patient to abandon the treatment; the consequences of this abandonment of treatment can be imagined. Several years ago, the Gelsinger Case in the field of gene therapy (Zhai and Qiu 2005) was seen as a conflict of interest, which has become a heated discussion topic in China. Similar kinds of problems in stem cell therapy have also been addressed.

7.4.3 Nationality vs. Universality

The relationship between universality and nationalism has become the focus of bioethics and the medical humanities debate. One viewpoint emphasizes the nationality and regional characteristics of medical humanities. Another viewpoint emphasizes

the universality of medical humanities, which points out that medical humanity itself does not belong to a certain nation.

In November 2007, Prof. H. Tristram Engelhardt from Rice University presented The Foundations of Bioethics Critically Re-examined at Nanjing International Bioethics Summit (Engelhardt 2007). He proposed the following viewpoints for the moral pluralism and postmodern moral crisis. There have been about 2500 years of philosophical contemplation about human moral and ethical diversity. However, almost no empirical basis exists to support a universal code of ethics known to the public. Therefore, from the clash of civilizations to Engelhardt's culture wars, some scholars believed that generally proper conduction of modern ethics itself has become a serious problem. In the context of cultural wars and the collapse of the global bioethics consensus, medical practice, abortion, euthanasia, public health, medicare, and private resources redistribution have all become content-full topics of debate.

On the other hand, we have witnessed that, since the mid-twetieth century, bioethics has a distinct wide range of universal and transcended ideological characteristics that stretch across national boundaries, transcend religious and political opposition, and have developed a common context in the human spiritual home rooted in the philosophy of everyday life (Qiu 2003). The reason why bioethics can be studied universally is mainly due to the United Nations' effort to respect human rights and dignity within all countries. International documents such as: the Charter of the United Nations (1945), and the Universal Declaration on Human Rights (1948) have normalized and regulated these governmental activities. In spite of the arguments on personal rights vs. state sovereign rights, hoodwinking and enslaving people in any country has become more and more difficult. Globalization in economy, culture, science, and education has made the world a global village. With the Declaration of Helsinki (WMA 1964), the Universal Declaration on Bioethics and Human Rights (UNESCO 2005), and the International Ethical Guideline for Biomedical Research Involving Human Subjects (CIOMS/WHO 2002), the UN, WHO, CIOMS, and other international organizations have constructed a platform for dialogue and communication across cultural differences, which has made international cooperation in biomedical research prevalent and new pharmaceutical human subject testing standardized.

Engelhardt argues that bioethics should be freed from improper customs and restrictions, being contrary to universal moral principles (Engelhardt 2006). In other words, bioethics should support the aspirations of the Enlightenment and the eagerness of achieving the universal moral society of the French Revolution. He believes that bioethics is not just international, but also a pursuit of the concept for a good, proper, and impartial content. It is because of this characteristic of bioethics that it has been accepted by different nations and individuals with different religious and cultural traditions.

Engelhardt's multiculturalist thoughts influenced the Chinese speaking/cultural bioethics schools, including scholars from China main-land, Singapore, Taiwan, Hong Kong, especially his student Ruiping Fan from the City University of Hong Kong and scholars from Mainland, such as Yongfu Cao in Confucians hometown

Shandong Province. Supported by Engelhardt, Ruiping Fan hosts the *Journal of Chinese and International Philosophy of Medicine* in Hong Kong, with the aim to bring together the Chinese and Western community of researchers and practitioners in the field of biomedical ethics to discuss the latest advancements in the discipline.

7.4.4 Problem Research vs. System Construction

Should the medical humanities be focused on the study of problems, or focused on the construction of a theoretical system structure? Domestic scholars have different views on this question. One view is that bioethics is developed within the framework of ethics of norms, ethics of rights, and ethics of procedures (Zhai and Qiu 2005). To establish theoretical systems is not the purpose of bioethics. Bioethics should focus on current Chinese-specific issues. Bioethics also puts an emphasis on problem research, emphasizing its practicality, rather than theoretical thinking. On the contrary, this theory of thinking is based on practice with the aim of meeting the needs of practice. In this view, bioethics is not a philosophical ethics or theoretical ethics, which is pursuing only the purest, the most complete, and the most self-consistent ethical theory. Bioethics is applied or practical ethics for solving problems, in which utilitarianism and deontology are the two most fundamental and effective theories. But the application is not a theory or principles of inference. Application must consider detailed circumstances. In some situations, some values are prominent while they are not in other situations. For example, clinical patients and research subjects are vulnerable populations, and their rights and interests should be placed first. But in the context of public health, their personal rights and interests must also be considered although not as primary values. The focus of bioethics, in this view, is not the construction of theoretical systems. But the effect of meta-ethics, normative ethics, applied ethics, descriptive ethics, modern biomedicine, and traditional culture on bioethics deserves serious research.

Another point of view is that bioethicists should have their own theoretical systems, to form different theoretical frameworks in different cultural circles (Sun 2007). How to make bioethics survive and develop in different cultural traditions and in various styles of philosophical thought has become one of the major areas of study. This second point of view emphasizes the structure of the theoretical system, the cultural roots of bioethics, Chinese cultural characteristics, and the post-modern cultural identity of bioethics. It has positive value and meaning for the construction of a bioethics theoretical system with Chinese characteristics.

Regarding the theoretical system bioethics, in some sense, it should be part of ethical life science. It should be a discipline that is questioning the moral status of human life, that is doing ethical research on the ultimate life issues, and evaluating and reflecting on life science, technology, and the moral philosophical interpretation of life, especially the essence of human life, meaning, and significance. The core of bioethics is not the trivial application of a particular moral theory, but the examination and development of moral philosophy theory that is adaptive to the

development of the life subjects and human life science technology. It is not limited to the explanation and demonstration of life behaviors and the validity of life science and technology. It must help people learn all the problems and difficulties of life and explore the ethical problems related to the fields such as the phenomena of life, biotechnology, medicine, and hygiene. More important missions are focused on the philosophical studies of spiritual life and real life. The applications of basic ethical principles and applied guidelines to explain detailed life science and practical or clinical problems must be established on the results of research of all schools of moral philosophy, which have determined that it is not a general sense of applied ethics.

Due to its cultural roots, Christian bioethics has greatly influenced Chinese bioethics scholars. Just as Sun mentioned, bioethics is a speculative system and a post-modern positivism strategy in accordance with the goal of promoting the life of human beings and other living creatures (Sun 2007). It is part of the post-modern culture and is the sign of awareness and comprehension during the post-philosophical era. It emphasizes caring for lives, and it has unique academic merits and research methods, since it applies special language symbols for different contexts. Bioethics is dependent on the special logical order to construct the inner relationship of humanities, life sciences, and social science. Due to its a priori consciousness of spiritual life, and its kinship with theology studies, it cannot be isolated from theology, especially Christian theology.

The two points of view mentioned above reflect different Chinese scholars' viewpoints regarding the disciplinary nature, role, and function of bioethics. The first focuses on dealing with specific problems of domestic biomedical research, public health policy, and clinical practice, centering on solving problems, and emphasizing international standards to solve Chinese issues. Therefore, it is believed that bioethics should be focused on solving current Chinese detailed problems, rather than aiming at establishing theoretical systems. It is also believed that bioethics should emphasize research problems and practicality rather than theoretical construction. On the contrary, the second view emphasized that theory is based on practice and is responding to the needs of practice. In other words, bioethics does not pursue its ultimate goal as constructing the theory, but emphasizes the importance of theoretical thinking. This viewpoint promotes the birth and development of Chinese bioethics, boosts biomedical research and clinical practices to follow the international standards and norms, and benefits the understanding of the international community of Chinese medical ethics.

In addition, there are many debates going on in China along with the international debates, such as the debate between normative ethics and virtue ethics, the debate between deontology and consequentialism or teleological theory, the debate between moral relativism/situation ethics and moral absolutism or principlism, and the debate between the subjectivity and objectivity of morality.

7.5 Conclusion

Medical ethics education in China gradually formed its scholarly tradition on the basis of translation, introduction, introspection, and reconstruction. China is now in the stage of discussing how to develop its own traditional ethics in the context of globalization. But we need to clearly recognize that with the strengthening of international cooperation, the continued development of universal medical ethics guidelines, medical ethics education in China is still far away from the promised land. There are still many things that medical ethics scholars need to do to shape the future direction of bioethics and promote its diffusion among the biomedical science community at large.

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Part II
Ethics Education for Professionals

Chapter 8
The Goal of Ethics Education in Institutions of Higher Learning: The Case of the University of Botswana

Paul Ndebele

8.1 Introduction

It is rare to go through a daily newspaper from front page to back page without coming across one or even more stories of professionals engaged in some scandals related to their profession. Scandals range from cheating, abusing clients, corruption, and others. This reality has made training organizations realize the central role that ethics education plays in the upbringing of upright professionals and citizens (Armstrong et al. 2003; McPhail 2001). Over the years, professional associations have developed ethical codes for individual professions. In many cases, the development of these codes has been a direct response to scandals and unprofessional conduct among their members. The medical profession is a clear case in point as the World Medical Association came up with the Declaration of Helsinki in response to various scandals committed by medical professionals, among these, those committed by the Nazis (Puri et al. 2008; Shuster 1997). Professional codes of ethics are a way of establishing standards that can be used by both professional associations and society in general in judging the behavior of individual professionals. Society has expectations with regards to how individuals in the various professions are expected to perform and behave. As developers of professionals from a range of disciplines, institutions of higher learning therefore have to play the important role of ensuring that the professionals they develop meet the ethical requirements of society in general as well as those of their own profession. In this chapter, the goals of ethics education in institutions of higher learning are explored using the case of the University of Botswana (UB). This case study is based on observations and practice by the author during a period of 4 years at UB (2008–2011). It is also based on various pieces of documented evidence that are highlighted in the sections of this chapter. The chapter is divided into various sections including an introductory part that briefly describes Botswana, Batswana culture, and the life philosophy of

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Botho. The later parts of the chapter discuss in greater detail the teaching of ethics at the University of Botswana and how that teaching has been influenced by culture.

8.2 Ethics Education in Botswana

The University of Botswana is located in Botswana's capital city of Gaborone and is the main and oldest institution of higher learning in the country. Botswana is a small country in Southern Africa, covering an area of 600,370 km^2. It shares boarders with South Africa to the north, Namibia in the west, and Zimbabwe in the north-east. Botswana has a population of about 2 million people and the majority of the population are of Bantu origin. The term Bantu people is used to describe the roughly 60 million Africans who speak languages in the Bantu language family. The Bantu people are found in Sub-Saharan Africa (covering Central Africa, Eastern Africa, and Southern Africa). Bantu peoples are known for their life philosophy of *Ubuntu* (Shumba 2011). *Ubuntu* is a Nguni word which is difficult to translate into English as it includes several elements of good behavior. Ubuntu is used to describe a particular African worldview in which people find fulfillment through interacting and relating with other people (Tutu 1999). Ubuntu has different names in various Bantu languages ranging from *Botho, Buntu, Umunthu, Unhu*, *Utu, Butu*, and others. *Botho* is the Setswana term and is commonly used in Botswana since Setswana is the dominant local language among Batswana. In the majority of literature on this life philosophy, the term *Ubuntu* is used. In this chapter, however, the Setswana term will be used from this section onwards since the chapter discusses a Botswana based case.

8.2.1 Botho (Ubuntu)

There are several ways of describing *Botho*. It can be described as a way of life and a moral and ethical ideal important to the lives of many people living throughout Africa. One way to describe *Botho* can be found in a famous Zulu proverb *umuntu ngumuntu ngabantu* and various other proverbs in the various Bantu languages, which imply that a person becomes a person with and through other people (Msila 2009). These proverbs suggest that individuals need others in as much as others need the individual. The proverbs also imply that an individual can be described as a *motho* (meaning a human being in Setswana) because of the existence of other people. Without *Botho*, an individual is just as good as any other animal implying that *Botho* is what separates humans from animals. *Botho* is a philosophy that promotes the good of society and includes humanness as an essential element of human growth. Through the philosophy of *Botho* the community always comes first and the individual is born out of and into the community and hence remains a part of the community. Individual action is therefore aimed at the best for the community.

Human beings are intertwined in a world of ethical relations and obligations of well-being with all other people from the time they are born. The social bond is not imagined as one of atomistic and individuated livelihoods (Venter 2004). *Botho* is a culture which places some emphasis on the commonality and on the interdependence of the members of the community. Through *Botho*, individuals are all inscribed with an ethical obligation to support each other because the development of our personhood is inseparable from the ideal of our shared humanity. Thus, the way individuals become human beings comes out of their relationships with other people. *Ubuntu/Botho* represents a spirit of kinship across race and creed as it seeks to unite mankind to a common purpose of life. *Botho* overlaps with views of humanness as espoused through various religious beliefs including Buddhism, Christianity, Islam, and others (Louw 1998). With *Botho*, the assessment of the religious other is expressed through his relationship and respect of others and theirs in turn through their recognition of the individual's humanity.

Interdependence, communalism, sensitivity towards others, and caring for others are valued aspects of *Botho*. The young according to the philosophy of *Botho* have to be socialized into realizing their roles in community meaning that the philosophy of life and education cannot be separated because the philosophy of life helps to identify the goals that the society holds (Venter 2004). The location of UB in a country that is dominated by the *Botho* philosophy has implications on how ethics education is delivered at the UB. In later sections of this chapter, the influence of the *Botho* philosophy on the delivery and content of ethics education at UB are discussed. The specifics of the history of UB are very interesting and they tie UB as an institution to the life philosophy of *Botho*. An understanding of these specifics is therefore essential as it further illuminates the role of *Botho* in shaping ethics education at UB. The Botswana Government and people use the term *Botho* to describe a person who has a well-rounded character; who is well-mannered, courteous, and disciplined; and realizes his or her full potential both as an individual and as a part of the community to which he or she belongs. *Botho* is taken to be an example of a social contract of mutual respect, responsibility, and accountability that members of society have toward each other, and it defines a process for earning respect by first giving respect. It is also taken to describe how individuals gain empowerment by empowering others (Pandey and Moorad 2003; Presidential Task Group of the Republic of Botswana 1997).

8.2.2 The University of Botswana

The University of Botswana has a long and interesting history. UB began as a part of a larger university system known as UBBS, or the University of Bechuanaland (Botswana), Basotoland (Lesotho), and Swaziland which was founded in 1964 to reduce the three countries' reliance on tertiary education in apartheid-era South Africa. UBBS opened with a population of 188 students on January 1, 1964. The establishment of the university was a case of three small Southern African countries

sharing similar cultures coming together to ensure that they would not rely on South Africa, which was then viewed in a negative way throughout the region due to its apartheid regime. After Botswana and Lesotho became independent in 1966, the university was called the University of Botswana, Lesotho, and Swaziland (UBLS). UBLS was equally funded by the Governments of Botswana, Lesotho, and Swaziland, but had comparatively little physical presence in Botswana and Swaziland in the first phase of its existence during 1964–1970.

Right from the establishment of the University in 1964, it had been recognized that the university had a great potential to serve as focus for the academic and cultural activities of the nation. The education provided by UBLS included aspects of *Botho* as the philosophy of *Botho* was relevant for all the three countries that were represented. Besides sharing similar cultures, Botswana, Lesotho, and Swaziland have a unique history in that they have not been direct colonies of European powers. Several authors have written about Africanization of African education which was bringing African culture into formal schooling (Ramose 2004; Msila 2009; Higgs 2003; Higgs and Van Wyk 2007; Hoppers 2001; Van Wyk and Higgs 2004; Waghid 2004). Some have written on the African renaissance which was a period when African societies defined themselves and their agendas according to their realities and the realities of the world around them (Msila 2009; Higgs and Van Wyk 2007; Hoppers 2001). The Africanization of education, as well as the period of the African renaissance, during the time that a lot of African countries were fighting for political independence, have increased the relevance of *Botho* in African education. To illustrate the usefulness of the life philosophy of *Botho* in African Education, several writers have written on *Botho* and its role in shaping education in Sub-Saharan African countries (Le Roux 2000; Mkabela and Luthuli 1997; Msila 2009; Shumba 2011; Venter 2004). The African renaissance as well as the Africanization of education both influenced the philosophy of education at UBBS as well as at the universities that resulted after the dissolution of UBBS. All three countries contributed staff for teaching at UBBS. Upon dissolution of UBBS, staff members returned to their respective countries to continue teaching using curriculum that had been influenced in content by both the African renaissance and the process of Africanization of education.

The UB formally came into existence on July 1, 1982 following the dissolution of the University of Botswana and Swaziland. It was the first institution of higher learning in Botswana. The University of Botswana was formally inaugurated on 23rd October, 1982 by His Excellency Sir Ketumile Masire, who was then the President of the Republic of Botswana. The student population at UB has grown to more than 12,000 students. The university has five campuses: three in the capital city of Gaborone (Main Campus, Engineering Campus, and Medical School Campus), one in Francistown, and another in Maun (Okavango Research Institute formerly Harry Openheimer Okavango Research Centre [HOORC]). The university is divided into seven faculties: business, education, engineering, humanities, health sciences, science and social sciences, and the School of Graduate Studies which runs as a central office supporting graduate students from all faculties. Since UB is an institution of higher learning that is located in a country in which *Botho* is the guiding

life philosophy, *Botho* guides the education programs that are offered by present day UB (Losike-Sedimo and Mbongwe 2008; Merriam and Ntseane 2008; Mmolai 2007; Pandey and Moorad 2003; Riemer 2008).

8.2.3 Professional Education

At UB, it was recognized right from its establishment in 1982 that the university had the additional role of bringing up professionals who conduct themselves in accordance with societal and professional expectations. Courses in all disciplines that are offered in the university including education, engineering, health sciences, humanities and social sciences, and sciences therefore include some content in ethics. Interestingly, UB was built using proceeds from the sale of cattle donated by Batswana citizens through the *One Man, One Beast* movement (referred to as *motho lemotho kgomo* in Setswana). The university logo includes two cow horns as a way of maintaining this interesting piece of history. The university is therefore literally owned by the citizens since they donated the cattle. The university is therefore expected to educate students in ways that make them appreciate the values of the society (Pandey and Moorad 2003).

8.2.4 National Vision

In 1997, the Presidential Task Group of the Republic of Botswana issued the Vision 2016 document titled *Towards Prosperity for All: A Long-Term Vision for Botswana*. The vision document states that Botswana's Economic and Social Development Agenda is based upon five national principles, which are: Democracy, Development, Self-Reliance, Unity, and *Botho*. This document of national importance clearly acknowledges *Botho* as one of the tenets of African culture:

> The fifth principle for Botswana will be *Botho*. This refers to one of the tenets of African culture—the concept of a person who has a well-rounded character, who is well-mannered, courteous and disciplined, and realizes his or her full potential both as an individual and as a part of the community to which he or she belongs. *Botho* defines a process for earning respect by first giving it, and to gain empowerment by empowering others. It encourages people to applaud rather than resent those who succeed. It disapproves of anti-social, disgraceful, inhuman and criminal behavior, and encourages social justice for all. *Botho* as a concept must stretch to its utmost limits the largeness of the spirit of all Batswana. It must permeate every aspect of our lives, like the air we breathe, so that no Motswana will rest easy knowing that another is in need (Presidential Task Group of the Republic of Botswana 1997, p. 5).

The National vision document notes that in building a moral and tolerant society, Batswana must be made aware of their civic duty and the need for self-reliance. They must preserve their moral values and eliminate the *give me* attitude. They must build *Botho* into a national principle and *Botho* must be central to education, home, community life, workplace, and national policy. The document encourages

religious organizations to play a full part in imparting a sound moral and human rights education in schools and in the community in general. The document also encourages that systems of education supported by public campaigns must stress the value of a multi-cultural society and the need for tolerance and understanding of the differences between people (Mofuoa 2010; Riemer 2008). It is important to note that ethics education and *Botho* are not only taught in institutions of higher learning. The Government of Botswana by declaring the philosophy of *Botho* as one of the main guiding principles ensures that ethics is taught throughout the education system from pre-school, primary school, secondary, and tertiary levels.

As a sign of support for this national vision statement, *Botho* has been formally adopted as a guiding principle for all programs within UB. At UB, it is formally recognized that society as well as the pillars of Vision 2016 require that university graduates leave with attitudes that provide leadership in society, embody a concern for others and promote a contribution to the community (University of Botswana 2009). The Learning and Teaching Policy approved in 2008 describes the learning and teaching philosophy of UB. The policy boldly states that the University's academic programs will aim to encompass cross-cultural fluency, accountability and ethical standards, social responsibility, and leadership skills among other attributes (University of Botswana 2008a). In pursuance of the requirements of Vision 2016, as well as the Learning and Teaching Policy for example, the School of Graduate Studies website clearly discusses and endorses *Botho* as a principle that is appropriate for a School of Graduate Studies committed to providing life-long learning opportunities and to educating tomorrow's leaders as it is for the national development. The School of Graduate Studies further recognizes that *Botho* enhances the educational experience inside and outside the lecture theater to fulfill the vision of learning to know, learning to do, learning to be, and learning to live together as equals with others. This adds to the sense of pride of UB's students and their communities and inspires the Botswana society to further interweave social, economic, political, cultural, educational threads together into a common tapestry. It aims also to attract resident and incoming scholars to participate in the School of Graduate Studies' mission, projects, programs, and research in order to generate added value for all stakeholders involved in UB's academic and corporate relationships (University of Botswana 2012a). The Department of African Languages and Literature has also adopted *Botho* as one of the core values that serve as its guiding principles in the role it plays in learning, teaching, training, research, service, and academic leadership. The Department views *Botho* as promoting mutual respect and respect for human and intellectual property rights (University of Botswana 2012b). Several writers have also written on the importance of *Botho* in UB's mission (Losike-Sedimo and Mbongwe 2008; Merriam and Ntseane 2008; Mmolai 2007; Pandey and Moorad 2003; Riemer 2008).

8.2.5 Internationalization

Several other factors have influenced the teaching of ethics education within UB, one of them being the internationalization of education at UB. In support of educa-

tion internationalization, UB issued a Policy on Internationalization in 2008 and also established the Office for International Education and Partnerships (OIEP), which was tasked with the responsibility of implementing the policy (University of Botswana 2006). Since the establishment of UB in 1982, international education has formed the hallmark of the university. Since Botswana has a small population, right from the beginning, it was evident that the university had to rely on other institutions for training of both students and staff. Over the years, students from the UB were sent to other countries for courses that were not being offered locally such as medicine and engineering. A significant proportion of staff members at UB have received further education outside the country. The past two decades have therefore witnessed a significant growth in students and staff exchange programs with universities throughout the world. The internationalization of education at UB has affected ethics education in several ways. UB staff members who received ethics education as part of their training in other universities would implement similar programs or content upon return to UB. Before sending students to other institutions, staff at UB would ensure that they provide some ethics education to their students in order to ensure that they are conversant with best practices and also with expectations in the institutions to which they will be going to study.

8.2.6 Ethics Courses

As a result of education internationalization, some academic programs at UB have, over the years, developed some stand-alone courses in ethics. These programs include library and information science, medical laboratory science technology, education, law, nursing, social work, medicine, and others. In such courses, students are taught the professional standards and how society expects them to conduct themselves when dealing with clients. Students are also taught about the professional code of conduct for their specific profession. Students need to be aware of ethical principles as well as societal expectations, so that they can avoid professional misconduct. For example, law students need to be aware of what is expected of them in terms of how they deal with their clients as well as issues of conflict of interest. A significant amount of ethical scandals that are recorded in history happened in the area of medicine. It is therefore very important for cadres in the areas of nursing, health, laboratory sciences, pharmacy, and other health branches to be trained in ethics that are relevant for their profession. All the health disciplines within UB include some content in ethics (nursing, pharmacy, laboratory, public health) as a way of ensuring that the graduates from those courses operate using high ethical standards.

8.2.7 Research Ethics

An additional factor to promote the ethics education agenda in the university has been the fact that more and more research is being conducted by staff and students

at the university through more and more collaborative projects. In 2008, the university set for itself a goal to increase the amount of research being conducted by staff and graduate students (University of Botswana 2008b). With the internationalization and intensification of research at UB, there was the realization that students and staff had to be familiar with expectations in partner institutions as well as international best practices in research. Researchers need to be aware of international guidance documents such as the Good Clinical Practice guidelines, the Declaration of Helsinki, and the CIOMS Guidelines as relevant for their particular profession. Acquaintance with best practice norms is essential in minimizing points of friction with international partners. It is also essential in ensuring the integrity of data, which is essential in ensuring research findings are publishable.

Research ethics is taught in the University of Botswana in different ways. Research ethics is coordinated through the Office of Research and Development (ORD): a central office based in the Office of the Deputy Vice Chancellor for Academic Affairs. The office coordinates the operations of three research ethics committees for human research, animal research, and biosafety. Through a program initiated by ORD, aimed at improving the ethical conduct of research within the university, lecturers who teach research methods courses in all the faculties were invited to participate in a workshop that aimed at sensitizing them on research ethics issues. This program resulted in several lecturers incorporating research ethics content into their courses. Some lecturers even proceeded to establish stand-alone courses on research ethics for their programs. In the various courses, students are taught the general ethical principles but also how to behave when they go to the communities to collect data. They are taught how to deal with community elders and how to approach homesteads. They are also taught how to ask their questions in ways that are respectful of their respondents as well as elders. They are sensitized on the sensitive issues that they need to avoid in their research. More importantly, they are taught how to provide feedback on research results to community leaders and also even through *kgotla* meetings. *Kgotla* meetings are chaired by the village chief or headman, and community decisions are always arrived at by consensus (Pandey and Moorad 2003; Riemer 2008).

8.3 The Significance of Culture

Besides the influence of *Botho*, Setswana culture has influenced the delivery of ethics education at UB. Setswana culture encourages consulting each other, within families, between people, and even at government levels. This is referred to as *morero* in Setswana language and is an important way of reaching agreements. Consultations are held through meetings which are referred to as *kgotla* that are public meetings held in villages. Anyone at all is allowed to speak irrespective of position and no one is allowed to interrupt while someone is having their say (Pandey and Moorad 2003; Riemer 2008). Because of this tradition, Botswana claims to be one

of the world's oldest democracies. It is common to find the president travelling throughout the country to meet people to talk to them about life and government programs. Such consultations are held in a culturally formal environment in which every individual present is given a chance to air their views despite their position in society. Students in school and university are taught about the *kgotla* system in preparation for their professional life. Before professionals engage in any programs, it is expected that they consult the communities, and that is where the education on the *kgotla* system and *Botho* comes in handy. In order to further promote the spirit of communalism that is encouraged by *Botho*, the university in 2010 established learning commons which are spaces that encourage group learning. In those spaces, students meet to discuss cases, assignments and issues of relevance for their disciplines.

It is not only important that students are educated in ethics, but students have to be taught using standards that are culturally relevant. *Botho* along with other ideals like human dignity, respect for persons, justice, beneficence, freedom, and equality must be manifested in all spheres of life including political, social, economic, and legal. The culture of *Botho* embodies the capacity to express compassion, justice, reciprocity, dignity, harmony, and humanity in the interests of building, maintaining, and strengthening the community. *Botho* speaks to inter-connectedness, common humanity, and the responsibility to each that flows from interconnectedness. This in turn must be interpreted to mean that as individuals work through their various professions, they should not allow their professional status to rob them of their warmth, hospitality, and genuine interests in the people they serve as fellow human beings. *Botho* recognizes a person as a human being, who is entitled to unconditional respect, dignity, value, and acceptance from the members of the community to which such a person belongs. The philosophy of *Botho* requires that students realize the importance of team work, that they realize the importance of respecting elders and community leaders and above all that they respect their own culture (Losike-Sedimo and Mbongwe 2008). Because of the emphasis on *Botho*, graduates from the various courses pride themselves in being culturally grounded as well as in serving their communities.

The content of ethics education in research methods and stand-alone courses at UB consists of individual level ethical issues focusing on individual professional responsibility and large-scale issues at the community or country level. The pedagogical framework of ethics education has evolved primarily toward utilization of case studies and codes of ethics. These are usually supplemented by an introduction to moral theory. Substantial progress has been made in the development of case materials including high profile cases, everyday cases, quantitative cases, and cases highlighting good character. Currently, there are ethics education courses or content that are not compulsory at both the institutional and national level. Changes in university senate requirements or accreditation criteria for institutions of higher learning that are aimed at making ethics education a requirement will potentially elevate this.

8.4 Goals of Ethics Education

Ethics education at UB serves various aims. First, it is aimed at ensuring that professionals are aware of professional standards. Students who are learning to be professionals in any kind of profession or discipline have to be familiar with the professional code in that specific discipline or profession. Over the years, professional associations have developed some codes that are supposed to guide their members in their dealings with individuals and society. Second, ethics education is aimed at sensitizing professionals on ethical issues. In any profession, there are ethical issues and ethical dilemmas that professionals come across as they perform their roles. It makes good sense for students to be sensitized to these, so that they are capable of dealing with the dilemmas in their professional life. Students need to understand how and why other individuals may be affected in particular ways by their own actions. They also need to empathize with those individuals by putting themselves in their positions, so that they can also experience the feelings and opinions of those individuals (McPhail 2001).

Third, ethics education is aimed at equipping students with skills to identify ethical dilemmas. It is not only important to sensitize students about ethical issues and dilemmas in professional life. The students also need the skills to be able to identify those dilemmas, so that they can recognize them when they come their way. Fourth, ethics education is aimed at improving students' ability to make ethical judgments: after recognizing an ethical dilemma or an ethical issue, students also need to be equipped with the skills of making ethical judgments on those dilemmas or issues. More importantly for UB, the students are taught to make judgments that are culturally appropriate and in line with the philosophy of *Botho*. That way, their judgments do not go against the requirements of cultural expectations.

Fifth, ethics education is aimed at encouraging responsible ethical action. Students are in a process of being molded into future professionals. They therefore need to be encouraged to serve using high ethical standards. This is achieved through various ways including the discussion of cases that include professionals who have served in ways that are cherished by society. This may also involve inviting some good professionals to talk to the students or having the students visit and talk to some professionals of high ethical standing in their work places. Sixth, it is aimed at ensuring professionals are aware of regulations that govern their professional practice including acts of misconduct. In Botswana, as is now common in various countries, there are government regulations that govern how certain professionals are supposed to behave. It is the role of the institution to ensure that their students' consciences are formed according to these laws, in preparation for the future of service to the country.

Lastly, ethics education is aimed at producing graduates with a sense of responsibility and accountability to both their profession and society. While it is known that individuals want to work so that they can make money for themselves and their families, students need to have a sense of responsibility to both their profession as well as society in general. They need to be aware that any unethical action

tarnishes the image of their profession, and also that society expects them to operate using high ethical standards. During training, individuals need to be provided with a broader view of their profession including the ethical dilemmas and issues that relate to their profession (McPhail 2001). The inclusion of the values that are espoused through *Botho* is one way of ensuring that the students are culture-sensitive.

All the above aims promote areas of growth that are important in any professional. The above aims are in line with James Rest's four component model of ethical behavior, which includes sensitivity, reasoning, ethical maturation, and ethical character (Rest 1986). According to this model, inner psychological processes determine observable behavior. It can be said that an individual with moral sensitivity, moral judgment, moral motivation, and moral character is more likely to engage in ethical behavior. Thorne has further developed Rest's model of ethical behavior by adding virtue to come up with the integrated model of ethical decision-making (Thorne 1998). For Thorne, sensitivity and reasoning are part of moral development while ethical motivation and ethical character are part of virtue. One has to have virtue to have ethical motivation and ethical character. The teaching of ethics education at UB is aimed at inculcating both moral and professional development by equipping the students with decision-making skills. It also aims at promoting virtue by motivating ethical intention and ethical character through the appeal of the *Botho* philosophy of life. There is need for subjects taught in school to be related to real life issues. The subjects need to fit into the learners' societal context if the educational experience is to be relevant (Venter 2004). McPhail (2001) further notes ethics education serves the role of developing emotional commitment to both the profession, other professionals, and society. The building of such commitment is essential to minimizing the tendency for professionals to dehumanize other people by only focusing on the performance of their job.

8.5 Conclusion

Ethics education can never be a separate part of the development of any profession. Professionals are trained so that they can play a role in improving society. Society invests resources in the development of professionals. Ethics education ensures that the returns from those investments are assured in so many ways. Ethics education ensures that professionals are more useful and that their services can be demanded by the public. It also ensures that the professionals avoid acts of professional misconduct, which can lead to some professionals being discharged from service and some being arrested or de-registered by their professional associations—all which contribute towards a serious waste of societal resources.

More importantly, the ethics education that is provided needs to be sensitive to cultural and international best practices in order to ensure that the end products are both locally and internationally relevant. In the UB, ethics education is guided by the life philosophy of *Botho* in order to ensure that while the graduates appreciate international ethical norms that they also appreciate local ethical expectations. Pro-

fessionals have to be able to perform their job and to perform the job in a way that is expected of them by their professional society as well as by society in general and, above all, using international best standards while at the same time respecting local norms and expectations. A trend in ethics education at UB has emerged from the above discussion; that is, there has been an increased emphasis on ethics in the teaching of students at UB since its establishment. Some academic staff have included ethics content in academic programs and content. Batswana as well as the Government of Botswana recognize the importance of *Botho* in education and in developing good citizens. The life philosophy of *Botho* continues to guide ethics education in UB. Many challenges remain, most notably the need for lecturers to be more acquainted with ethics education, so they can be in a better position to take ethics education at UB to an even higher level.

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Chapter 9
How Effective Can Ethics Education Be?

Bahaa Darwish

9.1 Introduction

For nearly two decades, universities throughout the world and specifically in the West have increasingly committed themselves to incorporating ethics education in their curricula for various reasons. Recent fraudulent financial scandals (e.g., Enron, WorldCom, Adelphia, Tyco) have led to public questioning whether accountants and auditors have forgotten their professional responsibilities (Shawver 2006, p. 49; Ho and Lin 2006, p. 33). Many researchers also attributed these ethics scandals to the lack of moral development of managers and the amoral, "profits first theoretical underpinnings of business education" (Assudani et al. 2011, p. 104). The result was proposals by bodies such as the Education Committee of the National Association of State Boards of Accountancy to increase the credit hour requirements in business ethics education, supporting the importance of ethics training for the current students who will become the new professionals (Shawver 2006, p. 49; Ho and Lin 2006, p. 33), and the Association to Advance Collegiate Schools of Business, the primary accrediting body of collegiate schools of business, to include ethics instruction in accredited business programs (Assudani et al. 2011, p. 103). Managing scientific misconduct is another impetus in the scientific community to provide ethics education to scientific researchers and practitioners. Scientific misconduct ranges from fabrication of data and harming research participants to inappropriate assignment of authorship and withholding details of methodology or results in publications (Antes et al. 2009, pp. 379–380). The growing public concerns with the accelerating development of science and technology, revealed by the public debates of the ethical dimensions of such products, is a third reason that prompted schools to provide students with the right tools to discuss such ethical issues that arise in their academic disciplines (Day 2006, p. xvi). Teaching ethics also matters because there is consensus among specialists on development issues that ethic education is the most important factor in global development and is the major indicator of

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progression and regression in today's world (ISESCO nd., p. 2). Development is now measured by the extent to which the ethics of human powers understand and use constituents of the technological and scientific revolution (ISESCO nd., p. 2).

9.2 Goals of Ethics Education

Ethics education is, then, seen as an important venue of moral education, or improving moral behavior. Consequently, the question "what are the goals of ethics education?" emerged as an important question to be answered in the respective schools.

Going through the literature on the goals of ethics education, one can note that goals of ethics education not only differ from one discipline to another, but there is hardly a consensus among researchers about ethics teaching goals, even in one and the same discipline: "agreement about business ethics teaching goals is not an easy task" (Ho and Lin 2006, p. 36); "ethics educators remain notoriously vague about the goals of medical ethics education" (Gross 1999, p. 330). Through a field research conducted in 2008 by Tom Cooper to determine how ethics and moral philosophy were being taught in six leading English-speaking universities and in five additional leading departments on programs elsewhere, the participants, who were 40 leading scholars at British and US campuses, differed in determining the ends towards which ethics was taught (Cooper 2009).

Nevertheless, across the different areas of ethics there are at least five goals that are repeatedly mentioned by researchers and instructors as the most important goals that can make ethics education effective.

The ability of students to recognize ethical issues is mentioned by many researchers as an important goal of ethics education. In the domain of business ethics for instance, Loeb (1988) thinks the college or the university accounting education should stimulate students to "recognise issues in accounting that have ethical implications" (Loeb 1988, p. 321). Gautschi and Jones (1998) suggest that the teaching of business ethics should focus on teaching students awareness of ethical issues, noting that this is a goal regarding which there is nearly a consensus (Gautschi and Jones 1988, p. 208). Ho and Lin (2006) also included such a goal among the goals of business ethics education, expressed by them as the goal that can "make students more sensitive to the ethical implications of some business activities" (Ho and Lin 2006, p. 35). Assudani et al. (2011) confirm that "most ethics instruction is undertaken with the objective of increasing students' sensitivity to ethical issues and of increasing students' abilities to employ their ethical philosophies," and that "within this context, the goal of ethics education is to strengthen students' ability to recognize and respond to ethics issues so they will be best able to apply their ethical philosophy to their decision making" (Assudani et al. 2011, p. 107).

In the domain of bioethics, improving ethical sensitivity is also characterized by Gross as a more abstract goal and is often rated among the highest goals by ethics instructors (Gross 1999, pp. 330–331). He believes that "moral sensitivity for example, marks the ability to recognize the ethical dimensions inherent in a clinical

setting and an awareness that ethical difficulties infuse medical practice" (Gross 1999, p. 330, 331).

In the domain of science ethics, Antes et al. (2009) note that emphasizing ethical sensitivity has been one approach to ethics instruction, explaining that "instructional programs based on ethical sensitivity assume that improving ethical behavior rests in enhancing scientists' ability to recognize the presence of an ethical problem, as this is the first step in real-world ethical decision-making" (Antes et al. 2009, p. 381).

Teaching ethical systems of analysis is also set in the various domains of applied ethics as one important goal of ethics education. Ho and Lin (2006) mentioned teaching theories of ethics among the goals of business ethics education since they "might be useful in handling business ethical dilemmas" (Ho and Lin 2006, p. 35). Felton and Sims (2005) mention the focus on theory and practice among the three categories into which they divided the goals of teaching business ethics (Felton and Sims 2005, p. 379). For Beauchamp and Childress, ethical theory "provides a framework within which agents can reflect on the acceptability of actions and can evaluate moral judgments and moral character" (Beauchamp and Childress 1994, p. 44). The importance of such goal, in educating medical ethics, lies according to ten Have (2005) in that the current conception of medical ethics, notably in the U.S., focuses on the use of moral principles to address ethical issues and to resolve conflicts at the bedside. Such conception has dominated ethics courses and the syllabi (ten Have 1994, pp. 78–79).

Provided with tools of analysis, students need to learn how to apply them to everyday activities. The very name of *applied ethi*cs indicates the importance of such a goal. Students need to understand that applied ethics is the discipline where theories, principles, and rules are applied to nearly any ethical issue in almost any area of life. Therefore, they need to learn how to apply these theories and principles through analyzing the ethical issues that arise in their respective areas of study. Felton and Sims (2005), for instance, mention the focus on analyzing issues facing managers in business situations among the three categories into which they divided the goals of teaching business ethics (Felton and Sims 2005, p. 379). Such a goal is what Loeb (1988) expressed as relat[ing] accounting education to moral issues, and considered this one of the broad goals for classroom instruction in accounting ethics (Loeb 1988, pp. 321–322).

Many researchers think that developing students' moral reasoning can be achieved through educational intervention. And this is the fourth goal. In the domain of business ethics, Abdolmohammadi and Reeves (2000) note that many business schools offer business ethics courses for the aim of educating students about ethical reasoning (Abdolmohammadi and Reeves 2000, p. 271). Gross believes that "moral education in general and biomedical moral education in particular strives to nurture principled moral reasoning and the ability to reason through moral issues in universal and impartial terms" (Gross 1999, p. 330). Moral education, according to him, thus, focuses on educating students how to think rather than *w*hat to think. Antes et al. (2009) also note that some ethics instructional programs focus on moral reasoning. In so doing, they focus less on philosophical dilemmas and put greater emphasis on analyzing complex ethical problems (Antes et al. 2009, p. 381).

Of the five goals mentioned here, developing students' moral behavior is the most controversial goal of ethics education in terms of the possibility of its being achieved; still many researchers and authors see that ethics education can and do improve students' moral behavior. Included in what is described as "the only comprehensive list of accounting ethics education goals" (Shawver 2005, p. 51), Loeb (1988) mentions as a goal of ethics education that it sets the stage for a change in the moral behavior of the accountant (Loeb 1988, p. 321).

In the domain of science ethics, there is a common approach to ethics instruction that emphasizes the developmental nature of moral behavior. In this approach, students can be exposed to the regular curriculum with the expectation that general education in this field might explicitly advance the students' level of moral development. They can also be exposed to courses that focus on abstract moral dilemmas, with the intention that such courses will promote students' progress to an advanced stage of moral development. Reaching such an advanced stage, it is believed, will translate into improved ethical behavior (Antes et al. 2009, p. 381).

In the domain of teaching ethics and moral philosophy, 40% of the 40 participants of the field research conducted in 2008 by Tom Cooper thought that classroom moral philosophy could or does make at least some students better persons (Cooper 2009, p. 18). In the domain of medical ethics, Gross notes that medical ethics education is often construed as moral education that is expressly formulated to transform the moral character of physicians (Gross 1999, p. 330).

9.3 Effectiveness of Ethics Education

Based on these goals, how effective is ethics education seen as a venue of moral education? The assumption behind designating the first four goals as goals that can make ethics education effective was that they can lead to improved students' behavior. Regarding the role *ethical sensitiv*ity can play in improving behavior, Antes et al. (2009) explains that instructional programs based on ethical sensitivity "assume that improving ethical behavior rests in enhancing scientists' ability to recognize the presence of an ethical problem, as this is the first step in real-world ethical decision-making" (Antes et al. 2009, p. 381). As for the role of teaching *ethical systems of analysis and applying them to everyday activities* in changing moral behavior, Shawver (2006) assumes that after a student completes an analysis of a real world problem, applying ethical frameworks, and develops possible solutions, a student may choose to modify their own behavior, demonstrating that case analysis may set the stage for a change in ethical behavior (Shawver 2006, p. 53). Finally, *nurturing principled moral reasoning through moral issues* can improve moral behavior because moral reasoning is a function of how one thinks through an ethical problem and not what one thinks. Thus, moral behavior improves as ethical problem-solving and decision-making skills are enhanced (Antes et al. 2009, p. 381).

These considerations lead us now to examine the extent to which such an assumption was proven. In reviewing the literature regarding the assessment of the achievement of such goals, we are struck with mixed results concerning such achievement. Though ethical sensitivity is often rated among the highest goals by ethics instructors, as mentioned before, we get mixed results regarding the role ethics education plays in the attainment of such an outcome, whether in business ethics or medical ethics. Lopez et al. (2005), Shawver (2006), and Assudani et al. (2011), for instance, all intended to empirically assess the effectiveness of business ethics education in raising students' awareness of ethical issues.

Comparing Lopez et al. (2005) who claim to be the first study to empirically assess the effectiveness of ethics education integrated across the curriculum (Lopez et al. 2005, p. 353) to Assudani et al. 2011, we find that though both studies assessed ethics across the curriculum, in comparison to Shawver 2006 who assessed students' awareness of ethics after taking one stand-alone course, each study has ended with different results. Lopez et al. (2005) claims to have noted positive change. The mean comparisons indicated that students who were completing their undergraduate degree in business were significantly less approving of the unethical behavior than were students at the beginning of their undergraduate program (Lopez et al. 2005, p. 351). Assudani et al. (2011), through incorporating ethics as a component in a Management Principles course offered to students in their freshman year, found no significant difference across the control group and the treatment group in their perception of the importance of ethics in business firms. Thus, they concluded that pedagogy did not increase students' awareness of ethical situations (Assudani et al. 2011, p. 112). Shawver, however, who wished to assess the impact of a one semester professional responsibility course on the students' ability to identify unethical accounting and business situations after completion of the coursework, concluded with finding increased awareness among students. Through a survey containing eight vignettes that are accounting and business related and administered twice, once during the first week of the semester and then after finishing the course, he found that for six out of eight vignettes, the respondents indicated that they believed each action to be slightly more unethical (means closer to seven) after completion of the coursework than they believed prior to taking the course (Shawver 2006, p. 59).

In analyzing these results, we cannot attribute the results difference to the difference between a stand-alone course against integrating ethics into a business course, since we have noted that the increase of awareness among students could be achieved with either vehicle of teaching. Add to this, studies that examined the effectiveness of integrating ethics across the curriculum are few, a fact that Assudani et al. (2011) mentioned and referred to Evans et al. (2006) who suggested that the reason could be that it was difficult to assess the quality and extent of ethics instruction in the programs in which it is supposedly integrated (Assudani et al. 2011, p. 108). Therefore, as Shawver (2006) concluded, it is difficult, with few studies in this area, "to assert whether a capstone professional responsibility course is more effective than an integration of ethics throughout the accounting curriculum" (Shawver 2006, p. 61).

The same mixed results are met with the other goals, whether in the field of business ethics or in other fields of ethics and consequently with the ability of ethics education to impact morality. For instance, attempts to measure the ethical sensitivity of medical students have met with mixed success (Gross 1999, p. 331).

The reasons behind the mixed results—about the attainment of any outcome—are controversial and subject to further research.

9.4 Ethics Education in Religious Societies

The mixed results of ethics education outlined above may be one of the reasons that support the conclusion that ethics education is non-efficacious in religious societies such as in the Arab world. Another supporting reason can be that it was empirically proved that religious observance of students and residents, in the domain of medical ethics, is a more effective factor, than ethics education, in achieving or influencing the ethics learning outcomes (Gross 1999).

In what follows, I will argue that religious students, Moslems in particular, more than others need to learn ethics and may benefit more than others from learning ethics, provided that they adopt the principled moral reasoning approach to instruction that aspires towards consistency. This claim is based on the following reasons.

It was proved empirically that moral reasoning approaches have some gains. In teaching professional ethics, Jones (2009), who utilizes a four elements pedagogical approach, one of which is critical thinking instruction with a focus on moral reasoning, decided "to retain these four elements in (her) classes as (she) has seen indications that they are effective for (her) students" (Jones 2009, p. 49). Mumford et al. (2008) noted that "moral reasoning models have evidenced some value as a basis for developing curricula to enhance ethical decision making" among biological and social scientists (Mumford et al. 2008, p. 316).

Religions, whose proponents stem from the premise that their teachings are heavenly, would not preach or accept inconsistencies. So, reasoning-based ethics would help people who would like to behave according to their religious principles to refine and reflect upon their principles and learn how they can apply them consistently. Moslems, in particular, require such instruction because they claim that Islam is a way of life, and it is so, and claim that they rightly follow and use Islamic principles consistently in their judgments and behavior, and this is not always so. Here two examples of inconsistent thinking will be given (one from my teaching experience and another from Islamic literature of medical ethics) to show that Islamic principles are not always used consistently. The examples will be used to show that ethics education focusing on the principled moral reasoning approach aspiring towards consistency and on training students to use reasoning can help students apply these principles more consistently and thus live according to them in a better way.

Through discussing with students the topic of resource allocation in the domain of medical ethics, my teaching starts with asking students the following question: Do you think that all people should be treated equally? Most probably they reply in the affirmation, saying that equality is an Islamic principle. Then the students will

be asked to imagine the following situation: "Suppose that only one place is available on a renal dialysis program or that only one bed is vacant in a vital transplantation unit, or that resuscitation could be given in the time and with the resources available to only one patient. Suppose further that of the two patients requiring any of these resources, one is a 70-year old widower, friendless and living alone, and the other a 40-year-old mother of three young children with a husband and a career. Whom should we treat and what justifies our decision?" (Kuhse and Singer 2001, p. 365).

Most of the students will think that preference should be given to the young, citing as reasons that the old have had enough health care during their life, so they should give chance now to the young, or that the young are those who will steer the driving wheel for the society in the future, so they should be given such priority.

If we put the students' claims in forms of syllogism, it will be easier to analyze them. The first claim can be formulated as follows:

> All those who have had benefit from health care should give chance to others.The old have had benefit from health care during their life.The old should give chance to others.

If we start with the second (the minor) premise, it is not necessarily true that such an old person has had benefit from health care, so the conclusion is based on a false premise, or that such syllogism does not apply to him. As for the other claim we can put it in the form of a syllogism as follows:

> All those who are not likely to benefit the society anymore should leave health care to those who can.The old are not likely to benefit the society anymore.The old should leave health care to the young.

The first (major) premise turns people into commodities that are to be assessed according to their people's benefit. It sees healthcare as a reward to be given only to beneficial people, not as a human right. This premise in itself is against another well-founded Islamic principle that humans are the vicegerent of Allah and as such should not be regarded as commodities. The second (minor) premise is factually wrong. Even if we assume that it is correct in any sense of benefit, but that the old were once beneficial, is it just to reward people in their old age in this way? Are we here displaying equality in treatment?

This is an example of how students can be trained to reason in order to come to justified conclusions, consistent with their beliefs in justice and non-discrimination.

The other example is from Al-Amrousy (2010). In justifying abortion, most ancient and contemporary Moslem religious scholars (*fuqahaa*) concluded that it is religiously impermissible (*haram*) for a woman to abort herself by herself or by the help of anyone in any stage of her pregnancy unless there is a medical necessity. They based this judgment on various Quranic verses. The *fuqahaa* differentiated between degrees of the religious impermissibility (*hurma*). Before 120 days, which is before ensoulment (before the soul enters the fetus), the sin is less that the sin after ensoulment. After ensoulment, abortion is equated to killing an existing living person. (Al-Qurradaghi and Al-Mohammady 2005, p. 445). The necessity which was approved by the majority of *fuqahaa* throughout history is saving the mother's life. The *fiqh* rule that is used to justify abortion in that case is to "accept the lesser harm" (Al-Qurradaghi and Al-Mohammady 2005, p. 429), which is a derivative rule

of the more fundamental rule: no harm or harming. Al-Amrousy (2010) sided with the few who saw that aborting the mother is impermissible after ensoulment even if it is dangerous for the mother's life, giving as a reason that it is not permissible to revive a soul—the mother's—by killing another—the embryo's (Al-Amrousy 2010, p. 212). When discussing the case of whether it is permissible to abort the mother because the embryo is deformed and will remain so for the rest of its life, she sided with those who saw that after ensoulment it is impermissible to abort the mother unless such deformed embryo constitutes a threat to her life, thus displaying a clear contradiction (Al-Amrousy 2010, p. 217). This contradiction has resulted from the lack of training of practicing reasons; of justifying the premises (in this case: it is not permissible to revive a soul by killing another) based on which the conclusion is reached. It is clear that such premise was not used in the latter case; a fact which needs to be explained.

Ethics education is not about instilling certain principles in people, but about teaching students how to think and live consistently. Principled moral reasoning approach to instruction aspiring towards consistency, in the way explained above, aids in getting such aims achieved. Understood as such, ethics education would benefit the secular as well as the religious. Because as long as one judges stemming from a certain religious or secular framework—whether it is a theory or a set of principles—and uses them consistently as criteria for deciding or behaving in some ways rather than others, then, this is what ethics is about. Reasoning leads to justified conviction. This may lead to moral change, which is the utmost goal of ethics education, because it is a fact that people mostly behave according to what they think since thinking affects behavior. According to one theory, the mind has three functions: feelings, desires, and thinking. Feelings and desires do not correct themselves. They change only through thinking. By controlling thinking, one controls feelings, desires, and, consequently, one's behavior (Paul and Elder 2006, pp. 47–48).

However, religious, as well as secular, people should understand that they are living in an interrelated world, where people have to display tolerance towards one another. This adds another goal to ethics education whose rationale is helping in spreading global peace and making ethics education more effective.

9.5 Conclusion

Since ethics education is seen as an important venue of moral education, it should be part and parcel of school and university curricula. The impact of ethics education can be great if it is not only restricted to helping raise students' sensitivity to the ethical issues, through understanding the ethical issues that arise in their fields of study or work, but if it focuses on educating students how to justifiably argue for their decision making, and consistently apply, the important principles in these fields. When ethics is introduced to students as a discipline that helps giving justified reasons for decisions or actions and consistently apply certain principles, it can lead to moral change and ethics education can, then, be made effective.

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Chapter 10
Teaching Ethics to Nurses

Rosemary Donley

10.1 The Beginning of Formal Nursing Education in the United States

Nursing education in the United States was strongly influenced by a hospital-based apprenticeship system that developed in Great Britain after the Crimean War and was imported to the United States in 1883 (Roberts 1954). Commonly called the Nightingale model, early American nursing education was hierarchical and stressed learning by doing or habitual practice (Begley 2006). As students matured, they assumed more responsibility for sicker patients, engaged in ward management activities, and taught and mentored younger students. In their third and final year, they were often placed in charge of hospital wards. However, the vision of the leaders of early American schools of nursing transcended the development of practical judgment and the mastery of clinical skills; they sought to develop moral character and professional behavior in their students, inculcating by word and example what today would be termed professional ethics, duty ethics, or virtue ethics (Fry 1989; Fowler and Tschudin 2006).

10.2 The Ethical Education of Students in the Nineteenth and Early Twentieth Century

Students in these early schools of nursing, single young women of good moral character were taught to respect their patients as they cared and comforted them; to hold what they learned in confidence; to obey their superiors; and to carry out the orders of physicians meticulously. The socialization of nurses educated in hospital schools of nursing was holistic. Students lived in special residence halls adjacent to hospitals; wore modest uniforms and caps, and attended prayer services before their

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duty began (Mayer 2005). This pattern of nursing education characterized private, religiously oriented, and government schools. The behavior cultivated in nursing students and in the trained nurses emphasized spiritual development and character formation. The nurse was perceived to be a person of character capable of discerning morally appropriate conduct in her practice of nursing. She was not regarded as a technician or a skilled worker, but rather as a conscientious moral agent. Years later, MacIntyre (1984) would use a farming analogy to frame the difference between a skilled worker and a thoughtful practitioner; he contrasted the planting of turnips, a skill, with farming, a practice. At a deeper level, MacIntyre is concerned with the cultivation of moral virtues that can motivate and sustain relationships that are integral to the practice of nursing. Like the early leaders in nursing, he is focused on the development of character and its expression in practice.

It could also be said that in these early days, nursing education in the United States resembled the preparation or formation, usually associated with programs in religious novitiates or military boot camps. Ethics, or professional development, as it was often called, was an inherent part of the fabric of the curriculum, programs of student life, and clinical education. In hospital wards, students observed ethical behavior in the nurses who were their directors, head nurses or teachers. Because hospital-based programs required many hours of clinical education, registered nurses were critically important influences in the moral development of nursing students. Students easily found role models among these more experienced nurses whose ethical norms mirrored the values emphasized in students' families and educational programs, interestingly, this system of hospital-based nursing education continued in the United States, more or less, until the 1960s.

10.3 Contemporary Students of Nursing

Today's nursing students enter the educational mainstream through enrollment in junior or senior colleges. The 50 remaining accredited hospital-based diploma programs have adopted the curriculum and student life practices of collegiate post-secondary schools (NLNAC 2012). It seems to this author that the scientific, clinical, professional, and moral development of the student nurse is now the sole responsibility of the nursing faculty. While hospitals and community agencies provide clinical sites and participate in the clinical education of students, for the most part, they are no longer actively engaged in their moral development.

The student body has also changed. A typical class in a school of nursing includes single and married men and women of diverse ages, races, religious preferences, and marital statuses. Some students are parents. Many students work to support their studies. When nursing students live on campus, they are randomly or purposefully assigned to live with co-eds from other disciplines in living centers or traditional dormitories.

From this brief overview, it is obvious that today's curriculum, student life programs, and nursing students differ from those of the past. And although opinion leaders endorse ethical development of students and practicing nurses in the United

States, ethics education in nursing lacks cohesion and focus. Although clinical experience remains an inherent component of nursing education, clinical immersion cannot assure that students will observe and learn ethical practice from their mentors and staff nurses. Their contact with students is limited. More significantly, contemporary nurses and health care providers no longer hold common ideals, values or beliefs; they do not use the same ethical language or engage in health care practices that reflect a shared ethic (Donley 2010; Engelhardt 2000). However, the hidden curriculum, casually communicated by doctors and nurses and encountered by students during clinical experience, influences the development of norms, values, and beliefs; it may overshadow personal values and the values taught in nursing classes (Hafferty and Franks 1994). This hidden curriculum reflects the views of contemporary society as well as the scientific, evidence-based orientation toward practice.

Many of the forces that drive contemporary health care delivery and financing challenge person-centered care. If nurses are to support patients and families in a rapidly changing, technologically-driven, market-oriented health care system, ethics must be formally and intentionally imbedded at all levels of the nursing curriculum. In practice and in health care policy debates, the cost of health care influences patients' access, health care outcomes and the care delivery system itself (Shiyu and Stevens 2005). There is reason for concern about health care expenditures that consume approximately 18% of American's gross national product (GNP) (World Bank 2011). However, the private sector's engagement in American health care emphasizes cost containment and the quest for a profitable return on investment. These goals compete with professional and moral values in health care decision making. To buffer secularism and market-oriented ideologies, nurses must be grounded in ethical principles.

The dominance of the market model of American health care gives insight into why access to adequate health insurance has been difficult to achieve in the United States. Historically, access to health insurance has been linked to employment in companies that offer health insurance. Because health insurance has been a work-related fringe benefit, not a right associated with citizenship, employers have been able to decide whether to offer insurance, the nature of the health benefit package, and the categories of workers that were eligible for these benefits. As the American economy weakened in 2008 and health care costs continued to rise, companies terminated workers and/or reduced contributions to the health insurance programs of employees who remained. Historically, government-sponsored health insurance programs targeted poor people, notably poor women and children, the aged, and the disabled. The lack of health insurance limits access to the health care system and is a serious problem; United States census data (2011) estimated that 48.6 million Americans lack health insurance.

It is not surprising that the health care insurance programs are under scrutiny. *The Patient Protection and Affordable Care Act of*2010 (ACA) represents a major restructuring of the health insurance industry in the United States. Beginning in 2014, ACA will expand coverage to people who have not been able to obtain health insurance; over 44 million Americans will have access to affordable health insurance by 2023 (ACA 2010). *The Accountable Care Act* prevents insurance companies from: discontinuing coverage for people whose illnesses require expensive treatments; denying coverage for pre-existing conditions; charging women more

than men; limiting essential health benefits; and setting life time limits on insurance coverage (OBAMACAREFACTS 2011). Insurance reform requires employers, with more than 50 full time or full time equivalent (FTE) employees, to offer approved insurance programs to their employees or pay a tax in 2015. Citizens and resident aliens will have access to a government-sponsored health insurance exchange where they can compare and select their insurance program. It is estimated that 60 % of the uninsured Americans will have access to government funding to enable them to purchase an approved health plan from the health insurance exchange (ACA 2010). Americans who decline to obtain health insurance will also pay a tax.

The *Accountable Care Act* has programs to assist persons whose lives are complicated by factors that affect their health and their capacity to follow therapeutic regimens. These determinants of health increase the risk of disease, intensify the experience and consequences of illness, and limit access to preventative and therapeutic services. Poverty, minority status, malnutrition, inadequate education and literacy, exposure to violence, unsafe neighborhoods, and environmental hazards are commonly experienced in the United States (World Health Organization nd). Health status is also influenced by personal choices. Analysis of personal responsibility must be balanced by an analysis of power structures and policies that restrict change and limit personal freedom. Nursing's patient-centered tradition and contemporary ethical questions affirm the relevance of ethics education and moral development in contemporary nursing education. Yet curriculum questions and conflicting opinions about the best modalities of ethics education delay action. Illustrative of recurring questions that are yet to be addressed at a national level are: What is essential ethical knowledge for nursing practice and research? What framework(s) should guide nursing's ethical education? How should ethics be taught? Who should teach ethics (Burkemper et al. 2007)?

For the past 40 years, nurse educators and ethicists have studied and debated approaches to ethics education (Aroskar 1977; Stone 1989). Yet 30 years after Aroskar's (1977) study, Burkemper et al. (2007) reported five distinct patterns in their sample of 345 accredited graduate (MSN) programs in the United States: interdisciplinary courses, discipline-specific courses, stand-alone courses, usually bioethics, courses that integrate ethical concepts and frameworks, and some combination of the curricular patterns that have been named. They also identified 13 objectives, 38 topics, 9 teaching methods, and 7 methods of student assessment in the graduate programs that they surveyed. The findings of Brukemper and her colleagues are discussed in the next section of this chapter.

10.4 What Ethical Knowledge Is Important for the Professional Nurse?

At the beginning of its *Code of Ethics for Nurses,* the American Nurses Association (ANA) (2001) posits that ethics is integral and foundational to nursing. In the *Code's* companion document, the ANA names selected ethical principles, theories,

and concepts and offers vignettes to assist nurses in the resolution of common ethical dilemmas. ANA's theories: relativism, feminism, deontology, and utilitarianism are topics included in ethics texts frequently adopted by schools of nursing. Some text books written for health care providers and students of health care ethics include methodologies: principlism, epistemic proceduralism, utilitarianism, deontology, and natural law. Other texts address goal-based, rights-based, duty-based and religious-based approaches; case studies are frequently provided to help with analysis. The importance of ethics in nursing education is also reflected by the use of terms as professionalism and ethical practice in mission statements, policy documents, and course syllabi. The unasked question in curriculum texts and professional statements is what do teachers expect students to do with this ethical information? Are we offering students *products* which they can choose as rational consumers or are we giving them a foundation for their ethical journey? Are we guiding them to translate theoretical ethics into clinical ethics? Are we helping them develop and participate in meaningfully discussions of principles and theories that can be helpful in patient care?

Another major barrier to meaningful ethics education is the lack of ethics preparation among nursing faculty and the lack of clinical knowledge among philosophers and ethicists. Ethics is specialized and distinctions are made among fields of ethical inquiry: bio-medical ethics, professional ethics, virtue ethics, business ethics, health care ethics, clinical ethics, social justice, environmental justice, and distributive justice. These epistemological barriers must be overcome because useful ethical knowledge is critical to the personal and professional development of the next generation of nurses. It is imperative that faculty and clinicians identify and come to consensus about which ethical principles and theories offer meaning and inform ethical nursing practice.

Health policy ethics is another emerging field. As nurses become engaged in policy work and articulate the impact of income levels and social class on health status, they embrace the term social justice. The American Nurses Association (ANA) speaks to nurses' responsibility for social justice in its *Code of Ethics* (2001), its *Social Policy Statement* (2010a) and its *Scope and Standards of Professional Practice* (2010b). The American Association of Deans of Colleges of Nursing (AACN) named social justice in its *Essentials of Baccalaureate Education for Professional Practice* and in its *Position Statement on the Practice Doctorate in Nursing* (AACN 2006, 2008). Specialty practice organizations, such as the Association of Critical Care Nurses and the American Public Health Association, emphasize the import of social justice in their publications. Yet, there is a lack of clarity around the meaning of social justice and how to apply its principles in nursing education, practice, and research (Bekemeyer and Butterfield 2005; Grace and Willis 2012). As an ill-defined but important concept, social justice creates another definitional challenge for faculty and students of the nursing profession.

Traditionally nurses have advocated for their patients by helping them and their families understand their illness and the benefits and burdens of treatment. For these nurses, social justice seems to mean advocacy. These nurses assess patients' health care literacy, provide patient centered information about health care options, and

assist patients' decision making. Others interpret social justice as the systematic engagement in political initiatives to lessen the impact of structures that contribute to health disparities and limit the impact of poverty and discrimination on persons and communities (ANA 2001). These interpretations reflect the action component of social justice, the *doing of justice*. However, it is difficult to initiate or sustain behavior, acting justly, without an underlying and coherent ethical belief system. As more nurses look for root causes of injustice, advocate for changes in policies and structures that limit access to care, and assist patients and families, they need language and methods of inquiry to mount strong and convincing arguments. Alluding to anecdotes or recalling the work of Florence Nightingale and Lillian Wald, recognized models of social justice practice, do not offer meaning or provide long term motivation for acting to achieve a just system of health care in the contemporary health care market place (Donley 2010).

Before nurse educators can teach students how to *do justice* and practice ethically with vulnerable populations, they need to participate with colleagues and students in fundamental dialogues about the philosophical underpinnings of human dignity, respect for persons, and the common good. Nurses can be assisted in these conversations by a critical examination of nursing's tradition, one that placed great value on the centrality of the patient in decision making. As noted earlier in this chapter, it is naïve to assume that nursing students and young graduates will find or assimilate an ethic to guide their practice from observing practitioners in contemporary health care environments. Ethics must be intentionally taught and integrated across all levels of the nursing curriculum if the next generation of nurses is to value and practice patient-centered care.

Fortunately, there is time to address the teaching of ethics to students of nursing. Although academic nursing shares many of the pedagogical challenges of academic medicine, keeping ahead of rapidly changing high technology and finding evidence to support practice, nursing does not face the indifference described by Howard et al. (2010) in their discussion of ethics education in medical schools and residency training programs. Although these authors bring a Canadian perspective, there is resistance to teaching ethics among some faculties of medicine in the United States. It is commonly perceived that ethics is not at the core of medical education, and that curricular time and faculty/student energy would be better spent in high technology medicine and specialty training. Nurse educators do not view ethics as something to be taught/studied if there is time. As is evident from opinion leaders, policy documents, curriculum studies and the nursing literature, the study of ethics is essential to the practice of nursing.

Contemporary nursing students are invited to think critically and holistically about the health status of their patients, families, and communities. They are challenged to search for evidence to support creative, caring interventions, and to assist people with health maintenance, prevention, and self-management of chronic conditions. Many of these initiatives focus on promoting safety, especially in our nation's hospitals. The startling findings of an Institute of Medicine (IOM) study on medical error, influenced and changed nursing protocols and accreditation standards (IOM 1999). Providing safe environments and minimizing error is a consistent theme in nursing's ethical tradition.

Yet the question remains, how can ethics education become a more integral component of curricular frameworks as nursing moves away from disease-centered medical models, hospital-based clinical training, and the use of lectures as the primary teaching modality? Any of the forces that drives contemporary health care delivery and financing can challenge person-centered care.

10.5 What Framework(s) Should Guide Ethics Education?

The accreditation processes in nursing have emphasized the use of frameworks and models in education, practice, and research for at least 40 years (Chaterm 1975). Given this history, it is not surprising that nursing is searching for a framework(s) or model(s) to help define nursing ethics education, such as the one suggested by Powers and Faden (2006) for public health and health policy or by Ruger (2010) who applies Sen's (1985) capability model to health care. However, consensus has not been reached around a common ethical framework to guide nursing education or practice. Perhaps decisions about ethical frameworks will become easier if more nurse faculty become engaged in ethical scholarship, through doctoral study or active participation in interdisciplinary programs that examine the ethics of interprofessional practice.

Like ethics, nursing is a practical discipline. Both fields are enacted; they are not just discussed. Doane (2002) advises that nursing's ethical practice "involves a synergy of humanly involved caring, critical consciousness, and creativity" (p. 522). Consequently, teaching/learning should be designed to help students find their ethical selves. Holland (1999) says that ethics education should help nurses cope with the moral dimensions of their practice. These observations merit some scrutiny. As has been noted earlier in this chapter, the early leaders in nursing recognized that nurses were moral agents. This belief explains the emphasis in early diploma schools of nursing on the development of specific moral qualities and character traits. The importance of acquiring personal virtue is also evident in nursing's historical documents by the frequent use of words as compassionate, trustworthy, and discreet. Rules of conduct that emphasized honesty, modesty, punctuality, integrity, and respect for patients, themselves, and authority figures were strictly enforced. Failure to follow professional norms resulted in punishment or expulsion from early schools of nursing. Early leaders recognized that ethics, like virtue, flourishes and achieves greater meaning when the academic and practice environments are good places to be and to work. If contemporary nurse educators want their graduates to become ethical practitioners, it is incumbent on them to act ethically in their dealings with faculty, students, patients, and each other.

Burkemper et al. (2007) identified, in their study of modes of teaching ethics, diverse organizational patterns and teaching strategies in graduate education. They found ethics is organized in separate courses, integrated into nursing courses and/or professional development modules, and discussed during clinical experiences.

An exhaustive review of the literature on the effectiveness and satisfaction with these various modalities in ethics education identified by Burkemper and others is beyond the scope of this chapter. However, educational theory suggests that because students learn differently, their engagement with diverse patterns and methods is most likely to be correlated with academic mastery and satisfaction (Illeris 2009). Yet discussing educational methodologies diverts attention from more critical questions: what are the essential components of ethics education in nursing and how should nurses be prepared to teach ethics?

10.6 Who Should Teach Ethics?

Deans and faculty of nursing have different ideas about the teaching of ethics (Counts 1991). Hiring lecturers, engaging faculty from other departments on campus, and enrolling students in existing ethics courses or in interdisciplinary ethics seminars are commonly employed modes of teaching ethics. Each approach has advantages and disadvantages. One obvious advantage of stand-alone or interdisciplinary classes is that the faculty members teaching these courses are academically prepared in the field of ethics. One disadvantage is that ethics faculty may lack first-hand clinical knowledge. Students of nursing and other health disciplines know pathophysiology; are conversant with medical terminology and high technology practice; and have more experience with contemporary ethical questions than their liberal arts faculty. The ethics textbooks, case studies or vignettes selected to illustrate modes of ethical analysis may be judged by these students as atypical clinical situations that do not address their day to day experiences. Ethics may be viewed as knowledge that is distinct and separate from real nursing practice; students may not see the relevance of their course(s) in ethics or how ethics can contribute to their effort to become knowledgeable and skilled professionals. In summary, ethics classes may not help them to bridge the gap between theory and practice. Students may not perceive that every patient encounter has an ethical dimension.

This gap between theory and practice can be accentuated when teachers of ethics are not regular members of the faulty of nursing. This form of curriculum planning limits interdisciplinary dialogue between ethicists and the nursing faculty. As a consequence, ethics is not adequately infused into theoretical and clinical courses in nursing. Separating theory and practice can also suggest to students that ethics may be an interesting topic or elective course, but is not essential for professional practice.

An obvious solution is to have nursing faculty teach ethics to their students. Academic nurses know their discipline, the context of clinical decisions, and the ethical demands of professional practice. As has been noted earlier in this chapter, most nursing faculty members in the United States have not studied ethics and are not prepared to teach it. Why has ethics not been a field of study that has attracted academically-oriented nurses? In the United States, contemporary undergraduate

nursing education emphasizes the biological sciences, nursing science, and clinical education. There are some exceptions to this curriculum pattern. For example, religiously sponsored schools and schools with strong liberal arts traditions may require their professional students to enroll in religion, philosophy, or ethics courses. However, most baccalaureate nursing programs do not mandate these courses. Nurses contemplating graduate study are strongly encouraged to seek degrees in their own discipline. Masters and the doctor of nursing practice programs focus on specialty education, preparing students for careers in advanced practice or clinical leadership. Nursing's PhD programs may offer philosophy of science as part of a research sequence, but ethics is not emphasized as a cognate field. Given this background, it is not surprising that nurse faculty members are uncertain about the content of ethics education. Yet they may be expected to integrate ethics into their theory and clinical courses. Although there are good intentions, the discipline lacks the structures and the personnel to execute its own mandates. The profession is yet to develop incentives, scholarships, fellowships, and post-doctoral experiences to encourage more nurses to become ethical scholars.

This is a challenging time to engage in ethical inquiry. American health care is in a state of flux. Access, quality, and cost are the language used to describe the barriers to obtaining care. While these terms are measurable, they also express values. Care that is impersonal and provided in a manner that diminishes the self-esteem and dignity of the patient is not accessible care. Health care disparities are intensified by poverty, geographic location, religious beliefs, gender, and race. The cost of health care is always on the agenda as the United States continues to spend more money on its health care than any other developed country (Squires 2012). At the same time, about 15.7% of Americans lack health insurance (Wayne 2012). The federal government's goal of making health insurance available to all Americans is yet to be achieved. Each concept that dominates the policy debate is a value laden term. Quantifying the money that is spent on health care each year, measuring the impact of health disparities on quality and cost, and counting the number of uninsured people do not answer a fundamental question: what is wrong about the health care system in the United States? Even young nursing students recognize that something is broken in the current health care delivery and financing systems. While the informed teaching of ethics in nursing and medicine will not solve our health care crisis, it will raise questions about the values that motivate people to seek and provide health care services.

Earlier in this chapter, the common ethical theories were named. Experienced teachers of ethics recount that contemporary students do not usually use ethical theories to guide their practices. Usually three patterns are evident among students in ethics classrooms: students who come from conservative families with strong religious beliefs about morality and behavior; a middle group of students whose values are idiosyncratic; and a third group of students, also small, who are oppositional and contest everything, although their values seem to be undecided. In clinical encounters, students usually select an approach that best reflects their experiences in their families or churches. In practice, they choose what feels right to them. It seems that

confronting and broadening notions of what is right and good would benefit young physicians and nurses. The profession of nursing has a window of opportunity to engage itself and its students in meaningful dialogues around the ethics of practice.

10.7 Conclusion

America's nursing leaders emphasize ethics in their codes of ethics, mission, policy and position statements, and in educational standards that name ethics as an essential component of beginning and advanced nursing practice. Unfortunately, ethics education has not kept pace with these lofty aspirations, the development of nursing science, or the preparation of a growing cadre of well-educated nurses. Ironically this limitation occurs as health care in the United States faces new ethical challenges flowing from the routine use of sophisticated health care technology, the force of market economics, and the increasing number of Americans with high expectations who soon will be eligible for health insurance. The rising costs of health care, unimpressive outcomes, uneven access to care, and undeniable health disparities, are familiar ethical themes. For although America invests more money for health care than any developed country, high costs, limited access, and questionable quality contribute to America's disturbing mortality and morbidity data (Kaiser Family Foundation 2013).

Ethics has been crowded out of nursing curriculums in the quest to and integrate evidence into practice to improve patient safety, or prepare advanced practice clinicians, and develop a cadre of researchers to grow nursing science. Erosion of nursing's ethical tradition has also been a subtle consequence of the growing secularism in America, the knowledge explosion, and the transformation of nursing from an art to a science. Yet the profession of nursing cannot achieve its potential or contribute meaningfully to improving care delivery systems and health policies if the next generation of nurses is unable to support and defend their practice and policy decisions with sound ethical arguments. The Accountable Care Act (2010) highlights the need for nurses, especially advanced practice nurses, to manage chronically ill patients in primary care settings. This responsibility, taken alone, demands more than technical competence and reform of practice acts; it calls for informed care and ethical practice.

Nursing's practice ideals challenge the faculty of nursing and influential nurses to take the lead in developing nurse ethicists. This calls for dialogue with interprofessional and interdisciplinary colleagues about the formation of ethical health care practitioners. Nurses' contributions to these dialogues will be strengthened if nurse leaders encourage and seek financial support to enable its brightest students to study ethics. When ethics becomes accepted as an *essential* component of nursing education, the profession of nursing will be capable of teaching and enacting an ethic of practice that informs the minds and hearts of beginning and advanced practice nurses.

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Part III
Educating Bioethics in Resource-Poor Countries

Chapter 11
Teaching Bioethics in the Socio-Ecological Context of Resource-Poor Countries

Claude Vergès

11.1 Introduction

At a time when technology is dominating healthcare, the teaching of ethics and bioethics becomes essential for all students; particularly those studying in the field of health sciences. In the context of resource-poor countries, teaching ethics/bioethics contributes to a better understanding of the relations between sciences and society and a better definition of the priorities in public health. Those teaching bioethics in resource-poor countries must take into account the socio-ecological context within which their teaching takes place. The answers to clinical bioethics problems are different depending on ethnicity, gender, economical status, origin, and cultural differences. Taking account of these aspects will benefit the clinical correlation during teaching.

11.2 Resource-Poor Countries

Resource-poor countries have many problems in common and they also present differences. One of these differences is the economic level of the country (UNDP 2004). The first group of economically extremely poor countries have few professionals in place, like Haiti or Sub-Saharan countries. To respond to their needs, rich nations have a moral obligation to offer them full cooperation in bioethics education as for all fields of development, as a result of the approach proposed by Peter Singer that links utilitarianism and equity (2009). This cooperation means financing the courses on bioethics, stimulating the return of professionals to their country and discouraging brain drain, and training local teachers. In these countries, bioethics education has to take into account the basic needs of the population to emphasize human rights to healthcare. Using the *Universal Declaration on Bioethics and Human Rights* of UNESCO (2005), foreigners and local professors have to be careful

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not to increase the frustrations of the students in the context of scarce resources. On the contrary they have to stimulate their self-esteem, sense of autonomy, and their imagination for proposing ethics-sustainable solutions.

The second group is represented by countries, where economical indicators may permit adequate policies in health and education. The last report of Human Development of the United Nation Program reflects a discrete positive change of these indicators (Minton 2012), but the biggest problems remains social inequities. Countries such as Brazil, Argentina, Chile, and Colombia are classified as economically emerging; that is, these countries present a rapid growth of industrialization and a rapid growth in participation in the global economy. Since the nineties the acknowledgment of social inequities in these countries has produced important work on bioethics among NGOs in human rights and the academy (Kottow 2005). This association and the analysis of national and global inequities led to a global approach on bioethics. In the field of education, from the late nineties on, bioethics programs for health careers and the promotion of bioethics in society and the media have been increasing. These experiences can be helpful for *north-south* (socio-political terminology used for relations between rich countries of the *north*: Europe, Canada, United States, Israel, and developed countries of South Asia; the *south* constitutes all other countries) and *south-south* cooperation that, since 1978, the United Nations has encouraged as a matter of stimulating trade and collaboration between Latin America and Africa exchanges on education in bioethics.

Chile and Mexico present great disparities in their populations though their economies put them in the middle range countries; Cuba and Santo Domingo are more homogenously poor, but all of these countries have developed bioethics with the help of the World Health Organization in the nineties, and they have put the focus on clinical bioethics and research bioethics with humans in their educational programs. This second group has experiences in ethics education, however, as Mexico and Colombia can assume the costs of it, for Cuba and the Dominican Republic, it is more difficult and they need financial help for it.

All other countries represent a third big group with different economic situations, but the main character of it is inequity, poor experience of democracy, and the recent beginning of bioethics. Inequity appears in the indicators of human development by gender, ethnic (particularly indigenous origin), and disability status. Democracy is generally just in name and corruption is often present. Bioethics is poorly developed, but individual doctors and nurses are sensitive about health and bioethics, and they are working to promote it. These countries need organizational, educational, and sometimes financial help aimed directly at the academy.

11.3 Socio-Cultural Context

11.3.1 Social Problems

Along with poor-resources, many countries experience corruption in their government at the legislative level, the jurisdictional level, and in the private sector. At

the inauguration of a seminar on education proposed during the VII Session of the Education Network (Regional Dialogue for Policies, Interamerican Bank of Development) in Washington (2005), Biehl considered that "The antidemocratic compounds of the political culture are: corruption, autoritarism and populism, organized crime and impunity" (Espinola 2005, p. 9). In many countries of Latin America, these factors are associated with violence. When the government has not developed public policies to answer to these daily problems, "…people are not confident with the institutions and between each other… and the societal relationship is scarce" (Espinola 2005, p. 16). This corruption affects the sense of national and personal self-esteem and the process of negotiation with others. Faced with frustration and anxiety, people do not want to participate in civil or politic life, and they find refuge with their family or with religious groups.

The Report of the United Nation Program of Development (2004) showed that in Latin America "…for 56% of the interviewed people the economical development is more important than democracy." (Espinola 2005, p. 14). The same author reports that the Study of Civic Education of the International Association in 1999 shows that younger teens (14–17 years old) do not trust their government until they have more information on its ways of working (2005). This attitude has to be linked with the proclaims of the governmental authorities and the level of corruption and impunity, the lack of job opportunities for young people, the poor level of salaries, and the recurrence of unfulfilled promises. Many choose to migrate to countries with rich-resources if they have the opportunity. The Declaration on Human Rights (UN 1948) recognizes that full liberty (and democracy) is possible only if economical needs (as other basic needs) are resolved. Bioethics in these countries has to promote the principle of justice and empowerment for autonomy and to reverse the attitudes described above.

11.3.2 Health Care

Problems of access to health services are directly associated with inequities on the basis of poverty, gender, and ethnicity. Primary care services are particularly affected. In these countries infectious diseases, diseases of poverty, and complications of malnutrition are still present with chronic diseases. At the same time high tech care is developed for attention of prematurity, intensive care, genetics, reproduction, end of life, and other clinical fields. And the clinical relation between doctors and patients presents the same problems as in all other countries. So bioethical education has to develop all these topics and integrate human rights into health.

11.3.3 University

The universities and the professors are known to be open to critical analysis, scientific rigor, truth and innovation, and to be conservative (Martinez et al. 2002). This attitude is reflected in the position of classical philosophers who have difficulties in

understanding the purposes of bioethics and why scientists (especially medical doctors) could be entitled to speak about it. Accepting this new perspective of knowledge and moral concepts took 10 years of open discussions on local health problems and on the necessary revision of the international literature. The bioethics principles were well accepted because they overlap with medical ethics. Their application for individuals and for social health (particularly for women) and mostly the methodology of discussion and consensus in a context of academic paternalism encountered more opposition. The educational reforms in the universities and the need of certification for global competiveness offer an opportunity to introduce bioethics in the curriculum of health professionals and in seminars in other scientific disciplines.

However, the budget for universities is often scarce, and resources for teaching ethics/bioethics are often limited. The internet has allowed for access to international literature, organizations, and programs on bioethics. Unfortunately it is frequently not possible to find funding for some of the online literature subscriptions, and professors have to find alternative ways to stay connected with current international bioethical issues. In even poorer countries it is more difficult to access the internet due to the cost of technology.

11.3.4 Education

Students often arrive to the university with poor preparation in science and the humanities. The biggest problem is that these students have not learned how to summarize and to analyze books, pictures, or movies. With the last reforms of the universities leading to more competition on the global level, the humanities have been relegated to careers in social sciences. Health sciences students only learn about anthropology, sociology, general history, the history of medicine, Spanish, and basic sciences in their first year. In the following years, medical students (and it is the same in Nursing and Dentistry) have so many scientific and clinical topics to learn that they have no time for literature and art. Some students are used to reading and to debating, but they are a minority. The Study of Civic Education of the International Association for Evaluation of Education in 1999 showed that young teenagers (14–17 years old) learn about their country and the world through the Internet and television (Espinola 2005). Eighty percent of the students of medicine in our faculty had not read a book in the last 6 months, but 92 % of them had seen a movie; literary deficit is a problem in Latin America except in Brazil (The Economist 2011). The introduction of cell phones has put the Internet as a permanent reference without critical analysis of precedence and dates. Professors of bioethics have to take into account these new elements to find new methodologies that can prepare students to understand the psychological problems of the patients whom need to search for information about their disease and the difficulties of health care.

11.3.5 Hidden Curriculum

Deontology has been included in the medical curriculum from the beginning, until 2006, medical ethics represented 16 h of all the career of medicine training at the University of Panama. In 2003 and with educational reform, the pre-graduate curriculum doubled the time to include bioethics, and the postgraduate program introduced a course of 48 h.

At the governmental level, laws on patient rights were proclaimed and promoted in the hospital. But the model of paternalism and top-down hierarchy, between doctors and patients and between doctors and health-workers, has not totally disappeared. In the hospital, students witness these models of clinical relationship: paternalism, dilution of responsibility between different specialties, and non-democratic cooperative relation. All doctors have been confronted with an ethical discourse based on the standards of beneficence. Psychologically violent relationships (as verbal aggressions, pressure, coaction) between health care workers are frequently the product of insecurity or of burnout; the tolerance of this situation by their colleagues and of the administration has a negative impact on students. Television also introduces conduct that reinforces inadequate models (Doctor House has been the model of different promotion of medical students as a smart doctor who can resolve the most difficult problems, and they copy without criticism his harsh relations with nurses and colleagues of inferior positions).

The conflicts of interests between professors (fights for power, political relationship with the administration) have been an obstacle for the constitution of ethics committees on research in many universities. The research for graduate theses and from laboratories is reviewed just for their methodologic basis, and the ethical aspects for review will depend on the reviewer. Protocols of clinical investigations are reviewed by an ethics committee when they have to be done in a hospital. Some students have chosen to ask the ethics professor for an ethical revision. Others try to follow the guidelines on this topic.

It is necessary to define the purposes of teaching bioethics in these contexts and how to teach it.

11.4 Panama as an Example

During the bioethics classes we tried to teach students how to use ethical theories and human rights theory for the resolution of bioethical problems in the social context of each individual, and to analyze their own thoughts and prejudgments in every situation. Taking into account the confusion among the students, professors have to teach them how to analyze the situation. Professors must teach the students to establish what the relevant moral principles are in each case, to propose ethical solutions that are feasible in a reasonable amount of time given the context, and how

to confront their own biases. The process of this analysis needs to be coherent and have clarity in the argumentation. Through the discussion of clinic-ethical problems in each class and in the exams, we try to develop a sense of clinical bioethics and specific skills (Galdona 2000). Between 2006 and 2010, we followed ten groups of students in their last year of medical studies. The numbers of students varied between 56 and 81 students; females slightly outnumbered males though the difference was not very significant.

With the approval of the students, we evaluated 4 years (2006–2010) of bioethics courses in the last year of the medical curriculum at the University of Panama. They voluntarily participated in the evaluation and some of them discussed the results (it was a volunteer process; the majority consented to a passive participation and accepted the use of their evaluations). The purposes of this evaluation were: (1) to define the problems encountered by the students in the integration of ethical and bioethical theories; (2) to examine the impact of different methodologies for this integration; (3) to propose alternatives of educational strategies. This process of evaluation took in account not only the exams but the discussions and the attitudes in classes too. The bioethics evaluation had assessed the moral development as empowerment, capacity of dialogue to transform the external context, critical and moral analysis of problems, empathy and social perspective (Aldea-Lopez 2000).

We analyzed the quantitative results of the three exams of each semester and used the same parameters of evaluation of a clinical case: (1) logical analysis as a reflection of comprehension, (2) concordance of analysis with the ethical and bioethical theories and references of human rights as a reflection of the course, (3) ethical proposals. Then we compared the differences between the best results and the poorest results using these parameters. Quantitative evaluation in the University of Panama is based on the following scale: A (between 91 and 100), B (between 81 and 90), C (between 71 and 80) and D (70 and under).

During 2006–2010 there were in total 772 students in the course of bioethics (between 56 and 81 in a semester), 17 were excluded from the study because they were reluctant to participate and eight quit the program. The students who were reluctant to participate did not express their opposition directly in the classroom, but they expressed privately to the professors their concern to be evaluated and compared a second time, so they were excluded from this investigation. Of the 745 students evaluated, 14% had the maximum evaluation (A), 24.16% had the poorest (C and D) and 61.84% was in the middle (B). There were no differences between the different promotions of students, or between males and females.

11.4.1 General Problems

The biggest problem was the lack of general knowledge of history and social context of the country and its impact as determinants of individual health. Because students were lacking knowledge in literature, they experienced problems with the logical analysis of the principal dimensions of the proposed ethical dilemmas and with

illustrating the correspondence between these dimensions and theories of human rights and ethics. Many of them expressed that secondary school exams were based on selection of the best answer, and it was very difficult for them to do a synthesis with their own words. One of the students ended his workshop with a definition of synthesis pointing out that he could not "change the words of the author." In this group, the analysis was full of repetitions and sentimental declarations about beneficence or justice without a true relation with the case itself (Heath 2001). Their lack of literature, human psychology, and even Spanish language added difficulties to their interpretation of bioethics although they may recognize the problems. Clinical professors have observed the same difficulty in relating medical history and clinical exams to reach a diagnosis; they have reported that students and young doctors are more confident with laboratory results to make a diagnosis. The minority group, who had the basis to analyze problems of bioethics, was also generally good in clinical situations; and some of them had very deep reflections about the proposed case of discussion. In fact, some of them were much implicated in the discussions and group works, and some entered the Bioethics Association of Panama when they completed their studies. In some semesters, I tried (with success) to transfer the coordination of the discussion to some students who have maintained good relations with their peers in order to stimulate participation.

A small group, because of their personal religious convictions, did not allow for interpretations other than those supported by their religious beliefs, particularly for sexuality, reproductive, and quality of life issues. Many Panamanians discriminate against indigenous thoughts, culture and traditional medicine, and medical students, as many health workers are intolerant although their attitude may affect accurate diagnosis for this vulnerable group. During the first years (2006–2008) they expressed their thoughts in the written exams. Since 2008, they have felt more confident to speak in the classroom, as they have found that bioethics means discussions with respect of all opinions. In these discussions, students have learned to criticize intolerant antiscientific positions with ethical arguments.

Another small group had a cynical vision of medicine as just a profession sought for financial success, and they saw humanistic problems and bioethics as a futile illusion. Their main objection was that justice and public policies on health are utopian and costly for people that do not have enough education to understand. The social background of these students was diverse: from medical families which had experienced power relations inside the profession to poor families who had the hope of a better social status through medicine. They did not participate in the discussion in the classroom, and they sought to be respectful in their written argumentations but their language betrayed their thoughts.

The majority of students were passive; they poorly participated in the discussions, and did only what was necessary to pass the exams. Some of them contacted their professor about a problem after they finished their study.

11.4.2 Bioethical Theories and Human Rights

A difficulty encountered by the students was the differentiation between autonomy and the health rights of patients and the beneficence and autonomy of health professionals. In my view, this difficulty originated from the impact of the hidden curriculum (the hidden curriculum is represented by all norms, customs, belief, language and symbols of an institution (Santos Guerra 2013)) and a restricted institutional perspective of the role of medical doctors. The sense of beneficence is essential for choosing any professions that serves the community. But students have difficulties in understanding that it is not an excuse to break the autonomy of the patients on the basis of their gender, ethnic, or social condition. In fact, the participation in the discussions and Internet forums promoted by professors of the University of Panama in some semesters reveal the preeminence of beneficence as a corner value for doctors and a great difference between the official declarations and the reality of conduct of the clinical tutors.[1] The students compared this situation with the social corruption masked by political discourses with the discourse on beneficence and goodness. They lost their confidence in the ethical principles and had a view of bioethics and human rights as a utopia for some individuals. At the same time, they were concerned by the need to change, and they tried to apply bioethical principles to their relationships with their patients and family during their clinical rotations. There is an important difference between basic students and postgraduates: the last one are more reflexives and compromised in bioethics.[2]

The implications of these results are important for the formation of professionals: how can we link theory with reality? In countries with great problems of inequity and justice in the distribution and the use of public health services, the respect of the individual is a corner principle as the poor have no other choice to resolve their problems of health and pathology. If health professionals are not prepared to listen to their complaints and to understand their social, economical, and behavioral difficulties, then there will be no changes in the health issues in these countries. The World Health Organization is reporting an epidemiological transition from infectious diseases to chronic pathologies that require greater attention to patient needs. We have to prepare clinicians to be mindful of these vulnerable populations. This approach is not limited only to healthcare professionals, but also to economists, lawyers, and engineers as they also have a responsibility towards the construction of democracy due to the consequences of their work.

Another point is the preeminence of technology to resolve any problem and the velocity of its implementation without understanding its scientific basis. This situation has been facilitated by medical emergencies that need the application of technical norms for good results. But the criteria of technical effectiveness are now extended to the evaluation of the quality of attention in all situations. The attention is put on hospital care and the results of technology for diagnosis and prevention

[1] See: https://www.facebook.com/pages/Asociacion-de-Estudiantes-de-Medicina-de-Panama-AEMP; http://www.revistamedicocientifica.org/index.php/rmc/index.

[2] See: http://www.redbioetica-edu.com.ar/.

is forbidden or disqualified. From this hidden curriculum, doctors prefer to discuss medical articles about new technologies as quoted for other countries by Judlkin et al. (2011), rather than about clinical care. In this context, bioethics has to replace the patient as a person at the center of the discussion.

In most countries of Latin America, the culture of appearance and consumerism is a real obstacle to ethical values and to bioethics. The appearance of success has become a main objective for doctors, and they make a strong relation between professional success and consumerism. For example, doctors with big cars appear to be better than doctors with a small car. It is also believed that the quicker you become successful the better you are. Medical students want to be doctors and doctors want to conserve their power. As long as the medical training is centered on illness and hospitals' attention, we will observe a hidden medical hierarchy: at the top, the specialized hospitalists, and at the bottom the generalists. So the students and their professors depreciate primary attention and health programs as not scientific. At the same time, countries with poor resources have the necessity to train midwives and health educators for the poorest districts, yet this is considered a devaluation of medical activities. Bioethics professors have to relate the actions of all health professionals for the quality of care, beneficence, and justice.

The few hours dedicated to bioethics in the pre-graduate program have been insufficient to compensate this cultural representation of the success of consumerism. In this context, the augmentation of the program has had a good impact for a better perception of the importance of bioethics and the understanding of the clinical relationship, but it is still insufficient. The incorporation of bioethics in the post-graduate programs has proved to meet the needs of the residents, the general practitioners, and the health professionals. Some groups have proposed an ethics code to their associations or institutions, others have created local ethical committees and some have incorporated bioethics in their protocol of investigation.

11.5 Philosophical Perspective

The World Declaration on University Education in the twenty-first century Vision and Action (by the ministers of education during the World Conference on Upper Education in the UNESCO, Paris, October 9, 1998) postulated that education means not only learning to know, to do, and to be, but also learning to live together and to construct the future society (IslaVilacha 2009). The professors have to show the relationship between bioethics, the problems of the world, and the pertinence of the ethical theories within any social context. Particularly they have to develop empathy and respect in clinical communication and need the participation of all the actors to resolve the individual and societal problems of health.

Another perspective is that bioethics is applied ethics and its purpose is to give a multidisciplinary answer to a social reality in pluralistic moral society (Cortina 2002). In many resource-poor countries, democracy is relatively new after decades of colonialism and dictatorship, and the experience of a public deliberative process

is more or less present as is the necessity to build a consensus about justice and injustice, right and wrong. In this context, the first responsibility of professors is to stimulate respectful discussions on the use of human rights and ethical theories from different points of view to reach a basic consensus for a better quality of life of both the patients' individual bioethical problems in health and public health policies. The publication of case-books by UNESCO has been an important progress (UNESCO Bioethics 2012).

The use of humanities is necessary "…to develop a more profound receptive sensibility: critical, esthetically sensitive and morally responsible" (Kleinman 2011, p. 804). Iona Heath cited by Tajer (2011) considered that we have to emphasize medical education in four directions:

1. *classical scientific professional formation* (knowledge and skills): this topic is very well done in the medical formation;
2. *corporal education learning from our personal experiences of pain and disease to understand the patient's complaints*: we observed that the personal or family experience of students prepared them to be more sensitive;
3. *cultural education for a sensibility to the human manifestations and experiences in different moments*: since students do not read novels, the discussion about selected films and local/international news was very helpful;
4. *emotional education to develop a capacity of empathy and comprehension of history of life and values of the patient in an holistic view; and the stimulation of voluntariness from the first years of the career is very important*. It has been done in basic school but, as a result of this registration of students with a poor level in humanities, the universities and the professors have to develop these topics.

To analyze and to understand health public policies we use the Universal Convention on Human Rights, the Universal Declaration on Bioethics and Human Rights of UNESCO, and the theories of utilitarianism, vulnerability, protection and intervention in Latin-American bioethics. This approach allows for the introduction of an ethics of liberty (Kant) with responsibility (Cortina, Habermas) equity and personal rights (feminist theories) for investigation in biology, health and social sciences, and juridical sciences and clinical relationship. Analyzing ethnic, gender inequities and socio-economical problems, the students have a better understanding of the problems of vulnerability of these groups for access to health services, and of the discrimination in healthcare, employment, laws and their participation in the society. The comprehension of the social and cultural construction of gender for policies on sexual health and reproduction is especially important.

11.6 Educational Implications

Narrative is very important for bioethics analysis (Maliandi 2002). Starting from the socio-ecological reality of their country in a global world, the students have to analyze the ethical problems of their professional education to propose alternative

ethical solutions. The discussion may be about an idea, a clinical case or a notice in the media, or a commercial film, as Farré and Perez Sanchez (2011) have suggested. The students have to investigate an individual case, and they need to analyze the interests of all the actors to find a consensus for concrete and feasible solutions. But, as we observed with our students in medicine, they often have no experience in narrative, and until they gain a sensibility to some aspects of the situation, the majority are not able to translate these perceptions into words and, they are even less likely to be able to translate these perceptions into ideas and proposals. Professors of bioethics have to find the methodology to answer this problem during the time of the course. As it is not materially possible, they have to convince their colleagues of the need of speaking of bioethical problems in all clinical courses, and in some basic courses too. For instance a professor of hematology can provoke a discussion about HIV-AIDS and transfusions and about genetic screening and thalassemia from the basic principles of bioethics.

Another important moment of bioethics is the observation of attitudes of the students in front of the clinic-ethical problems, particularly the changes between the first class and the end of the course (Aldea-Lopez 2000). Though it is difficult to address this in the undergraduate program for the majority of students, it is very useful in postgraduate training. This author considers that different indicators of these attitudes to be:

- *Register of incidences like changes in the language and participation in discussions, use of cell phone, or permanently moving from the classroom*. Many professors are now prohibiting the use of electronic devices during the class. Along with this register we can use scales, control lists, indicators of conduct, and attitudes.
- *Diary of classes* with a synthesis, and a report from written national publications or international verified news on internet of an incident associated to the theme of the class. There is a wide variety of relationships established by the students, some of them very significant.
- *Discussions in the classroom* as a permanent activity centered on the theme of the day. As it is difficult to implement in basic classes because of the short allocated time, students may ask or present their doubts during the exposition of the professor.
- *Participation in extra-curricular activities likes theater where students are the actors*. As long as this activity is voluntary, the professor has to motivate the students with an extra positive evaluation if they participate. It may represent coercion, but as pointed out by a student "the majority will come for the evaluation but then they will enjoy the activity and participate, and it is the most important." We do not have many experiences with this form of teaching as theater is not a frequent activity in Panama, but the sessions of movie-discussions were very productive.

The proposed methodology is not new but it takes into account the success and the difficulties of teaching bioethics. Particularly, it takes into account the pragmatic outlook of modern students who want to see the results of applied bioethics; the short times dedicated to bioethics by the curriculum of the universities; and most

important, the need for a holistic understanding of human life in context. We applied it in the faculties of health sciences, biology, economy and juridical studies, and the results were better than when we used the classical methodology of teaching.

The inclusion of bioethics in the curriculum of residents, for health professionals, and the integration of bioethics in the hospitals has constituted an answer to the formality of bioethics in the curriculum (Pattison 2003). The formation of associations of bioethics has been a non-academic answer that seems to be more attractive for students and professors as it is less formal.

This methodology does not need many resources but access to the international literature on bioethics and to national publications on the social, cultural and economic situation, and the historical evolution of the country. It is absolutely necessary to promote the free access to literature on bioethics to all resource-poor countries. In extremely poor-resource countries, all cooperation is needed in the respect of the culture and the priority problems of these countries. In all resource-poor countries, it is necessary to lobby with the government and universities to reinforce this methodology. The training of professors who are teaching bioethics is necessary. For both professors and students, it will be helpful to offer seminars on bioethics with international speakers as to promote their interest on bioethics. There are no differences between clinical and public health bioethical problems between different countries, just different priorities due to the causing factors.

11.7 Conclusion

It is imperative to give students and professionals the knowledge necessary to understand the ethical implications of the different problems in our society. For this reason we need to sensitize students by using the methodology of participation, investigation, and discussion on the basis of ethical theories, and human rights both in local and in the international contexts

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Chapter 12
Bioethics Education in Resource-Challenged Countries

Leonardo de Castro and Sarah Jane Toledano

12.1 Introduction

Bioethics Education in Resource Poor Countries was going to initially be the title of this chapter. The proposed title immediately called attention to what it meant to be resource-poor and what the phrase signified. What are those resources? What does it mean to be poor with respect to those resources? *Resource-poor* suggests a condition that renders a country inferior in a significant way when compared to others. This suggestion often is unfounded. It also tends to convey a notion of helplessness that invites charity and benevolence but also ill treatment, exploitation, and/or opportunism.

The suggestion often is unfounded because even the poorest countries in terms of one kind of resources have others at their disposal that they could count on, given the opportunity. This is particularly true when dealing with an activity such as education rather than a broader and more complex pursuit such as sustained economic development. The latter involves a lot of factors that are out of the control of a country seeking to extract itself from a period of economic stagnation. The former is more amenable to creative initiatives that are within the reach of countries facing economic difficulties.

Resource-poor also tends to convey a misleading notion of helplessness and vulnerability. Being poor in resources suggests that a country needs aid coming from elsewhere. This should not be a bad thing in itself. However, aid seldom comes without accompanying preconditions and demands. One has to be wary of the specific demands that may come with the aid. As with aid, there are demands that may

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not be bad in themselves. However, it is important to understand exactly what those may be so that the balancing of such demands and preconditions could be done in relation to the beneficial impact of the actual aid received.

More importantly, resource-poor is a label that fails to take into account the fact that what it refers to is very likely to be a temporary condition. In some cases it may have arisen in a historical context of foreign occupation and exploitation. Consequently, the poverty may lie in the absence of an adequately adapted educational system. This could refer to an almost complete dependence on educational materials crafted in a foreign language, or in the domination by teachers who have been honed to appreciate problems from a foreign perspective because of the circumstances of their training. The important thing is to avoid attaching a label that could unjustifiably stick permanently in people's perceptions of the country.

Resource is also too general a term in that it fails to provide a clue as to the particular type of resource that may be lacking. Thus, to proceed and identify specific countries as being resource-poor could be misleading and could give rise to prejudice and injustice even though the reference is merely to a limited factor in the area of bioethics education.

The preferred term here is *resource-challenged*. This term allows more flexibility in interpretation and does not necessarily connote poverty. While the challenge could come from the inadequacy of identifiable resources, it could also lie in the inability to harness resources that are available. This allows a discussion of specific challenges without being excessively concerned about whether the countries facing such challenges are truly poverty-stricken or not. The specific vulnerabilities may be seen as the crucial factor in defining the particular circumstances of the country. Countries that are low in economic resources may be more likely to find themselves in such vulnerable circumstances. However, they may be creative enough to handle their conditions of vulnerability.

The discussion of concerns facing resource-challenged bioethics education in this chapter is mainly illustrated by citing experiences relating to the Philippines, not only because of the familiarity of the authors with the situation in the country, but also because they hesitate to attach the label to countries not their own. Nevertheless, a reference is made when there is an appropriate illustration of particular circumstances that have been recognized by experts from selected other countries. For example, there is mention of countries that have seen a lack of teaching materials in their own language or of those that have seen a need for more published materials or of resources of some other kind.

12.2 An Invitation to Exploitation

It has been pointed out that the inadequacy of resources could be construed as an invitation to provide assistance. In addition, external forces may see an invitation to exploit—to take advantage of opportunities arising in a context of vulnerability. The emphasis on challenges rather than on poverty in terms of resources does not

necessarily take away the vulnerabilities that become manifest in these types of circumstances. The weaknesses need to be recognized and understood, so they would not be exploited unfairly and destructively. A generic vulnerability lies in an imbalance of resources. Even when a particular country is not truly resource-poor, an imbalance in available resources relative to another country that has so much more opens up the possibility of exploitation. For instance, there could be a temptation for a country challenged to provide educational resources to use materials that are much more widely available coming from some other country, even though such resources are not truly appropriate. In this regard, one can cite the example of the four-principle approach to bioethics. Having arrived at the contemporary bioethics scene in a timely fashion, the approach became well publicized and tended to be prominently featured in bioethics literature. Students and teachers who were eager to learn bioethics and had sought to understand the approaches of this emerging discipline were enticed to adopt the principle-based approach primarily because of the availability of materials and the lack of alternatives.

As part of early efforts to establish a bioethics department in the Philippines, some teachers went to Georgetown University for training. When the trainees came back to the country, they were quick to spread a doctrine learned from their foreign tutors—the four biomedical principles. It did not seem to matter whether those principles matched local ethical culture or not. More recently, a proposal by the Commission on Higher Education (CHED) to include bioethics in the nursing curriculum identified the major bioethical principles as "respect for persons and justice, non-maleficence and beneficence" (CHED 2009, p. 100)—the very same ones mentioned in the principlism of Beauchamp and Childress (2009) without including other principles that could be deemed more relevant to the local context, or without adapting those principles to local perspectives.

This is not to be taken as a rejection of the merits of the four-principle approach but as an illustration of the way that foreign education and the adoption of imported educational materials could impact local values and concepts. When education is pursued without being mindful of this possible impact, the process could be indoctrinating rather than enlightening, and confining rather than liberating. In some of the following sections, we see more of how these dynamics play out and how some countries are taking steps to make bioethics education truly enlightening and liberating in resource-challenged circumstances.

Having faced challenges in the area of financial resources, the Philippines provides an example of a country where bioethics education is recognized as a crucial part of medical and nursing education. The Commission on Higher Education (CHED) has required bioethics to be integrated into the Health Science Education curriculum (CHED 2007, p. 3) and as a subject of study for students of nursing (CHED 2009, p. 14). However, the implementation of corresponding policies and programs is often put to the test. Various institutions have undertaken initiatives, though not in accordance with an integrated and deliberate design. This seems to be the way things happen in resource-challenged countries—the initiatives take off if and when foreign funding becomes available. Funds go to particular projects that are capable of advancing interests of the funder. Otherwise, bioethics education

would not ordinarily be a priority since the scarce resources have to be allocated for the country's more basic needs.

In many resource-challenged countries throughout the world, foreign funds have supported various initiatives in bioethics education, including short training courses and degree-granting programs. The collaboration between well-resourced nations and resource-challenged ones provides the setting for the introduction and influence of foreign concepts in discourse pertaining to local healthcare experiences and values (Farmer and Campos 2004). In the effort to transmit bioethics expertise, conceptual influences are inevitably conveyed through packages consisting of teachers, educational materials, and even the language of instruction.

12.3 The Teaching of Bioethics in Philippine Higher Education

The University of Santo Tomas (UST) and the University of the Philippines are the two institutions that have engaged in formal bioethics education in the country. A part of the Faculty of Medicine and Surgery, the Department of Bioethics at UST has sought to develop in future physicians a capacity for mature moral reasoning and acting in accordance with principled moral judgment consistent with the attitudes of "a competent and compassionate Catholic physician" (UST 2011). Medical students go through a longitudinal bioethics program that complements their medical curriculum. As noted above, the bioethics teachers had an opportunity for foreign training either by attending courses at institutions abroad or by their engagement with foreign experts who have been invited to come as visiting professors.

A Master of Science Program in Bioethics was established at the University of the Philippines in 2006. The program became possible after the United States National Institutes of Health's Fogarty International Center provided funding for the training of philosophers, physicians, and social scientists who now serve on its faculty. The same funding also supported the development of the curriculum and the syllabi for all the courses on offer. In addition, the grant supported training programs in Research Ethics throughout the country over 5 years (Manaloto 2010). While aimed at educating local bioethics teachers, members of ethics review committees, researchers, research administrators, and health care professionals, training also benefitted professionals from other Southeast Asian countries. Given their professional backgrounds, the program's former students now hold responsible positions in the academe or in healthcare institutions.

Bioethics education in the country has also received assistance from the United Nations Educational, Scientific and Cultural Organization (UNESCO). In 2008, a Training Workshop on the Universal Declaration of Bioethics and Human Rights was organized by the University of the Philippines. UNESCO provided technical expertise and educational materials. The Organization also provided assistance for public symposia on the Universal Declaration a few years earlier in collaboration with the UNESCO National Commission. The types of assistance provided by the Fogarty International Center and by UNESCO for bioethics education in the country

represent different objectives that help illustrate some of the concerns that need to be addressed in foreign-assisted bioethics education. Some of these concerns are taken up below.

The assistance provided by UNESCO to the bioethics education activities in the Philippines and other countries may be seen in the context of broad efforts to promote a global ethics of science and technology. Among other things, the Division of Ethics of Science and Technology initiated the Assisting Bioethics Committees (ABC) Project to provide technical assistance in the establishment of bioethics infrastructure and long-term capacity-building among its resource-challenged member states. UNESCO has also had a broader Ethics Education Program. Activities under the program aim to reinforce and increase the capacity of member states in the area of ethics education. Thus far, the activities have been prioritized for Eastern Europe, Central Europe, South-Eastern Europe, part of the Arab region (Gulf region), and Africa. The educational content of the program has revolved around bioethics instruments that have the approval of the UNESCO member countries through the organization's General Conference—the *Universal Declaration on the Human Genome and Human Rights,* the *International Declaration on Human Genetic Data,* and the *Universal Declaration on Bioethics and Human Rights*.

12.4 Respect for Cultural Differences in Bioethics Education

In undertaking its objectives, UNESCO has been aware of the criticism that "the prevalent values in States in the developed world are often in sharp contrast with the values prevalent in the developing world…. [and] that with the trans-cultural expansion of bioethics, there is the danger that a new, intellectual imperialism will emerge, driven by the expertise and greater resources of the developed world…" (UNESCO 2005a, pp. 11–12). Also, a review of the ethical challenges in study design and informed consent for health research in resource-poor settings emphasizes the importance of strengthening collaborative partnerships and education among resource-rich and resource-poor countries within which investigators develop a stronger sense of respect and sensitivity to culture (Marshal 2007). There, Marshal speaks of the "need to be cognizant of the cultural differences in reviewing protocols for collaborative research" and to "develop culturally appropriate methods for obtaining informed consent" and "have adequate knowledge about community dynamics and existing power structures before conducting a study" in order to avoid conflicts (Marshal 2007, pp. 2–3).

In various bioethics training workshops in the country, concerns often have been raised about the congruence of Western standards with the local cultural and socioeconomic context. For example, there are varying views on health, illness, sickness, and death that may not be taken properly into account because of the way in which issues about medical care, treatment, and end-of-life concerns are presented for decision-making and possible resolution. A broad range of superstitions, folklore, and spiritual values can meaningfully affect a Filipino's medical decision making in

ways that might be incomprehensible from a purely objective and scientific viewpoint. One can cite the example of rituals that go with the use of herbal treatments. When processed tablets replace a herbal formulation, it may be useful still to continue with the attendant rituals. The rituals could serve the purpose of preserving the mindset that provides confidence in the efficacy of the treatment even if the latter already comes in a different form. An objective and scientific viewpoint can be enriched by the folklore surrounding illnesses.

The point is to be mindful of the broad range of superstitions, folklore, and spiritual values that provide the context for the understanding of diseases and illnesses. There is need for a serious effort to bring these factors into play in bioethics discourse and decision-making. If the process of bioethics education is unmindful of these factors, it could be doing a disservice rather than positively contributing to those who are being educated. This point relates to the view that bioethics education in resource-challenged countries has to be multi-directional rather than one-sided. The teacher and the student are mutual participants in the learning process. As the teacher tries to impart knowledge understood within her professional and cultural perspectives, she needs to be always mindful that that knowledge is subject to appreciation and interpretation from the students' perspectives as may be manifested during the teaching encounter. In this process, the teacher has to learn from her students and, more importantly, be ready to reinterpret and even revise what she is teaching.

The same needs to be said about education regarding the conduct of scientific research. Research should take into account the challenges facing resource-challenged (economically as well as educationally) participants and education needs to be correspondingly oriented. Well-educated professionals who have the tendency to speak beyond the level of understanding of research subjects can be intimidating. One way to address this is through an interdisciplinary approach in bioethics education that promotes greater awareness of the dynamic factors shaping the values and standards of the resource-challenged, whether in the Philippines or in other countries. At the University of the Philippines, curriculum development was informed by the need to balance the Western liberal thought pervasive in mainstream academic ethical theories against local narratives and the anthropology of Filipino medical practices. This was the idea behind course offerings such as *Social, Political, and Policy Contexts of Bioethics in Asia and the Pacific, Bioethics and International Health*, and *Sociocultural Perspectives of Health and Medicine*. These courses sought to take up the varying bioethics topics and issues in relation to varying social, cultural, political, and geographical conditions and outlooks. To be sure, this approach has not been peculiar to the Philippines—a similar culturally-grounded approach to principlism has been noted also in other Asian countries (Azetzop 2011, p. 5).

12.5 Research Ethics in the Global Bioethics Agenda

Research ethics has been very prominent in the Philippines' bioethics agenda. This focus has been in keeping with the country's interest in developing biomedical research. In the last decade, the country has also seen the establishment of the

Philippine National Health Research System that integrates health research functions across several government departments. The integration facilitates the ethics review of health related research by enabling a system of governance that covers the Department of Health, the Department of Science and Technology, and even the Commission on Higher Education. Research supported or undertaken by individuals or institutions under these governmental departments goes through an ethics review process that is overseen by a single body and covered by a single set of guidelines.

Given this environment, it is easy to understand why the University of the Philippines sought the Fogarty International Center grant for education in research ethics. The grant filled a need for assistance in an area that was a clear national priority. The country was also interested in seeking U.S. funding for various areas of biomedical research. Thus there was a congruence of interests of researchers and foreign funders. The Philippine Health Research Ethics Board (PHREB) has overseen the establishment of an ethics review system that stretches throughout the 14 regions of the country. It has also implemented a mechanism for registration and accreditation of ethics review committees. The National Guidelines for Biomedical and Behavioral Research have undergone continuing revision. Overall, PHREB has managed to perform its functions and pursue its educational objectives in collaboration with the University of the Philippines; the National Institutes of Health; the Ethical, Legal, and Social Issues (ELSI) Program of the Philippine Genome Center, and the Philippine Council for Health Research and Development (Manaloto 2010). By having its own ELSI Program, a resource-challenged country is able to access a mechanism by which to protect its own interests in the utilization of its genomic resources by dealing with issues of informed consent, privacy, confidentiality, and intellectual property. It helps oversee the regulation of genetic tests and products directly marketed to the public, agricultural applications of genomics, the nonmedical use of genomic information (e.g. forensic, litigation, paternity, migration patterns), the practice of genetic counseling, and the conduct of public education.

One can surmise that experiences and considerations similar to those of the Philippines weighed significantly in the decision of other countries to seek the United States National Institutes of Health's Fogarty International Center (FIC) grants for their own bioethics education objectives. FIC Awards appear to address the ethics related objectives arising from the growth of biomedical research being conducted in resource-challenged countries.

The FIC International Bioethics Education and Career Development Award is a capacity-building training program to enhance teaching and research in bioethics (with special attention to the conduct of clinical research) for trainees from developing countries by supporting curricular development in U.S. and other developed and developing country institutions. Announced in 2000, the program was an outcome of the 1999 Global Forum for Bioethics in Research. The forum itself was to evolve into a series of educational meetings held at international sites and sponsored by a rotating group of international organizations including the FIC and its NIH partners. The forum brought scientists and ethicists from the developing and developed worlds together to discuss the complex issues of conducting clinical research in developing countries.

The Fogarty International Center has also supported the International Research Ethics Education and Curriculum Development Award to enable resource-challenged countries to develop Masters level curricula and practical ethics education courses for academics and health professionals in developing countries who are involved in research ethics. Existing linkages of collaborating countries in the region are strengthened through the sharing of resources and human capital. Bioethicists from developed countries make up the senior faculty of a program. Local fellows are selected based on their likelihood to have a strong impact on their home country. The use of ICT has been incorporated in some of the recent FIC-programs. FIC also encourages courses dealing with issues pertaining to community engagement in research as well as to the varying cultural and legal standards concerning research on children and adolescents.

In the South Asia Region, Indonesia, India, and Pakistan have worked in collaboration with US-based institutions that provided the capacity-building projects and degree-granting programs to their countries. Culturally sensitive ethical conduct in research that is also in keeping with principle-oriented Western bioethics appears to be strongly emphasized. Fellowships have been given to Indonesian fellows for foreign study and training in biomedical research that include electives that will speak to the specific cultural, social, and economic challenges that will eventually enhance the ethical conduct of research in their home country. Similarly in India where there is an established central body in biomedical research—Indian Council of Medical Research (ICMR)—their FIC-funded curriculum development program involves tapping into their ICT strength and building research capacity in the areas of biotechnology and traditional medicine. The ICMR promotes bioethics education that is "culturally sensitive and is able to provide special emphasis on research ethics related to genetics, drug development including traditional medicine and social sciences as also international research ethics" (Mehendale 2012). The Bioethics Training Program in Pakistan offers a Certificate course or a Masters degree that is akin to several other educational training programs with mixed foreign and local faculty, and a balance of Western and local ideals. Islamic philosophy is specifically mentioned as part of their bioethics education, and they tap the expertise of those in the field of Islamic jurisprudence.

There is also a notable move among the programs to expand the approaches in bioethics. In the East Asia and Pacific region as well as in Latin America, bioethics education and training are characterized by a more multi-disciplinary approach. The collaborative program of Yale University with China distinctly offers short and intensive courses in multi-disciplinary research methodologies. In Chile, the FIC-project on Research in Latin-American Countries is conducted by the Interdisciplinary Center for Bioethics of the University of Chile among other institutions. Apart from traditional topics in bioethics, the program considers "ethnic diversity, role expectations in research and healthcare, and inclusion in a network of professionals conversant with bioethics reasoning and application" (Lolas 2012).

In South Africa, the program supports advanced research ethics training that addresses capacity in research methodology and grant application techniques. They also seek to address local health imperatives in their region—specifically, health

research ethics on HIV and TB and emerging chronic diseases. There is an effort to share information through the South African Research Ethics Committee (SAREC) online and trainee-driven newsletter. Career development of its indigenous scholars is a primary aim of the Middle East Research Ethics Training Initiative (MERETI). There are certificate and degree-granting programs using distance-learning and eNetworking approaches to expand coverage.

External observers have raised a concern that foreign funding of this kind would endanger locally held values by imposing Western ideals of doing ethics into the country. There have also been insinuations that lying behind these grants is an agenda that would further the interests of foreign researchers who tend to conduct their clinical experiments in comparably resource-poor countries. In response, grant holders claim to be aware of these concerns as they aim to pursue an ethically sustainable research agenda that is competitive within a global environment but still attuned to the pressing needs of the region. Obviously, responses of this sort need to be validated in the context of conflicts of interest that may arise from the fact that the research ethics training funds are being made available because of a need to conduct foreign-funded health research and to establish ethics committees that have the capability to examine the ethical aspects of such research.

12.6 Resource-Challenged Countries: Doing Bioethics From Below

The bioethical issues in the Philippines cannot be separated from the country's experience as a low middle-income economy characterized by a wide disparity between rich and poor. While affluent industrialized nations have addressed ethical concerns that result from advances in the most recent medical biotechnologies, Philippine bioethical discourse continues to be confronted with poverty-related issues such as the lack of or limited access to basic health care services by vulnerable populations. Philippine bioethical concepts emerge from within the tensions that arise in public health policy debates (De Castro and Toledano 2009; De Castro 2005). The ethical challenges in health that relate to the socio-economic background of the country figure prominently in bioethics research in the Philippines. There is a flourishing of academic research in topics of Philippine bioethics. There are theoretical works that characterize Filipino socio-cultural bioethical principles and concepts that stand in contrast to Western liberal thought (De Castro and Alvarez 2004; Tan and Lumitao 2001; Sy 2000; De Castro 2000; De Castro 1995) and those that tackle the specific ethical issues that emerge in controversial bioethical matters that confront the country (Padilla et al. 2012; Balein 2009; Awaya et al. 2009; De Castro and Toledano 2009; Padilla 2009; Sy 2003). Intersectional themes that cut across these works discuss the complex dynamics of family, spirituality, and poverty as they affect decisions in healthcare and bodily donation. The diverse narratives of disadvantaged and vulnerable Filipinos complicate Western ideals of autonomy and informed consent and serve as precautionary examples to those who hastily pass

ethical judgments that are thought to apply to all without qualification (De Castro 2012). In doing *bioethics from below*, the disadvantaged and vulnerable are not necessarily held accountable to the same rigid regulatory measures without the benefit of a sympathetic interpretation that is sensitive to their peculiar circumstances. For example, strictly implementing regulations meant to address organ trafficking in an inflexible way could have the effect of punishing the poverty-stricken sources of organs for transplant even when they themselves are victims rather than perpetrators of transactions organized by criminal commercial syndicates. By doing this, society unwittingly and unjustly imposes burdens upon the victimized poor that the latter do not deserve. *Bioethics from below* may be contrasted with bioethics imposed from above, which tends to uphold the interests of the strong and powerful. Bioethics from below upholds the primacy of social justice in the analysis of situations and issues.

All of these tend to support Farmer and Campos's idea of resocializing ethics by contextualizing ethical dilemmas arising in resource-poor settings through the lens provided by the social sciences. This also entails the active and critical participation of the disadvantaged and vulnerable in understanding, interpreting, and addressing the dilemmas they face. The *view from below* espoused by Farmer and Campos (2004) asserts that there are ethical and moral issues that are more prevalent and tangible within resource-poor settings than those arising from affluent modern biotechnological developments. *Resource-poor settings* are described by these authors to be those communities in dire poverty that continue to contend with problems of access to basic medical care, fair resource-allocation, and social injustice. Thus, there is a need to have an approach that considers the poor within the context of their vulnerability. For example:

> A 'view from below' would ask how poverty, racism, and gender inequality come to constrain agency, the ability to make choices. If one believes in the ability of research to lessen misery and suffering – as we do – what 'special measures' might one envision as we seek to conduct research in settings of great poverty? How might we ensure that the measures are not in and of themselves coercive, as many incentives are deemed to be? (Farmer and Campos 2004, p. 26).

The view being proposed should prevent the use of resource-poor settings as a euphemism that presumes these communities to be incapable of independent ethical analysis and reflection, in effect, justifying a dominant role for international institutions in defining for these communities the terms of reference and the curricula for capacity building.

Taking the example of the Philippines, one can say that people are able to easily dialogue with outsiders because of their fluency in English. The colonial history of the country has permeated it with foreign influences, and clinical medical records are largely in English. Institutional review boards in the country then remain sensitive in culturally-grounded practices that come from the outside. But what kind of resources are truly at stake in resource-poor settings? Covance, an international company that promotes the outsourcing of drug development in the Asia Pacific, describes its marketing in the Philippines as follows:

> With its large pool of patients, including patients that have not been exposed to many drugs, the Philippines offers an attractive clinical environment. The Philippines has a fairly straight-forward regulatory process and the investigators are particularly experienced and successful in the conduct of vaccine and tropical disease studies. With English as the official language, global clinical studies conducted in the Philippines are further facilitated by medical records kept in English. While the cost of conducting clinical trials within the Philippines is typically lower than Western countries, many of the physicians in the Philippines are US-trained and have experience with Western based clinical trials, bringing their expertise to the Philippines clinical environment. (Anonymous 2013).

One can see why it is misleading to use the resource-poor label in referring to a developing country like the Philippines as the site for international biomedical research. The mere fact that sponsor countries choose not to conduct their trials and research within their own resource-rich countries speak of their dependence on the wealth of resources available in the places that they identify to be resource-poor.

12.7 The Role of Bioethics Associations

In resource-challenged environments, the role of professional non-government organizations in bioethics education and development has to be underlined. These organizations fill significant gaps and thereby complement meager government allocations for bioethics education in resource-challenged environments. In Moldova, the initiatives of the National Bioethics Association have spurred academic activity and have been credited for the establishment of the National Bioethics Centre. With a multi-disciplinary membership and other public representatives, the National Bioethics Association has also been recognized as a catalyst for the creation of bioethics commissions operating in practically all patient care, preventive, scientific, and biomedical institutions. These commissions elaborate procedures for operation based on model regulation, set up trainings for members of the committees at workshops, and promote bioethical knowledge (Kubar 2007, p. 211).

A parallel phenomenon has taken place in Georgia where the Georgian Health Law and Bioethics Society (GHLBS) has been actively involved in educational programs in the field of bioethics. It has organized training courses aiming to improve bioethics awareness among patients, the medical society, and the general public. Through this initiative of the GHLBS, healthcare professionals can take short courses that are credited into their continuing medical education. Participants learn about basic principles of medical ethics; the rights of patients, ethical and legal aspects of patients' rights and informed consent, confidentiality, privacy, and the role of ethics committees (Kubar 2007, p. 155).

Elsewhere, specialists from the Society for Bioethics Development in the Ukraine have held seminars about norms and principles of bioethics where they have also discussed specific bioethical problems, thus calling the attention of the medical community to different bioethical issues. The effect has been to raise the level of legal competence in the medical community and in the public at large. Other public

organizations have played an essential educational role—the Ukraine Association on Bioethics, the Kiev Ecological and Cultural Centre, and the Kharkov Regional Society for Animal Protection (Kubar 2007, p. 311).

12.8 Other Practical Challenges for Resource-Challenged Bioethics Teaching

Access to educational resources has been a constant challenge. Books can be very expensive in relation to teachers' salaries and school budgets. When funds become available through foreign grants, it is important that local authorities exercise independence in choosing materials that are appropriate in the context of local culture, needs, and priorities. Given that the emphasis on bioethics education has only been seen in recent years, libraries remain understocked. Especially problematic is access to academic journals because of the high subscription costs. This is an important sense in which bioethics education has to grapple with the reality of being resource-challenged.

Related to the issue of access is the need to develop materials that can effectively be used. There is often a challenge of adapting international grants to the particular needs and traditions of the country and of translating them into the local language. Some of the resource-challenged countries have embarked on a program of local language bioethics resource development. For example, Azerbaijan has managed to create the first local language manual on medical ethics. Elsewhere, Armenia used support from UNESCO to produce materials in bioethics in the Armenian language after realizing that its educational materials were in foreign languages as these were received from the Russian Federation, Belarus, or Israel. The resulting texts contained views and ideas of medieval Armenian thinkers, philosophers, and physicians relating to the problems of life and death, good, and evil (Kubar 2007, p. 96). The project also managed to prepare for publication an Armenian language glossary on bioethics. Due to the efforts undertaken by the Ukraine Association for Bioethics, a number of foreign materials were translated into the Ukrainian language. Books and manuals for teaching bioethics were written for use in Ukrainian universities and institutes.

The introduction of courses in bioethics in the Ukraine, as in other post-soviet countries, is complicated by the fact that for a long time scientists and teachers had no opportunity to study foreign materials on the subject. The lack of home studies in the field of bioethics and the inadequate awareness of theoretical, methodological, historical, and cultural contexts of the development of bioethical discourse affects negatively the level and quality of teaching bioethics (Kubar 2007, p. 311). Thus we see how resource-challenged bioethics education could be confronted with a seeming paradox consisting in the need to appreciate foreign knowledge and literature, but at the same time also in the ability to transcend this need and develop relevant and responsive self-generated materials.

Public education is also a challenge and the expansion of bioethics awareness outside the classroom has had to be addressed creatively. Some countries have resorted to the use of innovative teaching methods. For example, Armenia has made use of available TV programs, documentaries, films, and theatre shows touching upon bioethics issues in order to stimulate critical reflection by students. Theatre performances followed by discussions with actors and directors, and students' being required to write essays have also been utilized (Kubar 2007, p. 98). Realizing the importance of public education in raising awareness of the effects of biotechnologies on humans and the environment, Moldova's National Bioethics Centre and the Department of Philosophy and Bioethics have used radio and television programs. The publication of interviews and articles in periodicals has also been undertaken (Kubar 2007, p. 210).

12.9 Conclusion

Doing bioethics education in resource-challenged countries involves an almost perpetual need to balance culturally appropriate and culturally responsive methods of teaching bioethics in the context of preconditions and demands that come along with the provision of external aid. International funding agencies have recognized this concern. Collaborative networks within regions have provided a source of strength that appears to enable countries to promote their own bioethics developmental objectives. They have thus found ways to cater to the needs and interests of foreign-funder stakeholders without necessarily compromising the integrity of resource-challenged countries. A more ethically sustainable research capacity has been part of the agenda together with a more meaningful educational competence. In international capacity-building projects, support has centrally been given for the training and education of human resources. Still, there is a need to give more attention to the further training of more competent human resources for teaching, the development of more relevant educational materials, and the creation of an educational resource base that is responsive to the requirements of the local culture as well as to local circumstances.

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Part IV
Can Bioethics Education be Improved?

Chapter 13
Ways to Improve the Bioethics Education

Berna Arda

13.1 Introduction

A person who has attained the age of majority is an adult, with all of the attendant legal rights and responsibilities. The age of majority is a legal definition that varies among jurisdictions, but commonly refers to anyone 18 years of age or older. University and college programs, whether undergraduate, postgraduate, or continuing education, must comport with adult educational principles. Likewise, vocational educational goals focus on adult skills. Students in these programs must be considered independent, with their own unique personality, experience and knowledge, and cognizant of their own requirements and interests. Accordingly, it is imperative that any schooling follows the principle of adult education (JHPIEGO 2009).

Adults should recognize the goals of an educational process, and that process must conform to the individual's abilities, environmental conditions, and culture. It is commonplace for an adult to join an educational program that he or she considers useful or interesting, and learning should be based on individualized needs, interests, and ability. The heterogeneity of adults with widely varying characteristics must be addressed in the preparation of educational programs. Teaching should develop in concert with and complementary to each individual's social roles and abilities. Thus, a proper learning environment warrants an appropriate site, adequate educational time, and the necessary teaching methods and techniques. Additionally, most adults want to apply their education, so it is crucial to include practice in the educational process, along with enough repetition to ensure permanent retention.

The learning process of any subject should be structured, progressing from simple to complex, and incorporating the connections allowing permanency as well as knowledge transfer to differing areas.

The prior experience of each individual should be appropriately integrated with new knowledge to form a more comprehensive learning process. Edification must

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be positive, constructive and beneficial, while respecting the student's values and honor. Formal systematic evaluation in combination with effective self-assessment will increase learning. Thus, adult learning programs should by functional, dynamic, and shaped to meet the varying needs of each individual and society as a whole. This chapter will underscore the importance of applying these principles to improve education in bioethics. Organ transplantation, with relevant samples, has been chosen to clarify the theoretical base for the development of a bioethical program.

13.2 Designs for Program Developing

Curriculum originated from the Latin word *Currere* meaning race course or run way, perhaps referring to a course traversed on foot or by chariot. Subsequently the word evolved to describe the overall acts and experiences through which children mature into adults. Curriculum was adopted into the English language two centuries ago as a figurative reference to a course of study, and now has several definitions. It may broadly refer to all of the courses offered at an educational institution. Or, it may refer to a defined course of studies which students must pass in order to fulfill a particular level of education. More specifically, curriculum may mean the courses required in order to receive a certificate or diploma.

The definitions of education, learning, and lecture programs are relevant to the remainder of this discussion. An education program represents the schedule of a university, college, or other educational institution. A learning program covers the schedule of a teaching and learning process. The schedule of one or more lectures represents a lecture program.

Dynamism is the basic principle of an educational program. Developing a successful program mandates a scientific, practicable, functional, goal-oriented, flexible approach that remains respectful of societal values. It must be economic, and avoid administrative burdens. Education programs should be divided for every class hour for the whole curriculum, term, or full-term lectures: a unit, a day, a subject (Demirel Yılmaz 2001). More importantly, the program must be shaped with a focus on the aims and goals that were set forth at the outset.

There are three different designs for developing a suitable bioethics education program (JHPIEGO 2009). *Subject based programs* are commonplace, with a virtually universal acceptance throughout most educational institutions. Lectures are arranged within a distinct course structure and students advised accordingly. The individual educational needs of each student are satisfied through scheduled lessons and assigned homework. This represents a lecturer focused approach. *Student based programs* are specified by each student's individual needs, interests and goals, and planned with student-teacher collaboration. Special subjects may be designed or adapted to meet individual needs and arranged according to functions. The student in this type of program will learn based on his or her own endeavors, with self-directed learning activities. In student based programs, the student learns through his or her own endeavor, and specifies learning activities according to his or her own interests and needs. The third design type are *question based programs*. The

vague student based design model precipitated a need for question based programs, which focus on learning through life activities. This type of educational program is designed to resolve societal and individual issues stemming from social living problems. The heart of the learning process is a problem solving or problem based learning (PBL) methodology. It incorporates each student's needs, skills, and knowledge with a flexible educational style. The specific functions are planned through student-teacher collaboration, thereby removing any boundary between lectures and subjects.

13.3 Process of Program Development

The process of developing an educational program is a collaborative team effort, which starts with planning, and is followed by complex preparation stages. Once complete, the program must undergo a trial and evaluation period and, if acceptable, will eventually gain continuity. This chapter focuses on the preparation phase—arguably the most difficult and time consuming step in developing an educational program. Defining mission and vision, determination of educational requirements and determination of aim, determination of learning objectives and target behavior are the first main components of program development. After that planning, the content and planning of the teaching process are the other important steps, and planning the assessment is the last stage of this developmental process.

13.3.1 The First Step

The key to success in establishing an education institution is the creation of a common mission and vision. Answering the question "What do I exist for?" provides the mission statement. Vision is then determined by answering "What kind of future will my mission create?" It is impossible to properly structure an educational program without first articulating the mission and vision. An education institute's mission and vision cannot be defined without agreement among teachers, managers, and employers (JHPIEGO 2009).

The difference between the knowledge, ability, and attitude possessed by an individual and that which is expected from the same individual constitutes an educational requirement. The sum of these educational requirements shape the program framework, and determine the interaction between the subject, individual, and society. There are several different methods that can be utilized to determine the requirements including the Delphi technique, occupational analysis, interview techniques, and others (Demirel Yılmaz 2001).

The educational process is designed to facilitate specific changes in a student's behavior. Determination of the aim establishes the necessary direction of the process, while learning objectives define the expected finish line. Together, aim and learning objectives shape the very foundation of an educational process. Target

behaviors define the condition of the student upon completion of the process. The content of an educational program cannot be properly organized without describing the aim, learning objectives, and target behavior. Moreover, the failure to delineate any one of these features would preclude appropriate measurement and evaluation (JHPIEGO 2009).

The aim represents a series of general terms designed to provide an expectation of the objectives of the educational process. It determines the role of an educational institute by setting parameters for a host of factors including content, teaching activities, and teacher-student motivation. Thus, aim encourages program development and provides a basis for evaluating the educational process.

The aim of education may be hierarchically divided into general aims of the institute, lecture, unit, and subject. These may be subdivided into specific aims. It is imperative that designated aims be suitable for, and meet the educational requirements of, each student, the subject, and societal conditions. The aims should be practicable, ensuring attainment of intended behaviors, and satisfying appropriate democratic ideals.

Learning objectives are the behaviors (knowledge, skill, and attitude) that each student intends to acquire during the educational process in order to achieve his or her goal. These behaviors are determined by a combination of four factors: society, subject, individual, and nature. The learning objectives must avoid conflicting with any of these four behavioral determinants, yet comport with educational psychology, philosophy, economy, and sociology. Additionally, learning objectives must be compatible with the number, age, and gender of students; social, economic, and political characteristics of the student body; level of readiness; educational infrastructure; and a variety of other factors beyond the scope of this chapter.

The learning objectives (knowledge, skills, and attitude) should be developed to further the aims of the educational institute, lecture, unit, and subject. In this context, it is important to consider several principles.

By the end of a module on ethics in organ transplantation, participants should be able to analyze their ethical awareness and basic knowledge to the daily practice as an aim. The learning objectives of this module are recognized by the necessary steps to reach this aim and can be formulated as follows: describe basic ethical concepts in the light of human rights; describe ethical principals; describe justice principle in resource allocation; realizing the importance of solidarity, underline the importance of transparency; describe respect for autonomy principle in organ transplantation process; list medical malpractice samples in organ transplantation.

First, the desired attitudes must be clearly, completely, and effectively expressed, which entails specifying the intended behavior with a clear and definite verb. The recommended language includes: definition, recall, recognition, description, pointing, interpretation, inference, inkling to results, arrangement, selection, allocation, determining relationship, establishing a relationship between cause and effect, comparison, differentiation, generalization, abstraction, conceptualization, criticizing, collocation, assignation, utilization, awareness of value, understanding to importance. The instructor should try to find the best style to formulize the writing of her or his learning objectives to reach in the end of course. Second, learning objectives

must be characterized by their specific effect on student behavior. They should illustrate the role of either teacher or student. For example, the educator must teach how to use the scientific method, with the aim of the use of scientific methods, so that the focus of student target behavior is actually using the scientific method. Third, learning objectives (knowledge, skills, and attitude) should be suitable for societal needs, as well as laudable for teaching and learning, in accordance with teacher and student values. It is crucial for these objectives to be logical, attainable, and ranked from easy to difficult, and from simple to complex. Fourth, the objectives should be comprehensive albeit narrowed, internally consistent, and mutually supportive. For example, lectures should share a common theme and reinforce an institution's ultimate aim (Demirel Yılmaz 2001).

Target behaviors are the knowledge, ability, and attitude a student achieves by completion of the education process. They reflect the aims for student behavior, and should incorporate terms such as: "Defines, remembers, describes, indicates, interprets, concludes, understands the implications, separates the items, determines the relations, establishes cause-and-effect relationships, compares, distinguishes, suggests, generalizes, abstracts, conceptualizes, judges, criticizes, sorts, identifies, uses, be aware of the value, understands the importance, etc." to the end of the target behavior sentence (Demirel Yılmaz 2001).

Target behaviors should be separately configured, in a stepwise fashion, of a desirable nature, and amenable to observation. The content must be limited to avoid one target behavior from bleeding into another. Additionally, it is important to specify the precise target behavior expected from each particular subject content (JHPIEGO 2009).

The content of a program is formulated by answering of the following question "What will we teach?" It is impossible to properly answer this query without first determining the aims, learning objectives, and target behaviors. Once those points have been firmly established, then the content may be planned to harmonize with the aims and learning objectives. The content will be determined by the conceptual framework, main themes (sine qua non), key ideas, and side-information (examples, knowledge, experiences, practices). The content must fit the subject, but it should be oriented to student readiness which includes the possession of certain knowledge, skills, and attitude, as well as interests, ability, and physical-mental maturity. Readiness or the level of student may be delineated by the ability to comprehend content, which should be ordered from concrete to abstract, simple to complex, easy to difficult, near to far, and known to unknown.

The content should provide students with a solid preparatory foundation for life's challenges, including strong values, sound philosophy, and essential knowledge, skills, and attitude. It must complement the subject matter, both in topic and adequate depth, while remaining valid, meaningful, coherent, and interesting, as well as learnable. In order to meet these requirements the content will have to be beneficial to the individual and society, and fall within economic limitations. Transferred knowledge, skills, and attitudes should be scientifically correct and sociologically acceptable in order to provide useful life skills. (JHPIEGO 2009; Demirel Yılmaz 2001).

The content should build on students' prior knowledge, utilizing the audiovisual tools, and interactive teaching methods necessary to ensure a consummate learning milieu. It must be developed with the intention of emphasizing salient features and enhancing recall of the important points. The educator should consider addressing medical humanities throughout the development of the subject or unit program, as well as the whole program (Grant 2002).

Possible content for organ transplantation and ethics module's conceptual framework, main themes (sine qua non), key ideas and side-information (examples, knowledge, experiences, practices) include: main ethical principles, the concept of death from ethical point of view, respect for autonomy in organ transplantation and local legislation. The instructor will develop the content through experiences and practical cases.

13.3.2 The Second Step: Content

Planning the most effectual teaching process cannot commence until target behaviors are determined and content planning is completed. The process must focus on the aim and learning objectives, and include separate plans for a year, for a term, for a course, or just for a lecture. Four main points are planned during this process (JHPIEGO 2009; Demirel Yılmaz 2001; Özyurda and Dökmeci 1999).

Structured to chapters: There must be separate planning to determine which lectures are included by the institute program, which units are included in each lecture, which subjects are included in each unit, and which points (*introduction, body, final remarks, summary*) are included by subject (introduction (the main aim is to focus on the subject; needs a provocative short part from a movie or an impressive newspaper article relevant organ transplantation); body (the important subjects related with organ transplantation), final remarks (consent and legal responsibilities), summary (a few multiple choice questions or true and false questions help to summarize the basic information)). If the number of students is not too many, then the lecturer can divide them into subgroups and request that they prepare a few questions, and at the end of the limited time, all questions can be discussed together with the entire class. The lecturer should prepare a few multiple choice questions in advance for crowded groups.

Structured to period: The whole educational process must be organized by weekly, daily, and hourly lecture periods. The specific teaching periods should be scheduled within 6–8 h a day, and include appropriate breaks. Further, theoretical and practical subjects should be planned in the morning and afternoon, respectively. Different educational methods are best divided into different periods.

Relevant to planning educational methods and techniques to be enforced, the definition of method is to choose a path and conscientiously follow that route to achieve the overall aim. Techniques refer to the transfer of methods to actual practice. Regardless, these terms may be used interchangeably.

The factors that should be addressed when choosing educational methods and techniques include but are not limited to the following: aim and learning objectives, qualification of subject (level of knowledge, ability, and attitude), position of student (number, readiness), position of education environment, talents of educators, content, available facilities, period of education, overall monetary outcome and ease of use (JHPIEGO 2009).

The routes of teaching refer to educational methods and techniques utilized for a productive educational process. It is the educator's effective use of these routes that determines the success of a program, although effective use is not enough to refine or improve the education. For example, the educator adapting to traditional education with effective use of the routes of teaching will provide adequate teaching of the subject matter, but will not enhance or polish the education.

Class organization should be planned according to the chosen education activity. For example, a student based class organization, should be arranged so that participants can see each other, allowing the educator to easily move about the classroom, establish eye contact, and communicate with everyone. A U-shaped setting works best for this scenario. In contrast, a working group should be arranged in a comfortable, face to face position, with structured order to the discussions.

Educational methods and techniques are chosen according to the desired transfer of knowledge, skills, and attitude. For example, methods like debate and role-playing work best in attitude education; dramatizing and debate serve communication skills; and presentations are more effective for knowledge transformation (Tulsky et al. 1998; Suchman et al. 1997; Shapiro 2002; Hulsman et al. 1999). This rest of this chapter will review the case study method which represents an important approach for ethics education.

The case study method presents problems referencing actual events or real subjects. The problems are debated and analyzed, with a detailed examination of potential solutions, and a discussion of how the case relates to actual work situations. The method concludes by summarizing the advantages and disadvantages of each solution.

The effective use of this method necessitates choosing a suitable case example that presents a basic problem amenable to analysis. The student must receive all relevant preliminary information and have access to the appropriate infrastructure (library, internet) in order to advance from analysis to solution. Prepared debate questions will allow the educator to guide discussions, with recording of the principles and measures. Subsequent evaluation should include an assessment of how the results are enforced and the benefits gained. The educator should plan the period to end with a conclusive summary.

There are a number of distinct advantages to the case study method. In particular, the student develops problem solving and decision making skills, allowing a hands-on approach to real life situations. Additionally, this approach solidifies newly acquired knowledge by translating academic theory into actual practice. The disadvantages to this method are that it is limited to small setting, usually a handful of students, and if improperly directed the solution becomes very complicated (JHPIEGO 2009).

A case story relevant to organ transplantation and parental paternalism is as follows:

> The parents of a preschool girl R, who went into a liver coma and needed a liver transplantation since she accidentally swallowed toxic substance, applied to be donors. As a result of the examinations, it was deemed suitable to transplant the liver of R's father and await the mother as the reserve donor. Before the operation, the informed consents of both mother and father were received. Soon afterwards the transplant operation, both the relatives of father and R's mother objected to the operation. In their opinions, the child had no chance of survival and the father was taking an important risk with that operation. R's mother stated that she withdrew her consent and requested the termination of the operation. However, during that time, laparotomy was applied to R's father and the liver unit was about to be resected. The fact that physicians suspended the operation, had a talk with the patient's relatives for about an hour, told the sensitivity of that phase and retold them that the child had a survival chance of approximately 70% owing to the transplantation did not produce a result. Due to the insistent and even threatening attitudes of the patient's relatives, physicians terminated the operation at that phase, closed the laparotomy of the father and withdrew the transplantation. Although the father reacted to the abandonment of the transplantation after the operation, physicians decided to wait for an organ to be transplanted from a cadaver at that phase. However, R died two days later (Guvercin and Arda 2013).

Planning to audio-visual tools, audio-visual devices arguably represent the most important tools in our modern educational setting. These tools run the gamut from a simple blackboard to a complex video presentation. These diverse means impart knowledge in different ways, but all have the capability to improve communication and thereby increase the quality of learning. It is, of course, a prerequisite that these tools are correctly used in an appropriate fashion. Each educator bears the responsibility of effectively using the tools most suitable for his or her aims (JHPIEGO 2009; Özyurda and Dokmeci 1999).

13.3.3 The Last Step: Assessment

The purpose of assessment is to test whether or not specified target behaviors were acquired and to provide a numerical measurement. An evaluation ascertains whether a program's aims and goals were realized. This phase warrants planning how to accurately measure the gain in specified target behaviors and ensure that evaluation is neutral, valid, coherent, versatile, and continual.

The assessment of attitudes gained by audio learning is very difficult. It is generally impossible to measure or evaluate occupational attitudes in the educational system, as these attributes are markedly different from knowledge and ability. And, yet, the evaluation of attitude in a very important feature in the overall assessment.

Gained attitudes can be measured and evaluated according to "competency based assessments" criteria (Norcini 2002). But, scholars disagree about whether the criteria are applicable to the "attitude learning guide" and "attitude assessment guide." Negative attitudes and apathies should not be interpreted as a failure in the assessment. Attitudes are measured for inexactness or mistakes and repaired or corrected accordingly. A complementary educational program may be required to correct the attitudes (Mc Crorie and Cushing 2000; Demirel Yılmaz 2001; JHPIEGO 2009).

The Objectively Structured Clinical Examination (OSCE) is a special type of assessment often used in medical education. This type of testing allows separate and combined assessment of various behaviors (knowledge, ability, attitude). The student goes through a series of pre-prepared stations examining phenomena, cases, or events. In each station, the student is tested in a neutral manner for knowledge, ability, and attitude. Evaluation guides satisfy the requirement of examination neutrality, while providing a high level of validity and reliability. The preparation of an OSCE is challenging; however, its practicality and outcome make it a comparatively easier examination than others for certain measurements. A prior report on informed consent describes the unique educational experience stemming from this method (Arda et al. 2009).

The pre-education preparations should include a list of everything needed during the educational process. These preparations may be divided into the following parts: meet the participants, prepare facilities, prepare physical conditions of learning places, prepare for requirements of participants, prepare educators (JHPIEGO 2009; Özyurda and Dokmeci 1999).

Trying the educational program requires a planned demonstration of it in a particular institution or classroom. This makes it possible to evaluate the program, specifying that the aim was either achieved or not. Gaining continuity in an education program is a vital figure.

13.4 Bioethics Education As a Communicative Media

We are learning and developing ethical attitudes as a part of our personalities through various interactions in society, which are influenced by cultural differences, role modeling, and formal education. Founding and maintaining interactivity seems is the most effective method of education in ethics. Thus, applicable means of developing attitudes through interactivity include case studies, role playing, simulations, and structured discussions utilizing movies. All of these methods have a vital role in the medical humanities (Evans 2002).

The physician's attitude has an ethical component and it is accepted as a broader educational part that provides humanistic perspective. The final aims are encouraging a critical and questioning attitude to professional identity. Integration has been accepted as an important educational strategy in medical education. Harden describes 11 points on a continuum between the two polarized debates in favor and against integrated teaching. These points are stressed as isolation, awareness, harmonization, nesting, temporal co-ordination, sharing, correlation, complementary, multi-disciplinary, inter-disciplinary, trans-disciplinary. Didactics and seminars will be taught as part of the curriculum inevitably, but all of them must not be lectures. Interactive learning experiences are best suited to help medical students achieve the program's educational objectives (Pellegrino 1989; Harden 2000; Arda 2004).

Providing a consistent on-going positive educational environment has a beneficial effect on development in ethical education. Educators should give feedback to

the participants regarding the phase of evolution or level of learning performance. This feedback should be positive, with the goal of guiding the participants to success. Therefore, the bioethics learning experiences should be ordered from simple to difficult and from known to unknown. The educator must give positive feedback by conversing openly and objectively, using positive verbal expressions, supporting proper activities, guiding the overall aim, and empathetically discussing points that warrant further development (Özyurda and Dokmeci 1999).

Educators in ethics should recognize that many participants suffer anxiety during the educational process. It is important to employ warming exercises, meeting organization and related techniques to create a safe environment, which will be less anxiety-provoking. Useful learning activities include those that support and encourage participants, and reinforce their relationship with the group.

The adult participant prefers to be treated as a unique individual with an independent personality. The educator in ethics should be respectful to each individual, frequently utilizing his or her name, and ensuring that each person has the opportunity to participate in the group activities. There should be a learning environment that allows participants to exchange information. If the participants' self-confidences are preserved and supported, then the educational requirements will be fulfilled. Participants need reinforcement of their own self-sufficiency and self-confidence as a means to estimate their success. It is, therefore, axiomatic that the educator in ethics must avoid negative feedback.

Participants generally have high expectations for themselves and the educator. The educator should candidly acknowledge his or her particular limitations. However, at the beginning of the process, both parties should negotiate the rules applicable to the whole educational period (Ozyurda et al. 2002).

An educator's presentation style is the main determinant in creating an overall positive educational environment. That is, the manner of speaking is often more important than what is said. The astute educator develops a positive educational environment from the beginning of a course by taking the following series of steps: insist the participants meet each other; review the course aims and learning objectives; clarify the educational activities; recognize the students' prospects; share the rules of the educational process; examine the program and facilities; answer each participant's questions; and advise regarding the ease of the upcoming requirements.

Warming exercises serve to reduce anxiety, support communication, improve active participation, and increase attention. These exercises should be performed intermittently at the beginning of the educational process, and taper off over the ensuing days as indicated. It is incumbent upon the educator to facilitate these exercises by providing group integration and reinforcement of communication. These exercises may be arranged as needed throughout the education, including as a lecture-introducer to increase energy and focus concentration.

The manner of expression is also crucial in education in ethics. Important points must be emphasized with the proper enunciation including appropriate tone, volume, and pitch. There must be an effective start to every chapter or subject. Students should be addressed by names to establish personal communication. Relevant points

should be reconciled with students' ideas and experiences, which will increase their level of attention, interest, and self-confidence. Inconsequential repetition must be avoided. The overall theme presentation manner, timing, and rhythm allows the educator to focus on the most important chapters or subjects. There should be a smooth, logical, and flowing change from one chapter to another. In some cases, the summary of one subject provides an excellent introduction to the next topic. A natural transition to the next chapter is best supported by appropriate audio-visual aids. The educator must make every effort to discern the students' socio-cultural characteristics, and avoid using unacceptable words (Keidar 2005).

Nonverbal communication is as important as oral communication in ethics, perhaps more so given the ancient origins of the former. In fact, nonverbal communications comprise almost 60% of the total communications during a typical interaction. The educator should be energetic, walk in the classroom when making a presentation, establish eye contact, turn to a student asking questions, and make positive use of jests, mimicry, and facial expressions. It is beneficial for the educator to adjust his or her body language to comport with the students' body language. He or she should be enthusiastic and effusive during the lecture, while avoiding distractive or repetitive behaviors (swaying, playing with pencil, etc). In short, the educator's feelings will be mirrored by the students. The use of appropriate humor including stories, anecdotes, and caricatures provides a positive addition to the educational environment, but should never serve to humiliate or attack someone.

After completion of the education, it is important to follow participators through their professional area in order to help arrange new courses and establish a positive environment that will assist with necessary educational planning. Avoid making empty promises or failing to satisfy mutually agreed upon plans. In order to address problems that arise after the program evaluation, the educator must focus on program development, continual in-service education, and on-going research throughout every step of the process. Consequently, there will be an enduring, renewable, and improvable level of education in the bioethics field.

13.5 Conclusion

Medicine today has lost much of its humanity. Healthcare systems are complicated, confusing, bureaucratic, and profit oriented. They function as a business, no different than a car assembly factory or shirt manufacturing plant. It is difficult to ascertain the humanistic features of biomedical education in this environment. In fact, the ethical aspects of medical education are frequently pushed aside for a multitude of reasons—an absence of space in the existing curricula; no time or resources to develop new curricula; a lack of expertise and literature on bioethics education; and overall skepticism by educators and scientists concerning the need for this type of education.

Subject based program designs are mostly preferred in bioethics due to economic reasons, shortage of lecturers, and crowded pupil groups. Many of the schools

have just lectures in the medical curriculum and basic audio visual tools. There are not much educational facilities and sources.

The educational dimension will play an important role in erecting a value-based biomedicine program. Bioethics education represents an education founded on the humanistic approach. In the light of daily life; it is possible to emphasize that the necessity of an effective and functional education in ethics. This necessity needs the usage of more different methods and more equipment. The learning process must be enrichment together with different tools like role playing or small group discussions in a student based approach and also to this must added educational activities leading to the develop of communicative skills. This chapter reviewed the basic rationales of the educational process, discussed the general framework of developing an educational program, and outlined an appropriate assesment process.

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Chapter 14
Moral Improvement Through Ethics Education

Bert Gordijn

14.1 Introduction

Broadly accepted goals of ethics education are knowledge, skills, and moral improvement. The first goal involves gaining more familiarity with ethical theories, concepts, arguments, debates, important ethicists and so forth. The second one entails acquiring abilities regarding ethical analysis, argumentation, deliberation, and the like. The third goal involves moral improvement of behavior.

With respect to these three goals this chapter claims that there is a key difference between teaching ethics at a philosophy department and teaching it elsewhere. Supposing the third goal, moral improvement, should turn out to be too ambitious, aiming for the first two goals can still legitimize ethics education in a philosophy department. After all, academic philosophers are expected to be knowledgeable about ethics and able to develop sustained ethical arguments or detect non-sequiturs in the ethical reasoning of others. Ethics related knowledge and skills are considered pivotal assets for academic philosophers. This is markedly different when focusing on ethics education outside academic philosophy departments within schools of business, medicine, engineering, journalism, and the like. Their graduates are neither expected to be able to explain the subtle differences between Bentham's and Mill's versions of utilitarianism; nor are they believed to be better business professionals, doctors, engineers, and journalists if they could. Instead the chief rationale of teaching ethics within many non-philosophy departments—religious studies programs may be an exception—is to positively contribute to the moral development of their students. The overarching aim is that these students become morally better professionals. If teaching ethics merely enhances their knowledge and skills, but lacks any positive effect on their later professional behavior and decisions, it fails to achieve its main goal. However, the question of whether, and if so, how ethics education can contribute to moral improvement, is not easily answered.

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This chapter tackles the issue of moral improvement through ethics education by reviewing three views on the matter. First, it focuses on the Socratic approach to ethics education and moral improvement as revealed in the early Platonic dialogues, especially the *Protagoras*. Here Socrates claims that knowledge is not only a necessary but also, more controversially, a sufficient condition for moral behavior. The chapter then turns to Aristotle who—taking into account additional insights in moral psychology—claims that, besides knowledge, appropriate character development is required in order to solidly guarantee moral behavior. Characters, however, are formed in a long process of habituation from early youth. In order to steer the latter in the right direction, appropriate legislation is indispensable in order to create social conditions suitable for the development of good habits. Two contemporary philosophers, Ingmar Persson and Julian Savulescu (2012) advance the third view examined in this chapter. They argue that even a combination of education and legislation does not suffice to improve human moral behavior to the extent that it can tackle the main ethical challenges of the twenty-first century. In addition to these traditional vehicles of moral improvement, we will have to explore biological ways of enhancing our moral qualities, or so they argue. Following a more detailed presentation of these three views, they are one by one assessed. In addition, the chapter looks at the implications of these assessments for present-day ethics education and how it might be improved.

14.2 Socrates

It is not easy to develop a precise historical portrait of Socrates and his teachings. After all he has not left behind any writings of his own. We know about him mainly through the descriptions by three authors: Aristophanes, Xenophon, and Plato (Nails 2010). The first was a comedy writer, the second an historian, and the third arguably one of the most important philosophers who ever lived. Not surprisingly, philosophers often intuitively seem inclined to believe Plato's account of Socrates to be closest to the truth. This belief might be based on the idea that Plato, because of his own superior intellectual capabilities, was the one most capable to fathom the philosophical brilliance of Socrates. Indeed, the figure of Socrates as he appears in the writings of Aristophanes and Xenophon is intellectually less sophisticated than Plato's Socrates. Then again, presupposing Socrates' genius in the first place might amount to begging the question. For all we know, Plato's unquestioned superior intellect might also have created an idealized, larger than life literary character, in comparison to which the historical figure of Socrates would grow pale. Be that as it may, this chapter does not embark on the problem of how the historical Socrates relates to portrayals of his character in literary and philosophical writings (see Nails (2010) for a more detailed analysis of this problem).

Instead, it focuses on the views of Socrates as a character in Plato's early dialogues. In the dialogues *Crito* (Plato 1892a, pp. 148–149) and *Gorgias* (Plato 1892b, p. 362 ff.) Socrates argues that virtue and vice or good and bad behavior have an

effect on the soul comparable to the way in which health and disease impinge on the body. Therefore, it is not only in our own interest to achieve health, but also—and perhaps even more so—to acquire virtue (*arete*). However, in order to effectively attain virtue we must know what it is we wish to achieve first. Accordingly, Socrates is very much inclined to start debates about the virtues. In doing so he always tries to select collocutors who claim to have some sort of special expertise on this topic. Amongst these people are the so-called sophists. These are scholars who would travel around offering courses and continuously looking for new pupils. In Plato's *Protagoras* the eponymous central character is quite a well-known sophist. In this dialogue Socrates and Protagoras explore the question of whether virtue can be furthered through teaching.

As usual in Plato's dialogues the discussion is presented almost like a theatre play, rich with contextualized details. It has its own particular dialectical dynamic and touches on a variety subjects. Socrates and Protagoras both change their positions in the course of the debate. At the very beginning of their discussion Protagoras supports the claim of the teachability of virtue. After all he claims to be a teacher of virtue himself and contribute to the moral improvement of his students. However, Socrates rejects the idea that virtue can be taught. Perhaps he only takes this initial stance in order to trigger a lively debate. As usual in the early dialogues of Plato, Socrates starts the debate by challenging his interlocutor to substantiate his initial view on the matter at hand. In his reaction to the challenge Protagoras takes the opportunity to demonstrate his rhetorical skills. After Protagoras's sophisticated speeches Socrates is appropriately impressed but for a couple of little issues. The latter then turn out to be a lot trickier than initially expected. After some digressions—amongst others a discussion about the rules of the debate itself—the two debaters refocus on the initial question about the teachability of virtue. Yet their respective positions have now diametrically changed.

Socrates currently states that virtue can be furthered through teaching (the further *Protagoras* analysis below is based on Gordijn and ten Have (2013)). After all, nobody doubts that knowledge can be taught. And Socrates argues that virtue consists of nothing but knowledge. In order to substantiate his thesis of the teachability of virtue he develops the view that happiness consists of various forms of pleasure. However, it is certainly not always intuitively obvious how to maximize pleasure. Nor do we always know how to avoid pain. It is a delicate skill to appropriately balance enjoyments and discomforts both in the short and the long run. After all, depending on the specific circumstances, this can be rather difficult to accomplish. Therefore, specific knowledge and understanding are required for the right acquisition and appropriate management of pleasure. This is what we call virtue (cf. Homiak 2011).

Somewhat counter intuitively, however, Socrates argues that possessing this particular sort of knowledge is not only necessary but also sufficient for behaving morally. This is contrary to common sense according to which the mere acquisition of knowledge of what is right and wrong does not suffice in order to display moral behavior. Common sense says that we are often encouraged by temptations of many different kinds to act against our rational judgment about what would be

the virtuous course of action. As a result, it is not always easy to act rationally. After all, our capability to follow reason and refuse to go along with contradictory inclinations is determined by various variables, such as our strength of will or the lack thereof. If we are weak-willed, we easily sway from the right track and end up committing wrong actions. According to common sense, incontinence (*acrasia*) is sadly enough a rather widespread phenomenon (cf. Homiak 2011; cf. Woodruff 2010).

Socrates, however, argues that wrongdoers are not weak-willed; they just lack the necessary knowledge. "This, therefore, is the meaning of being overcome by pleasure;—ignorance, and that the greatest" (Plato 1892d, p. 182). If one genuinely understands good and evil, i.e. if one truly masters the art of measuring enjoyment, equally considering current and future pleasures and pains, one will never select a suboptimal course of action that is less enjoyable *summa summarum*. Why would one act against one's own knowledge and thus against one's own interests? (cf. Woodruff 2010). According to Socrates then "…no man voluntarily pursues evil, or that which he thinks to be evil." (Plato 1892d, p. 183).

If Socrates is right in holding that appropriate knowledge is a sufficient condition for virtuous behavior, good education that increases the students' knowledge of virtue would thereby improve their moral behavior. For Socrates the pursuit of this kind of knowledge necessarily involves critical debate as a crucial method to gain a deeper understanding of what it means to behave virtuously. However, the first step on the road to true knowledge is getting rid of false knowledge. Accordingly, in the early dialogues Socrates is very much focused on creating awareness in his discussion partners of their own ignorance, as this is a stepping-stone to deeper understanding and proper knowledge. The educational significance of this endeavor is explained in the *Meno* where Socrates reflects on the state of perplexity to which he has guided his discussion partner: "…do you suppose that he would ever have enquired into or learned what he fancied that he knew, though he was really ignorant of it, until he had fallen into perplexity under the idea that he did not know, and had desired to know?" (Plato 1892c, p. 44). As a result of the debate his discussion partner is now freed from the illusion of knowledge. Instead he is aware that he still lacks true understanding, which encourages him to further examine the issues discussed. This marks a process of intellectual growth (Plato 1892c, pp. 44–45).

Socrates' method to achieve this effect is as follows. Socrates would start the conversation by asking his discussion partner about his take on a particular virtue. His interlocutor would then usually somewhat naively advance a first definition. In a critical analysis of the latter's initial response Socrates would lay bare that certain implications of this first attempt at a grasp of the virtue at hand are not in agreement with the *communis opinio* or with other important views that his discussion partner holds. By pointing out these inconsistencies Socrates would prompt his discussion partner to advance a novel and more sophisticated characterization of the virtue under consideration. This process of proposed characterizations and refutations would continue for a while. Finally, the debate would end leaving his discussion partner in a state of puzzlement and perplexity (*aporia*): the very goal of Socrates' endeavor.

14.3 Aristotle

Compared to Socrates' almost naively enthusiastic take on ethics education, Aristotle's less buoyant approach is at the same time more commonsensical and sophisticated (cf. Gordijn and ten Have 2013). His *Nicomachean Ethics* advances one of the most influential ethics theories in the history of the discipline. In Aristotle's theory the concepts of *eudaimonia* and virtue are pivotal. *Eudaimonia* is often translated as *happiness* or *human flourishing*. It is the highest good of human life, and involves enduring virtuous activity of the soul (Aristotle 1998, pp. 11–15, I 7). Aristotle defines moral virtue as "… a state of character concerned with choice, lying in a mean, i.e. the mean relative to us, this being determined by a rational principle, and by that principle by which the man of practical wisdom would determine it. Now it is a mean between two vices, that which depends on excess and that which depends on defect; and again it is a mean because the vices respectively fall short of or exceed what is right in both passions and actions, while virtue both finds and chooses that which is intermediate" (Aristotle 1998, p. 39, II 6).

Unfortunately, there is no easy formula for the virtuous way to organize our behavior and engage with the world, as the situations we might encounter in life are so diverse. Instead, virtue—both in acting and feeling—requires a rich appreciation and awareness of the context of particular situations. This is necessary in order to adequately identify the intermediate between the various possible pairs of extreme passions and actions that are to be avoided (Aristotle 1998, pp. 36–40, II 6). Aristotle formulates it as follows: "…both fear and confidence and appetite and anger and pity and in general pleasure and pain may be felt both too much and too little, and in both cases not well; but to feel them at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way, is what is both intermediate and best, and this is characteristic of virtue. Similarly with regard to actions also there is excess, defect, and the intermediate" (Aristotle 1998, p. 38, II 6). Understandably the ability to choose the appropriate intermediate between two extremes in a large variety of different situations is not an easy feat to achieve. Aristotle calls this intellectually capability practical wisdom: "a reasoned and true state of capacity to act with regard to human goods" (Aristotle 1998, p. 143, VI 5). Acquiring practical wisdom necessitates experience with a large variety of particular situations. Therefore, practical wisdom can only develop fully in the more advanced stages of life (Aristotle 1998, pp. 147–149, VI 8).

As Aristotle conceptualizes moral virtue as a state of character it is important to explain his view on the development of character in general. States of character result from frequent repetition of similar activities. Therefore, it is imperative that our activities in the early stages of our development be of the appropriate kind. After all, most of our habits are formed during childhood (Aristotle, 1998, pp. 28–29, II 1). Depending on the kind of habits we develop, we end up with a particular state of character as adults. Aristotle distinguishes three negative states, incontinence, vice and brutishness, as well as three contrary positive states, continence, virtue and superhuman virtue. Whilst the two states at the extreme ends of the moral spectrum, brutishness and superhuman virtue, are rarely found amongst human beings, the

remaining four states are pretty common. Amongst these states, virtue and vice are opposites as are continence and incontinence (Aristotle 1998, pp. 159–160, VII 1). Whereas Socrates denied the existence of incontinence (see above), Aristotle remarks in a down-to-earth way that this Socratic analysis "plainly contradicts the observed facts" (Aristotle 1998, pp. 161, VII 2). Therefore, Aristotle allows for two states, both continence and incontinence, in between virtue and vice.

In order to attain a virtuous character "…we ought to have been brought up in a particular way from our very youth…so as both to delight in and to be pained by the things that we ought; this is the right education" (Aristotle 1998, p. 32, II 3). In contrast, when we develop the wrong set of habits during childhood we may end up incontinent or even vicious. In that case it is not realistic to expect that moral education might still fix the problem. Aristotle decidedly diverges from Socrates' exclusively intellectual approach to the improvement of moral behavior. Instead, according to Aristotle: "… argument and teaching… are not powerful with all men, but the soul of the student must first have been cultivated by means of habits for noble joy and noble hatred" (Aristotle 1998,p. 270, X 9).

Given the importance of habituation it is important to have suitable laws in order to facilitate a correct character development during childhood: "…for to live temperately and hardily is not pleasant to most people, especially when they are young. For this reason their nurture and occupations should be fixed by law…" (Aristotle 1998, p. 271, X 9). However, appropriate legislation is also vital for adults who have already been habituated. After all, external pressure and sanctions can be brought into play as effective means to steer their behavior in a desirable direction: "…for most people obey necessity rather than argument, and punishments rather than the sense of what is noble" (Aristotle 1998, p. 271, X 9).

Compared to Socrates then, Aristotle has a more realistic view on the effects of educational interventions on moral behavior: when habituation has already gone wrong during infancy, ethics teaching cannot be expected to set it right again during adulthood. In this spirit, Aristotle states at the outset of the *Nicomachean Ethics*: "…any one who is to listen intelligently to lectures about what is noble and just … must have been brought up in good habits" (Aristotle 1998, p. 5, I 4). By no means, however, does Aristotle abandon all hope relating to ethics teaching. When students have been brought up correctly, the study of ethics may very well further improve their moral behavior, which is exactly what Aristotle is aiming for with the *Nicomachean Ethics*. He is trying to improve moral behavior: "… we are inquiring not in order to know what virtue is, but in order to become good …" (Aristotle 1998, p. 30, II 2).

14.4 Ingmar Persson and Julian Savulescu

More than two thousand years after Socrates' energetic heralding of ethics education, Persson and Savulescu (2012) conclude that ethics teaching has not sufficiently contributed to the moral improvement of human beings to enable them to successfully deal with the great ethical challenges of our times (Persson and Savulescu

2012, p. 2, 106). Legislation—advocated by Aristotle as a means to improve moral behavior—receives an equally negative assessment. In liberal democracies legislative and policy frameworks tend to mirror the preferences of electoral majorities. If the latter are morally not up to scratch, the former will be inadequate as well. Persson and Savulescu argue that while science and technology have developed very fast creating intricate ethical challenges, our moral behavior has not caught up sufficiently to be able to adequately address these challenges, making us unfit for the future (Persson and Savulescu 2012, pp. 9–10, 106).

The authors hypothesize that human moral traits have resulted from natural selection (Persson and Savulescu 2012, p. 4). They also claim that our current moral behavior still reflects the conduct and attitudes that granted survival advantages when we were living in small hunter-gatherer tribes with primitive technologies. At that time it did not make sense to sympathize with strangers; they were rather met with suspicion. Our altruism was limited to well-known people whom we could trust (Persson and Savulescu 2012, pp. 32–39). Equally, we did not worry about the long-term future since our actions had no foreseeable distant future impact (Persson and Savulescu 2012, p. 27). These and similar human moral traits have hardly altered in the last few thousand years (Persson and Savulescu 2012, p. 10).

During the same period, however, the way in which we live has hugely changed as a result of rapid growth of science and technology. We now live in large societies that are globally interconnected in myriad ways. In addition, modern technologies facilitate actions with both geographically and temporally far-reaching and possibly disastrous effects (Persson and Savulescu 2012, p. 3). Yet, during this period of explosive technological growth our moral dispositions have failed to undergo a proportional improvement (Persson and Savulescu 2012, p. 106). Thus the authors identify a "widening gap between what we are practically able to do, thanks to modern technology, and what we are morally capable of doing, though we might be somewhat more morally capable than our ancestors were" (Persson and Savulescu 2012, pp. 106–107).

To illustrate this problem the authors zoom in on global warming. Rich countries have the biggest average per capita greenhouse gas emissions. Unfairly, poor countries with the lowest per capita emissions bear the brunt of global warming. Although by now many citizens in affluent countries are aware of this problem, their obsolete moral dispositions make them unwilling to substantially change their lifestyle. They tend to only care about their near acquaintances and lack empathy with foreign people (Persson and Savulescu 2012, pp. 74–75). In addition, the most dreadful consequences of global warming will only occur in the remote future. However, human beings do not really care about what lies far ahead in time. Their concerns are limited to the present and the near future (Persson and Savulescu 2012, p. 74).

Persson and Savulescu argue that moral education alone is unlikely to change our moral behavior. In order for mitigation of greenhouse gas emissions to be effective, the cutbacks on our consumerist lifestyle would have to be momentous. Why would we be motivated to significantly change our opulent way of life? After all we cannot even be sure that sufficient numbers of others would do the same in order for

the cutbacks to have any significant beneficial effect. Also the introduction of harsh legislation so as to enforce cutbacks amongst the general population by means of sanctions is not likely to be established in liberal democracies since there is no back up from the electorates (Persson and Savulescu 2012, pp. 79–83).

Thus neither education nor legislation seems to be able to achieve the kind of moral improvement of our behavior that might help us tackle global warming. Therefore, Persson and Savulescu consider it appropriate to explore alternative ways of improving our moral behavior. In order to better understand the problem at hand they distinguish between "moral doctrines" and "moral actions and reactions" (Persson and Savulescu 2012, p. 106). An improvement of the latter demands the internalization of the former. However, this has proved problematic. Though there have been noted improvements of moral doctrine over time, our behavior has not changed accordingly. So, in contrast to Socrates, the authors argue that improvement of moral behavior requires both knowing what is good as well as the motivation to act accordingly. However, this mobilization of moral motivation is difficult to achieve through moral education alone (Persson and Savulescu 2012, p. 117).

To address this problem the authors propose exploring the option of "moral bioenhancements": medical interventions in order to boost the "motivational internalization" of moral doctrines (Persson and Savulescu 2012, p. 107). The authors review empirical research suggesting that what they see as our key moral dispositions—altruism and a sense of justice—might have a biological basis (Persson and Savulescu 2012, pp. 108–109). Accordingly, so they argue, it makes sense to explore medical approaches of strengthening these dispositions in order to improve our moral behavior. We already know, for example, that certain pharmaceuticals have effects on moral behavior. However, as yet no medical interventions have been established that can precisely achieve certain desired moral improvements (Persson and Savulescu 2012, pp. 118–121). Hence the authors admit that research on moral bioenhancement is still in its infancy. Yet they think it should be seriously pursued given the enormity of humanity's challenges. If feasible, moral bioenhancement should be applied alongside education and social reform (Persson and Savulescu 2012, p. 121). The authors claim "…moral training will have to be more thoroughgoing and pursued intensively in school from the start" (Persson and Savulescu 2012, p. 123). The kind of moral bioenhancement that the authors propose is meant to motivate "…ourselves to do what we already believe to be right" (Persson and Savulescu 2012, p. 123). It should help overcome our "moral weakness of will" (Persson and Savulescu 2012, p. 123).

14.5 Discussion and Implications for Contemporary Ethics Education

After the presentation of the three positions on moral improvement by means of ethics education, the chapter now focuses on their discussion and assessment with a particular focus on their implications for present-day ethics education and the question of how it might be improved.

14.5.1 Moral Improvement

Reviewing the three views portrayed above it immediately strikes that they all accept moral improvement as an important, if not essential, aim of ethics education. Aristotle seems to speak for all of them when he states "…where there are things to be done the end is not to survey and recognize the various things, but rather to do them; with regard to virtue, then, it is not enough to know, but we must try to have and use it, or try any other way there may be of becoming good" (Aristotle 1998, pp. 269–270, X 9). Indeed, the very same concern with moral improvement seems to characterize Socrates as well as Persson and Savulescu.

In the first half of the twentieth century moral improvement of behavior as a goal of academic ethics education seemed somewhat neglected, as university ethicists were more focused on a metaethical research agenda. As a result, they were scarcely interested in normative analysis of real-world problems or attempts at moral improvement through ethics education. The renewed focus on moral improvement shining through in the work of contemporary academic philosophers such as Persson and Savulescu is commendable.

14.5.2 Socrates

Socrates arrests the attention by his energetic optimism. He is remarkably hopeful about the prospects of an educational approach to moral improvement. He stresses the importance of arguments and critical debate in order to get a clearer idea of basic moral concepts. This approach has had a lasting effect on the further development of ethics as a discipline.

However, when reviewing modern ethics teaching one might wonder whether Socrates' approach is actually sufficiently employed. It seems that more critical debate on basic ethical issues would be most welcome in arenas like medicine, business, engineering, journalism, and science in general. Socratic debate would not only be valuable amongst students but likewise in professional organizations. The fact is that the cathartic effects of Socratic *aporia*—the realization that the things one thought one knew are not really solid knowledge, and the resulting yearning for further inquiry—are likely to have positive effects within practices that do not automatically cultivate critical reflection on their own goals and standards. If top bankers, for example, had practiced regular Socratic debates as a means of guaranteeing moral conduct and keeping their institutions focused on worthwhile goals of banking, the global financial crisis might perhaps have looked differently. Ethicists could play an important educational role by triggering, framing, and chairing these discussions.

As said earlier, Socrates regarded the knowledge ensuing from these debates not only as necessary but also as sufficient for virtuous behavior. He also denied the role of weakness of will. However, Aristotle, Persson, Savulescu and most other philosophers who have pondered the subject contest this Socratic understanding of

moral psychology. Indeed, in the last couple of years Eric Schwitzgebel has completed several interesting empirical studies focused on academic ethicists' moral behavior, thereby putting the Socratic idea that more knowledge leads to improvement of moral behavior to the test (cf. Gordijn and ten Have 2013). His research departs from the premise that academic ethicists can be expected to behave morally better on average than other academics, if the study of ethics results in moral improvement. After all, ethicists spend a great deal of their time analyzing ethical issues and generating new insights (Schwitzgebel 2009; Schwitzgebel and Rust 2009, 2010; Schwitzgebel et al. 2012). However, the hypothesized pre-eminence of the moral behavior of academic ethicists' is not substantiated by Schwitzgebel's findings. For instance, philosophers attending ethics sessions of philosophy conferences do not behave more courteously (in terms of avoiding door slamming, talking loudly during presentations, and leaving behind litter) than their colleagues attending other sessions, at least not at conferences of the American Philosophical Association (Schwitzgebel et al. 2012). Likewise, academic ethicists do not display better voting behavior than non-ethicist academics (Schwitzgebel and Rust 2010). Moreover, based on a study of the rates at which ethics and other philosophy library books are missing, it does seem that lenders of ethics books do not behave any better than readers interested in other sorts of philosophy books (Schwitzgebel 2009). Finally, the bulk of respondents at the Pacific Division meeting of the American Philosophical Association in 2007 confirmed that non-ethicist philosophers do not generally seem to behave any worse than their ethicist colleagues (Schwitzgebel and Rust 2009).

Schwitzgebel's research results seem in line with the idea that knowledge about ethics is not sufficient condition for moral behavior. If one were intent on defending Socrates at all costs one could of course argue that the academic ethicists in Schwitzgebel's studies, whose moral behavior turns out to be similar to that of academics from other fields, do apparently lack additional relevant knowledge about ethics. But this would be begging the question. In addition, it would be highly counterintuitive to hold that scholars who spend their academic careers studying and teaching ethics do not gain any more relevant understanding of ethics than those who do not. Finally, if one were to give up on the knowledge claim in addition to the claim of morally superior behavior, this would most certainly imply a coup de grâce for academic ethics.

Let us therefore posit—as common sense suggests—that academic ethicists do indeed have more insight into ethics but lack better behavior, at least in Schwitzgebel's test settings. Moreover, let us continue to understand knowledge as a necessary condition for moral behavior, but repudiate Socrates' claim that it is also a sufficient one. Based on these assumptions, Schwitzgebel's findings could perhaps be understood as follows. His test settings could be seen as simple situations, i.e. circumstances where it is relatively straightforward to determine what would be the right action (being polite, returning books, voting etc.). However, the specialized insights of academic ethicists might have no added advantage in these straightforward conditions where everybody effortlessly knows what is right and wrong. After all, it does not seem to be necessary to be an academic ethicist in order to distinguish right

from wrong in Schwitzgebel's test settings. In his studies doing what is right is not a matter of figuring it out intellectually in the first place. Instead, moral behavior under clear-cut conditions might rather hinge almost completely on moral motivation or strength of will. This trait, again, might very well be equally distributed amongst ethicists and non-ethicists, thus explaining the equal outcomes in moral behavior.

On the basis of this explanation, behavioral outcomes might change when focusing on behavior in non-routine or indisputably complicated situations. Here more advanced ethical insights might be necessary to disentangle all the morally relevant aspects in order to chart the right course of action. Hence it would be interesting to see further empirical studies focusing on intellectually more challenging test settings. Of course, these studies would have to deal with the added methodological difficulty that moral behavior in complex situations is less amenable to measurement and easy assessment.

All in all, the empirical study of the relationship between knowledge of ethics and moral behavior does still seem to be in an early stage of development. It is important to conduct more sophisticated studies focused on intellectually challenging test settings. The implications for the improvement of ethics education are obvious. If we wish to aim for moral improvement as an important behavioral outcome of ethics teaching, we need to know what kinds of additional knowledge are necessary for certain kinds of behavioral improvement. These insights would facilitate targeted improvements of existing ethics programs.

14.5.3 Aristotle

Aristotle clearly points out the limitations of education as a means to improve moral behavior. Intellectual arguments and teaching do only have a chance of being effective when a student has already been sufficiently cultivated by means of appropriate habits, "… like earth which is to nourish the seed" (Aristotle 1998, p. 270, X 9). This Aristotelian insight has at least two important implications with regard to the project of moral improvement through ethics education.

First, it should warn us against inflated expectations regarding the outcome of ethics education. The effectiveness of ethics teaching does not only depend on the person of the teacher or the teaching program but also on contextual factors, such as the upbringing of the students, existing regulatory frameworks and, more generally, the fabric of society (as these factors influence habituation). This means that the very same educational intervention might have a beneficial effect on moral improvement in a particularly favorable social context while lacking any significant result in another unpropitious setting. Also this has consequences for the assessment of outcomes of educational programs. It is important to regard educational interventions against the backdrop of their social context as the latter might substantially influence the way the program yields an impact on real-world behavior. For example, an ethics course about scientific integrity taught in an academic context, where the hidden curriculum is contrary to the standards imparted in the instruction, will yield

different results than the same course in another academic environment where the senior academics comply with the relevant normative standards already.

Second, when aiming for moral improvement we should not exclusively focus on moral education. Virtue and moral behavior should be developed and sustained by a combination of decent upbringing and suitable legislation. Not only do these contextual factors influence habituation. They might also force people who are not necessarily virtuous or open to arguments to abide by the rules through the threat of sanctions. It is important to realize that besides education there are alternative ways to steer behavior into ethically acceptable patterns.

Ethicists who are interested in improving the moral behavior of their fellow citizens through their professional activities might avail themselves of these alternative means. They might, for example, have an advisory role in the process of establishing new policies and regulatory frameworks on a wide range of subjects such as new technologies, end of life decisions, research, and so forth. In this way ethicists might sometimes—depending on the particular situation at hand—more effectively contribute to moral improvement of manners and conduct of their fellow citizens than through moral education alone.

14.5.4 Persson and Savulescu

Since these authors are our contemporaries they have the advantage of hindsight when looking back at the effects of ethics education and legislation on the improvement of human moral behavior over the last two and a half thousand years. Their retrospective assessment is rather downbeat: there is hardly any significant improvement of our moral dispositions and moral capabilities while the ethical challenges, especially those triggered by massive technological developments, have only grown larger. Therefore, we are morally deficient and unfit for the future, or so they argue. For the assessment of their position it is important to distinguish between their diagnosis of the problem and their proposal for a solution.

Diagnosis Their diagnosis involves a portrayal of our moral deficiencies in the face of an unfolding environmental crisis that could severely disrupt humanity in this century. At the time of the writing of this chapter one might be inclined to lend the authors some leeway in their pessimism as yet another climate change conference—the 18th, held in Doha—has just ended without any significant results. The heading of a *New Scientist* editorial poignantly summarizes the results: “Another Wasted Year” (Editorial 2012, p. 5).

The authors identify a “widening gap” (Persson and Savulescu 2012, p. 106) and a “big chasm” (Persson and Savulescu, p. 117) between our moral behavior and the present state of technology. Though this diagnosis might be intuitively convincing, it would need more profound analysis in order to capture precisely how this gap is to be understood. If two phenomena α and β have a common denominator it is quite easy to conceptualize a gap between them. For example, it is no problem to determine a widening gap between expenditure and revenues leading to a growing deficit

as both factors have the monetary unit as their common denominator. However, how should we conceptualize the gap between our moral and technical capabilities? Is there a common denominator at all, and if yes, what exactly is it? If there is no common denominator, are we not comparing two incompatible variables?

Furthermore, one wonders whether the authors' denial of significant progress in our moral capabilities and traits over the last few thousand years holds ground. Steven Pinker (2011), for example, presents a wealth of research data suggesting that many kinds of human violence have gone down over the course of history, both over long time stretches and more recent periods. He identifies five historical forces that have been pivotal in the reduction of violence: (1) the development of states monopolizing the legitimate exercise of violence, (2) the advance and expansion of commerce, (3) the empowerment of and increasing respect for women, (4) the advance of literature, literacy, mass media and mobility, and (5) the evolution of knowledge and rationality and their exercise in human affairs (Pinker 2011, pp. 680–692). If Pinker is right, it seems that changes in historical circumstances might indeed have had a significant impact on human moral behavior.

Another example of recent research that seems to contradict Persson and Savulescu's denial of moral improvement of human behavior in the last couple of millennia comes from Lynn Hunt (2007). In her book Hunt claims that epistolary novels were pivotal in creating a wider acceptance of the concept of natural rights in the eighteenth century. "New kinds of reading (and viewing and listening) created new individual experiences (empathy), which in turn made possible new social and political concepts (human rights)" (Hunt 2007, pp. 33–34). As examples of influential epistolary novels Hunt focuses on Samuel Richardson's *Pamela* (1740) and *Clarissa* (1747–1748), and Jean-Jacques Rousseau's *Julie ou la Nouvelle Héloïse* (1761). She regards these as "the three greatest novels of psychological identification of the eighteenth century" (Hunt 2007, p. 39). By reading the letters in these and similar novels, in which the protagonists expressed their inner thoughts and concerns, the readers could gain intimate familiarity with their personal predicament. In this way the epistolary genre boosted the emotional involvement of the readers and helped them sympathize with others across social and gender divides as they increasingly understood that all humans had a similar "inner core" (Hunt 2007, p. 48). As a result, readers of epistolary novels became more inclined and habituated to regard other human beings as equal to themselves. This again persuaded them to accept and promote the idea of unalienable rights inherent to being human (Hunt 2007, p. 58).

If Pinker and Hunt are right, human moral behavior and capabilities might very well have changed quite significantly over time—contrary to the analysis of Persson and Savulescu. If this were indeed the case, it would also mean that we might perhaps rise to the moral challenge of tackling climate change after all. Yet, even if we assume that favorable historic circumstances might indeed significantly improve human moral behavior, global warming and its dismal effects such as glacier retreats and disappearances, sea level rises, disappearing islands and freak weather events, will probably have to get a whole lot worse before the message is driven home and effective action taken. Besides, if history can significantly change

morality, it might also mean that our moral behavior can substantially deteriorate under detrimental historical circumstances. This seems to have happened during the abysmal ideological fiascos of the last century: Nazism, Stalinism, and Maoism, to name just a few recent examples. Thus accepting the claim of historic variability of human moral behavior is certainly no reason for complacency. Further historical, sociological and psychological research is needed to develop a clearer idea of the development and variability of human moral behavior over time and in different social contexts.

Solution Turning to their proposed solution to the problem of the widening gap between morality and technology Persson and Savulescu readily admit that moral bioenhancement is still an early stage idea and might perhaps never turn out to be feasible. Prima facie, their claim, that we should explore medical ways to enhance our core ethical dispositions, might not sound unreasonable. Why should we not explore the whole plethora of possible approaches to tackle the global warming crisis? However, it seems also somewhat paradoxical at first sight that the authors who identify an increasing gap between technology and morality as a problem seek a technological fix as the way out. The solution is not sought in a reduction of technology but rather in the further development and application of yet another novel technology that is again expected to boost morality. However, if we are already morally incapable to responsibly deal with the current level of technological sophistication, how can we be trusted with even more technology? After all, knowledge about the biological improvement of human moral behavior would probably also imply a better understanding about biological ways to steer moral behavior in undesirable directions. In addition, supposing targeted medical enhancement of human moral motivation or an effective increase of altruism and the sense of justice were technologically feasible—with acceptable side effects of course—even then it is difficult to imagine how these interventions might be essential in thwarting global warming. Why would people who are morally deficient to begin with ever be willing to submit themselves to any form of moral bioenhancement or let their children undergo it? A society of ethically defective individuals would perhaps be inclined to exploit persons with enhanced empathy and fairness. Why would parents decide to morally bio-enhance their children, if this does not seem to be in their interest in the first place? To begin with they would probably not be interested to participate in the clinical trials necessary to develop trustworthy and safe methods of moral bioenhancement.

Of course, Persson and Savulescu are not naïve about the problems to be tackled in order for moral bioenhancement to be successful. For example, they readily admit that it might be problematic to find enough people interested in undergoing moral bioenhancement and to avoid abuse of the new technology. They call this the "bootstrapping problem" (Persson and Savulescu 2012, pp. 2–3, 124). However, it will be difficult to get to the bottom of these problems and demonstrate that they can actually be adequately solved. If people are not interested in moral bioenhancement, should they undergo forced interventions? This scenario seems highly unlikely and difficult to justify from an ethical point of view. Supposing the problem of how

to get people to undergo moral bioenhancements would be solved in a particular country, how would such treatments on the level of individuals translate into better and more effectively tackling highly complex global ethical problems such as global warming? After all, many different countries are involved, each with their own different interests. In liberal democracies moral bioenhancement of a significant part of the population might perhaps yield electoral majorities in favor of morally better governmental policies. However, this would not work in authoritarian led countries. As long as these and similar questions are not further analyzed and effectively tackled, the suggestion—that moral bioenhancement should be developed and employed alongside the traditional methods of moral enhancement such as education and legislation—remains underdeveloped as a serious solution to the problem diagnosed.

For the time being therefore, instead of trying to combine ethics education with moral bioenhancement, it might be more fruitful to think of other ways to improve the effectiveness of ethics teaching. Most ethics education, for example, still seems to be dominated by an exclusive focus on theory, intellectual skills, and arguments. Based on the analyses of Pinker and Hunt, who both emphasize the importance of reading and literature, one might think of other, perhaps complimentary, methods of teaching that might involve ways of vividly demonstrating what it might feel like to encounter moral and especially immoral behavior. One could, for example, draw in resources from the humanities such as art, theatre, music, literature and movies in order to attempt to further the imagination and widen the radius of our empathy and sympathy. All in all, new and more sophisticated ways of ethics teaching should be developed. New approaches should be given a trial run. Finally, more refined ways of assessing these teaching programs and their effects on real world behavior are needed.

14.6 Conclusion

Never before has ethics education been more important than at present. The moral challenges of our time are daunting. Persson and Savulescu are right in claiming that technology has developed to such an extent that with its help human beings are able to wipe out all human life. Global challenges such as global warming do indeed pose grave dangers. However, their idea to use moral bioenhancement in order to boost motivational internalization, thereby making moral education more effective, is yet too immature to count as a compelling strategy. Hence, we will have to seek recourse to alternative approaches to help us face up to the challenges of our times.

Improvements of ethics teaching seem possible in the following areas: First and foremost, in order to contribute to addressing the current challenges, ethics education should step up and focus more systematically on moral improvement as an important goal. This is especially vital in teaching programs for non-philosophers. Within the range of the dominantly intellectual approaches to ethics education Socratic debate could be given more room. This approach forces participants to

confront their own lack of thorough understanding of the ethics of whatever it is they are engaged in, thereby facilitating deeper and more elaborate ethical reflection and the improvement of moral behavior. Socratic debates should be pursued with students and professionals alike.

Next to the intellectual approach to ethics teaching, alternative methods should be developed and employed, for example, methods using literature and theatre to inform the imagination and boost sympathy. More sophisticated research is needed to assess different methods of ethics instruction in terms of their effects on real-world behavior. Especially, studies focusing on intellectually challenging test settings are needed in order to learn more about the role of complex ethical insights as a help for moral behavior.

That being said, we should be mindful of Aristotle's take on the limits of ethics education as a means for moral improvement. Social policies and legislative frameworks should be improved simultaneously as they are important factors influencing human moral behavior. Further historical and social science research might shed more light on the ways in which social contexts shape moral traits and on the development of moral behavior over time. The results of this research might give us valuable means to more effectively improve our moral behavior by optimizing social conditions.

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Chapter 15
Challenges for Bioethics Education in Brazil: Adapting the Core Curriculum of UNESCO for Critical Practice

Volnei Garrafa, Natan Monsores and Cláudio Lorenzo

15.1 Introduction

Brazil is the largest country in Latin America and the fifth largest in the world in geographical area, with 8.5 million km^2. Its population of almost 200 million inhabitants forms a rich mixture: while the south, the most developed region, has a population of predominantly European origin, the population in the north is mainly indigenous, while the other regions (southeast, center-west, and northeast) have a mixture consisting mostly of Europeans, Africans, and Amerindians. Although Brazil's economy is now the sixth biggest economy in the world, with a GDP of approximately $ 3 trillion, the country still presents great social disparities. At the same time Brazil can boast of a prominent position in the world in relation to, for example, biofuel production, deep-water oil extraction, and advanced agricultural technology. These achievements exist alongside high rates of illiteracy (10 %), infant mortality (16 deaths for every 1000 live births), and absolute poverty (8 %).

Despite estimates indicating that 60 % of the population (around 120 million people) will be in the middle class 2 years from now, Brazil still has pockets of misery that are incompatible with the present level of economic development. In this respect, the healthcare sector continues to be rated poorly by the population, even though the country's constitution provides for a universal healthcare system (known by its acronym SUS—Sistema Único de Saúde—in Brazil) and assures that healthcare is a right that all individuals have and that the State has a Constitutional duty to furnish access to quality medical services.

The SUS has principles, established by the Brazilian Constitution, that guide largely Brazilian bioethical discussions: (a) Universality is the guaranteed health care right to every citizen, namely all citizens have the right of access to all health services; (b) Equity is the guaranteed right that every citizen is equal before SUS and will be attended in health services at any level of complexity of care, regardless

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of their place of residence, without privilege or barriers; (c) Completeness is the understanding that each human needs integral care and needs to be cared for by an integrated system to promote, protect, and restore health.

Some moral and cultural idiosyncrasies need to be considered in applying these principles in State decisions and academic research, which implies to admittance of autochthonous ethical thinking linked to regional aspects. In this way some concepts such as social justice, critical solidarity, historic pluralism, and cultural diversity are central to the design of health policies and guidelines for scientific development that attend to the needs of the Brazilian population. So, Brazilian bioethical thinking must have due regard for the protection of the people's interests through theoretical constructions that come from a *Brazilian ethos*, and that do not have an origin in other cultural contexts. The importation of some ethical theories, for example Beauchamp's and Childress' Principlism, (Beauchamp and Childress 2013) to substantiate discussions or decisions that do not give rise to an adequate discussion of local moral questions is problematic. For example, the principle of respect for autonomy, central in Principlism, is secondary if compared with principle of solidarity in Brazilian indigenous culture.

The SUS principles are the origin of bioethics thought in Brazil, and they are central to professional Brazilian education in health sciences. Despite the growth in field of bioethics, just 44 % of post-graduate courses have regular courses with workload averagesof 25 h. A principlist view of bioethics has been established, in our view, a mistaken perspective on this field of knowledge, focused on medical knowledge and not in public health, social, and environmental issues, which motivates our criticism (Figueiredo et al. 2008; Figueiredo 2011).

There are some systematic studies on the teaching of bioethics in undergraduate courses in Brazil (Gomes et al. 2006; Caramico et al. 2007; Musse et al. 2007; Pereira 2007; Vital-Santos 2007; Azevedo 1998; Dantas and Sousa 2008; Zaidhaft et al. 2009; Mascarenhas and Rosa 2010; Gomes 2010). These studies primarily focus on medical ethics, incorporating some elements of bioethics, but still maintain the deontological tradition. Particularly, at the University of Brasilia (UnB), our institution, we have been successful in offering lectures in bioethics for about 20 years. At UnB we discuss not only the ethical problems raised by the application of new biomedical technologies, but the greater range of bioethical themes, such as social, economic, and environmental challenges to the Brazilian population.

15.2 Public Healthcare in Brazil as a Study Reference Point

To discuss whether ethics education can be improved, the reference point taken for the present paper was the experience developed within the UNESCO Chair and Postgraduate Program in Bioethics (specialization, masters, and doctoral levels) of the University of Brasília (UnB), Brazil. The Bioethics Study and Research Group of UnB started in 1994 at Department of Public Health of the School of Health Sciences. It initially offered separate disciplines for different careers at the under-

graduate level. In 1998, the Group created the first Brazilian bioethics annual specialization course (375 classroom hours). In 2008, the activities were extended to masters and doctoral levels. Up to 2013, the postgraduate program has produced 360 graduates with a specialist title, 37 with a masters degree and 12 with a doctorate. The Bioethics Group has an annual enrollment of 30 students for the specialization course, 14 for the masters program (which can take up to 2 years to complete) and 8 for the doctoral program (which can take up to 4 years).

The postgraduate program is organized in three research lines with 10 research topics: (A): *Foundations on Bioethics and Public Health*: [(1) Epistemological basis on bioethics; (2) Applied Ethics; (3) Bioethics and pluralism; (4) Bioethics and Human Rights]; (B): *Emergent situations on Bioethics and Public Health*: [(5) Ethics and biotechnoscience; (6) Ethics in research; (7) Environmental ethics and animal rights]; (C): *Persistent situations on Bioethics and Public Health*: [(8) Bioethics and health care; (9) Clinical bioethics; (10) Social bioethics].

Starting from the stimulating but contradictory national panorama (the coexistence in SUS between scarcity of health resources and advanced technologies such as stem cell therapies), the Bioethics Group of UnB has placed its academic focus especially on persistent topics relating to the population's health and quality of life. It has participated in organizing the majority of the national congresses that have been held every 2 years in Brazil since 1996, always covering health and social topics. Among these, in 2002, the Fourth Brazilian Congress of Bioethics was held concurrently with the Sixth World Congress of Bioethics, which was promoted in partnership with the International Association of Bioethics (IAB). This brought together 1400 researchers from 62 countries, in Brasília, the capital of Brazil, under the central theme of Bioethics, Power, and Injustice.

More recently, the Ninth Brazilian Congress of Bioethics, also in Brasília, which was held in 2011 with participation from 900 congress attendees and invited speakers from 21 countries, discussed and updated the same central theme that had been covered in 2002. This focus is what has led the Bioethics Group of UnB to campaign, along with other countries in Latin America, for the inclusion of health and social issues (in addition to environmental issues) within the context of UNESCO's Universal Declaration on Bioethics and Human Rights, which was adopted by acclamation in 2005 (UNESCO 2005).

15.3 UNESCO's Universal Declaration on Bioethics and Human Rights, the Core Curriculum and Its Contextualization as the Basis for Improvement of Bioethics Education

In 2008, the UNESCO's Universal Declaration on Bioethics and Human Rights gave rise to a curricular proposal called the Bioethics Core Curriculum, which was organized by UNESCO's Division of Ethics of Science and Technology (UNESCO 2008). This proposal has become a central reference point for research, courses,

and academic disciplines offered by UnB. The pedagogical policy reference framework of our institution involves critical incorporation of knowledge that has been produced internationally, but only after it has been rigorously placed within the context of Brazilian sociocultural realities. For a transcultural view, we use some local examples in classroom, and we encourage the students to create some cases to exemplifying different chapters of the Core Curriculum.

We work along two lines of action to achieve our goal. The first of these lines consists in an offer of two introductory classes in the masters and doctoral programs: Foundations of Bioethics and Conceptual Basis of Bioethics. Within these, seminars are developed with participation by students and professors, with the aim of delving into each of the 15 principles and adapting them to the concrete realities of this country. The final product from this process will result in a book (in press), with individual chapters dedicated to the Brazilian interpretation of the principles of the Declaration.

The second of these lines of action consists of applying the above mentioned content, in a programmed manner, to the undergraduate disciplines that are offered to students from the School of Health Sciences on a regular basis, as part of the training for professional careers in medicine, dentistry, nursing, nutrition, pharmacy, and healthcare management. In addition, there is another discipline called Introduction to Bioethics, which is a mandatory field of training for doctoral students. The general outcome from this process, based on a significant number of academic published papers, has been that epistemological foundations for bioethics that restore respect for the cultural diversity existing in this country have been constructed with adaptation of the different issues involved to national realities.

15.4 The Transcultural Conceptual Basis for Constructing Course Content

Brazilian culture has basically been shaped by its Portuguese and therefore Latin origins, with influences from African, indigenous, and other European cultures. Common topics within bioethics such as autonomy, beneficence, justice, non-discrimination and non-stigmatization, solidarity or cooperation, among others, have meanings in Brazil that differ from what is understood in North America, Europe, or Asia. For example, the communitarian element in the Brazilian territory have much higher specific weight. Autonomy, for example, tends to be a weaker principle in contexts of poor communities or traditional peoples, as the *quilombola* (descendants of African slaves). In these places solidarity tends to be prioritized, because it establishes cooperative relationships that ensure survival.

Starting from these observations, the Postgraduate Program in Bioethics of the UnB has been gradually increasing the quantity of socio-anthropological material within its different curricular activities, projects, and discussions. Controversial topics such as ethical universalism versus historical pluralism, or autonomy (Beauchamp and Childress 2013) versus empowerment (according to the ideas of the

Indian economist Amartya Sen) (Sen 1999) or even liberation (according to the Brazilian educator Paulo Freire) (Freire 2002), for example, have started to be worked on from the viewpoint of interculturality, which is a form of dialogue between different cultures with mutual respect (Garrafa 2005). Freire, under the influence of socialist thinking, advocated education as a practice of freedom and an essential feature in the development of critical consciousness. Two quotes demonstrate the importance of this Brazilian thinker for Brazilian bioethics. The first, from the book *Pedagogy of Autonomy* (2002):

> Respect for the autonomy and dignity of each person is an ethical imperative and not a favor that we may or may not grant each other. (…) in this sense the true dialogicity, in which subjects learn and grow in dialogic difference, especially in respect for difference, is the way of to be consistently required by beings who, unfinished, assuming as such, become radically ethical. It must be made clear that the transgression of ethics can never be seen as a virtue, but as a break with decency. What I mean is this: someone to become sexist, racist, classist, what not, but if you take a transgressor of human nature. Do not give me genetic or sociological or historical or philosophical excuses to explain the superiority of whiteness over blackness, of men over women, of employers over employees. Any discrimination is immoral and fighting it is a must to recognize the power of conditioning to face.[1]

Another text fragment, from *Pedagogy of the Oppressed* (Freire 1987), highlights the motivations for the development of educational practices in bioethics that are contextualized to the Brazilian reality:

> The pedagogy has to be forged with him (the oppressed) and not for him, as men or people in the constant struggle to regain their humanity. Pedagogy that makes oppression and its causes an object of reflection to the oppressed, which will result in a necessary engagement in the struggle for liberation, in which this pedagogy will be made and remade.[2]

This thinking has originated a variety of studies about the different ways in which moral imperialism is wielded and is exported directly and uncritically from the more developed countries to the peripheral poor countries (Garrafa and Porto 2003; Garrafa and Lorenzo 2008). In the field of applied ethics, these concepts have a direct relationship with presumably ethical proposals for international multicenter clinical studies developed in poorer countries by transnational drug companies. For

[1] "O respeito à autonomia e à dignidade de cada um é um imperativo ético e não um favor que podemos ou não conceder uns aos outros. (…) É nesse sentido também que a dialogicidade verdadeira, em que os sujeitos dialógicos aprendem e crescem na diferença, sobretudo, no respeito a ela, é a forma de estar sendo coerentemente exigida por seres que, inacabados, assumindo-se como tais, se tornam radicalmente éticos. É preciso deixar claro que a transgressão da eticidade jamais pode ser vista como virtude, mas como ruptura com a decência. O que quero dizer é o seguinte: que alguém se torne machista, racista, classista, sei lá o quê, mas se assuma como transgressor da natureza humana. Não me venha com justificativas genéticas, sociológicas ou históricas ou filosóficas para explicar a superioridade da branquitude sobre a negritude, dos homens sobre as mulheres, dos patrões sobre os empregados. Qualquer discriminação é imoral e lutar contra ela é um dever por mais que se reconheça a força dos condicionamentos a enfrentar."

[2] "A pedagogia tem de ser forjada com ele (o oprimido) e não para ele, enquanto homens ou povos, na luta incessante de recuperação de sua humanidade. Pedagogia que faça da opressão e de suas causas objeto da reflexão dos oprimidos, de que resultará o seu engajamento necessário na luta por sua libertação, em que esta pedagogia se fará e refará."

example, that trials cover conditions and diseases of little epidemiological significance in the countries where they are conducted, using methods that would not be ethically acceptable in the countries sponsoring these projects: the so-called double standard of clinical research (Garrafa et al. 2010).

Starting from this theoretical-practical reference framework, and also on the basis of Latin American studies relating to the concept of coloniality (developed by scholars such as Aníbal Quijano from Peru (Quijano 1992); Enrique Dussel (Dussel 1993) and Valter Mignolo (Mignolo 2003) from Argentina; and Rita Segato (Segato 2012) from Brazil), the principles listed in UNESCO's Declaration started to be revised with the aim of reaching moral interpretations that were more appropriate to Brazilian realities and in consonance with Brazilian society's values and the population's habits and customs (Nascimento and Garrafa 2011). According to Quijano, coloniality can be understood as a regime of power that some countries or peoples exert over others, based on idea of development, thereby imposing economic, political, moral, and epistemological patterns not only in order to establish mechanisms for expansion of the developed nation-states, but also especially to propagate their own cultural identity (Quijano 2000). From the criticism in these ideas, an expressive thinking from the South emerged. This implies entering into a dialogue with concepts produced in the North, but with attention to the risk of becoming subordinated to such concepts, and thus it implies seeking to have a horizontal dialogue of knowledge, that is, a dialogue in which all are equal (Santos and Meneses 2009).

Based on this work proposal, we are adapting all modules and principles that originally formed part of UNESCO's Universal Declaration on Bioethics and Human Rights and incorporated in the Bioethics Core Curriculum that were reviewed in the light of the Brazilian cultural context, with some adjustments and local examples, as described before. This is an ongoing process and all adjustments are being worked out in our research group. This will result in the publication of a textbook for the guidance of Brazilian teachers and students who approach discussions of bioethics.

To give an example of the difficulty in establishing theoretical concepts from the different cultural inferences that exist around the world, one only has to recall that at the time of the discussion about the definition of bioethics that should appear as Article 1 of the Universal Declaration on Bioethics, the countries that were participating were unable to come to a conclusion, and it was decided simply to omit the definition from the document. This historical fact illustrates the difficulty in establishing universal ethical consensuses and reinforces the premise that there is no single form of bioethics but a plurality, which starts from the reference point of respect for transculturality (transcultural dialogue) that is advocated here.

Another problematic situation—an example that refers to Article 12 of the Declaration (Respect for cultural diversity and pluralism)—is the discussion about the practice of infanticide in indigenous communities in Brazil, an example taken from a study conducted in the UNESCO Cathedra of Bioethics of the UnB (Feitosa et al. 2010), involving two children of the Zuruahá people. Our students are stimulated to identify the ethical problems and moral dilemmas relating to differences in the cultural comprehension of to live and to die. Also they are encouraged to discuss the possibilities of an intervention in traditional practices of infanticide and other

ethical alternatives, like the dialogue between individuals or groups with different moralities. These are just examples of the challenges we have faced in establishing a native reflection, guided by the principles discussed in the Universal Declaration.

15.5 Final Remarks

Although the Bioethics Core Curriculum proposed by UNESCO for international use maintains its originality, it has received a different and transcultural focus in Brazil as a result of the experience reported above. The genuine content of the universal ethical principles proposed was duly adapted to the cultural plurality that exists in Brazil. Exhaustive sessions of academic discussion that were developed within two basic disciplines of the Postgraduate Program in Bioethics of the University of Brasília, involving both professors and students, took into consideration the yearnings of the nations in the Southern Hemisphere of the world to construct their own forms of epistemology (Nascimento and Garrafa 2011; Santos and Meneses 2009). In other words, to show that is possible for peripheral countries to view the moral problems within their own societies, through their own eyes, and not through foreign eyes, and also to think out their ethical conflicts with their own minds and not with minds from elsewhere, no matter how capable and well-intentioned these might be.

This does not consist of reinventing the wheel or refuting important knowledge coming from other nations that historically had greater experience, but consists of using such knowledge critically, with proper filters, so as to adjust it to local realities. As the poet Thiago de Mello (Mello 2012) who was born in the Brazilian Amazon region, put it: "I don't have a new path; what I have that's new is the way of walking along it."

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Chapter 16
Movements and Movies in Bioethics: The Use of Theatre and Cinema in Teaching Bioethics

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"Fiction is fact distorted into truth"
(Edward Albee)

"To be fully successful as arguments, arguments must be such as to change the heart"
(M.C. Nussbaum).

16.1 Introduction

Why did Plato write dialogues? This question is a recurrent theme among Plato scholars past and present. Historically speaking, however, the question is a very naïve one since the dialogue form Plato used in his philosophical writings was the *form norm* of his day. That is, Plato lived in a culture where poets and their texts—epic, lyric, tragic, and comic poetry—where considered the most prominent teachers and sources of ethical wisdom. Besides, the kind of philosophical prose we are familiar with and take for granted as the paradigmatic form of text for ethical argumentation and reasoning was at the time of Plato still practically non-existing (Nussbaum 1986, pp. 123–124).

This chapter represents in some sense a blue print of Plato's own project, namely to *move* students morally through the use of a medium that displays moral discourse as something taking place not between fixed arguments set up according to the logic of syllogism, but as a discourse going on between living human beings and which engages us on all levels, i.e. intellectually, aesthetically, emotionally as well as somatically.

Plato took his inspiration from the ancient Greek theatre, the forum to which the citizens of Athens went when they wanted to watch moral conflicts displayed in vivo. In this chapter attention will not only be paid to the different forms of moral dialogue displayed in Plato's dialogues and in the ancient Greek theatre but also to the kind of forum most people visit today when they want to experience and be

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moved by lived morality (i.e. to the cinema). The chapter title aims to capture this ambition.

Since its very origins, cinema has promoted awareness of ethical problems as problems that not only affect the minds of people, but they engage their appetites, beliefs, emotions, and desires as well. Thus, through the cinematic medium ethics emerges as a discipline genuinely and profoundly entangled in the human affairs of this world. With the expansion of the film industry, this way of representing moral conflicts has reached wider audiences and promoted interesting discussions inside and outside the academic world. With the creation of digital technology, many people are participating in a renewed wave of cinematographic passion. The ability to film and project in high quality at low cost, along with the ability to access wide size screens and sophisticated audio systems have extended the cinematic experience far beyond commercial theatres. During the last 15 years many publications on bioethics and cinema have seen the day, including books, articles, websites, and even refereed journals of regular occurrence, something which indicates a growing interest in exploring the didactic potentials of using movies in teaching bioethics. (Michel Fariña and Gutiérrez 1999; Muñoz and Gracia 2006; Shapshay 2009; Blasco 2011; Colt et al. 2011; Dvoskin 2011; Michel Fariña and Solbakk 2012).[1]

Ethical problems are displayed in cinema productions in at least two ways. On the one hand, movies explicitly present contemporary ethical dilemmas. On the other hand, audiences and critics often find in movies the opportunity to discuss ethical issues that the movie-makers did not intend to present, often surprising the makers themselves. In both instances, the result is an extraordinary experience of thought and real or potential action.

While there is widespread agreement on the didactic potentials in using visual and audiovisual resources in teaching bioethics, no systematic studies on the methodological challenges pertaining to using such sources have been undertaken so far. This chapter seeks to investigate not only the didactic effects of visual and audiovisual representations of moral conflicts—as displayed in the ancient Greek theatre and in movies—but also to introduce a concept that may help us to make moral sense of these effects and to propose a methodological framework to systematically make use of such poetic sources in ethics teaching.

16.2 The Concept of Catharsis

We shall start by recalling the envisaged concept as it occurs in Plato's dialogues and in the *Poetics* of Aristotle (Aristotle 1984) the concept of *catharsis*—a concept which I believe captures in a very precise way the effect we aim at when teaching ethics to our students. In the dialogue the *Sophist*, Plato uses the medical model of

[1] http://www.teachingbioethics.org/english/index.php?option=com_content&view=article&id=18&Itemid=21.

a physician ridding his patient of internal obstacles before the latter may be able to benefit from treatment, to underline that a kind of cathartic treatment is needed before the soul can have any hope of benefiting from moral or other forms of learning (230c3–d3). When reading the quote introducing the concept of *catharsis* and cathartic treatment, four things should be kept in mind. For a first, the use of the physician-patient relationship as an analogy to capture the relation between the philosopher and his dialogue partner(s), does not imply that the philosopher should be thought of as the physician in this relationship. Secondly, the dialogue partner(s) should not be conceived of in analogy with a patient. Third, the only true physician in this relation is the dialogue going on between the philosopher and his dialogue partner(s). In other words, in a genuine dialogue about moral issues all parties involved become to some extent patients, since they all will undergo some sort of cathartic treatment. Fourth and last, but not the least, in such a relation the philosopher may play the role of a drug (a *pharmakon*) in the dialogue partner's attempt at coming to term with his own morality. Now to the quote itself:

> For as the physician considers that the body will receive no benefit from taking food until the internal obstacles have been removed, so the purifier of the soul is conscious that his patient will receive no benefit from the application of knowledge until he is refuted, and from refutation learns modesty; he must be purged of his prejudices first and made to think that he knows only what he knows, and no more.[2]

This quote and the observations made in relation to it raise the question whether, eventually to what extent, and in what forms and formats cathartic treatment can still be viewed as a necessary preliminary to moral learning. An answer to this question will be pursued through a systematic investigation of the use of the concept of *catharsis* in Plato's dialogues the *Charmides* and the *Sophist* and in the *Poetics* of Aristotle.

The notion of *catharsis*—belongs to a family of words (*catharos, catharsis, catharmos*)—that were in use in Greek antiquity in many different contexts in the sense of *cleaning up* or *clearing away* obstacles (Nussbaum 1992, pp. 280–281). The fact that both Plato and Aristotle in their writings on ethics and poetry make use of this notion, notably in this particular sense of *purification* or *clearing away*, makes it all the more interesting to try to find out what kind of clarification and purification they actually had in mind.

In the first section, the focus of attention will be on Plato's conception of cathartic treatment and moral regimen developed in the *Sophist* and the *Charmides*. In a second part, the notions of *tragic* and *comic catharsis* in Aristotle's *Poetics* will be the subject of similar attention. From a reconstructive synthesis of Plato's and Aristotle's competing conceptions, I shall then propose a notion of catharsis—*tempered catharsis*—that may be of help in identifying bits and parts of theatre plays, movies, and other forms of fiction for use in ethics teaching. Finally, the chapter proposes a methodological framework to be used when analyzing the didactic effects of such sources in teaching bioethics.

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[2] Translation is from Plato, edited by E. Hamilton and H. Cairns (1989). *The dialogues of Plato. Euthypro. Apology. Crito. Meno. Gorgias. Menexenus*. London: Yale University Press. All subsequent quotations from Plato's writings are from this edition.

16.2.1 A Platonic Account of Catharsis

In Plato's dialogue the *Sophist*, *catharsis* is introduced as a normative method or procedure of discernment or cleansing, whereby the *better* or *good* part of the object undergoing treatment becomes separated and removed from what is *worse* or *inferior* (226d4–8; 227d5–6). In the further substantiation of this method, Plato (through the voice of Theaetetus) draws a distinction between two types of cleansing or purification, "one of them is concerned with the soul and…there is another which is concerned with the body" (227c7–9). In relation to bodies, Plato's main speaker in the dialogue, the Eleatic Visitor, continues the discussion by distinguishing between living and non-living bodies and by exemplifying different kinds of cleansing of bodies:

- cleansing of the inside part of living bodies (with the aid of medicine and gymnastics),
- cleansing of the insignificant outside part of living bodies (with the aid of bathing), and finally
- cleansing of non-living bodies.

As for the soul, Plato (again through the voice of Theaetetus) envisages two possible kinds of badness or deficiency (*kakias*) that may require cathartic treatment: Wickedness (*ponêria*)—examples mentioned are cowardice, intemperance, and injustice (228e1–5); and ignorance (*agnoia*), which is considered a sort of disproportion or ugliness (*aischos*, 228e1–5). Of ignorance, the Eleatic Visitor continues, there are two sorts which may affect the soul:

- *techne-based ignorance*, which Theaetetus argues can be removed from the soul by the teaching of handicraft arts *(dêmiourgikas didaskalias),* and more important
- *active or willful ignorance*, i.e. "when a person supposes that he knows, and does not know" (229c4–5).

The cathartic procedure prescribed for the second and morally most relevant kind of ignorance is the *elenchus*, i.e. the "moral methodology of testing people and their pretended knowledge and avowed moral principles" (Brickhouse and Smith 1996, p. 139). From the further discussion between the Eleatic Visitor and Theaetetus, it becomes clear that the ensuing function of this procedure is to inflict *negative* learning, through the painful process of uncovering and doing away with inconsistent or unfounded beliefs and of bringing to the fore unacknowledged forms of ignorance held by the person undergoing the cross-examination (*Sophist*, 230b1–c2). The *elenchus* is, however, not meant to be used only to eradicate inconsistencies of a *theoretical* nature in a person's beliefs, opinions, and thoughts. Often such inconsistencies are only symptomatic, in the sense that they may indicate the presence of deeper and more fundamental forms of incoherence in a person's life. More appropriate, therefore, is to say that the *elenchus* has a *critical* as well as a *therapeutic* function: It purges the soul of internal obstacles that risk interfering with learning

(*Sophist*, 231e3–5), and in this way, it renders the dialogue partners to go through the cure of moral learning as well as other forms of learning. For these reasons Plato also makes Theaetetus draw the conclusion in the *Sophist* that the *elenchus* represents the foremost method of cleansing of the soul (*Sophist*, 230d6–7).

16.2.1.1 Plato's Conception of Cathartic Treatment and Holistic Therapy

It remains to clarify what kind of moral cure or philosophical therapy Plato envisaged should follow the elenctic cleansing of the soul. A fascinating, but at the same time puzzling attempt at prescribing such a therapy is found in one of his earlier dialogues, the *Charmides*. The dialogue revolves around three apparently disparate themes: the ethical virtue of temperance (*sôphrosynê*), headache, and a new conception of medicine. The men forming the physician-patient duo are Socrates and Charmides. Socrates acts as a kind of physician, pretending to know a cure for headache, from which Charmides suffers in the mornings. Socrates offers a treatment consisting of a remedy (*pharmakon*)—a leaf—together with a verbal charm or incantation (*epôdê*). Socrates stresses that the charm must be used simultaneously with the medical remedy since, used independently, the remedy will impart no medical benefit.

Socrates claims to have learned the treatment while on military campaign from a Thracian physician, a follower of the doctrines of the deified king Zalmoxis. In order to explain the effect of the treatment he reminds Charmides that good physicians (*iatroi agathoi*), later identified in the dialogue with Greek physicians, always treat specific organs through treatment of the whole body by means of a suitable regimen. The Zalmoxian therapy of the charm also follows this principle of treating the whole and the part together. But the Zalmoxian physician seems to carry this principle beyond the framework of Greek medicine by expanding the conception of the whole (*Charmides*, 156d6–157a3).

Compared to the kind of medicine practiced by physicians contemporary to Plato, the therapy of the charm seems to represent a new approach to understanding and dealing with bodily health and disease in at least two ways. First, the reconceptualization of the whole to include not only the body but also the soul of the sick, broadens the scope of the physician's medical responsibility: the physician's main concern and responsibility becomes not simply the health of the body or the soul, but the health of the *whole* patient. Consequently, the Zalmoxian physician also warns against anybody attempting to treat bodily health and moral virtue in isolation from each other. Second, the idea that every disease originates in the realm of the soul seems to imply that medical treatment of all diseases, including those which seem to be present in the body alone, must begin as a certain kind of *therapeia tes psychês*: a *moral* cure of the soul.

In the secondary literature this conception of medicine has been interpreted in various ways: as pure irony directed against Greek medicine (Vegetti 1966); as an authentic form of medicine (Laín Entralgo 1958, 1970; Friedländer 1964) and finally, as the Socratic-Platonic ideal of what medicine should strive to be (Lichtenstädt

1826; Schumacher 1963). The problem with these interpretations, however, is that they do not take into account what happens with the proposed therapy of the charm, with which the dialogue opens. As the discussion between Socrates and Charmides' companion, Critias, develops into an investigation of what *sôphrosynê* is and six different definitions of this virtue are proposed and scrutinized only to be rejected, notably through the use of the procedure identified in the *Sophist* as the foremost method of *catharsis*—the *elenchus*—it becomes evident that the Zalmoxian therapy introduced at the outset of the dialogue should not be considered a new and authentic form of *medicine*. It is rather a pseudo-medical conception resulting from Plato's philosophical transposition of the good Greek physicians' holistic art of bodily good and evil over to the realm of the soul in order to serve as a conceptual framework in his attempt at developing a general *têchne* of good and evil, i.e. a *therapeia tês psychês*—a *moral* cure or therapy for the soul.

16.2.1.2 The Didactic Potentials of Cathartic Treatment and Holistic Therapy

To what extent can Plato's conception of cathartic treatment and holistic cure shed light on the questions about teaching and learning of (bio)ethics formulated at the outset of this chapter? As to the first question, Plato's way of conceptualizing the process of moral discourse and learning supports the view that it is a process not confined to the *rational* parts of the soul only; it engages appetites, beliefs, emotions, and desires as well. Thus, moral learning emerges as a process not only targeting theoretical inconsistencies in a person's moral beliefs, opinions, and thoughts; it also aims at unveiling more fundamental forms of moral imbalance and disorder in need of treatment. From these observations several implications as to the way teachers of bioethics should conceive of themselves and didactically treat their students may be drawn. First, they should not think of themselves merely as providers of moral-theoretical knowledge; they are endowed with a role as cathartic and therapeutic agents in relation to the students' attempts at coming to terms with the different forms of disorder or imbalance (*ametria*)—intellectual, emotional, belief-based—hampering their moral lives. Furthermore, they should treat their students not merely as ignorant and passive receivers of moral knowledge, but as individuals in possession of their own moral beliefs, opinions, and thoughts and who strive to live full-fledged moral lives. Finally, recognizing cross-examination as the foremost method of cleansing moral disease and disorder, and as a (self-)recruiting device in need of moral treatment, makes clear that the teacher should not envisage herself to be the doctor providing the cure nor should she think of the student to be that doctor. Instead, she should rely on the moral dialogue taking place *between* herself and the student to be the real provider of that cure. Consequently, she should look upon herself as a cleansing and therapeutic agent or remedy—a *pharmakon*—in the hands of the only true doctor of morality: the dialogue.

16.2.1.3 How Ethics Teachers Today May Make Use of the Paideia-Gogics of Moral Dialogue

This last statement represents an invitation to review the dialogue-form employed by Plato in somewhat more detail and try to assess its didactic potential in practical teaching. Its first asset is that it "preserves the form of living speech" (Cushman (1958) 2002, p. xvii). Second, it brings drama and vivacity into the text by displaying the exchange of arguments between characters holding diametrically opposed views on fundamental issues (Roochnik 1990, p. xii, and pp. 141–142; Kuhn 1941, p. 9). Consequently, the reader is exposed to a discussion evolving at a particular time and place between a multiplicity of voices, rather than to "…a monological argument, about a single specified object" (Roochnik 1990, p. xii). But the characters are not simply depicted as mind-puppets in a "crystalline theatre of the intellect", as might be inferred from Nussbaum's Aristotelian (mis)reading (Nussbaum 1986, p. 133); on the contrary, they stand out as utterly humane, as *whole* personalities of body, heart, and soul. Thus, the dynamics of real communication is clearly portrayed in the dialogue, and by means of it ethics emerges as a discipline genuinely and profoundly entangled in the human affairs of *this* world.

Another characteristic of the literary form of dialogue is that it invites the reader to be critically engaged in the debates and controversies that take place in the text (Sayre 1992, p. 235). The participating spectators, however, are not forced to sympathize with one particular voice; on the contrary, they are free to listen actively and carefully to the different voices as they express themselves in the drama and to see where their own beliefs and convictions fit in (Nussbaum 1986, pp. 126–127; Moes 2000, p. 26). Furthermore, as the dialogue links the different views and positions to characters of flesh and blood, it displays possible connections between belief and *lived* morality and brings us to see how moral development and moral learning might take place and materialize (Nussbaum 1986, pp. 127–128).

When making moral use of bits and parts of a theatre play or of a movie I believe it might be of crucial importance to keep in mind the didactic assets of the dialogue form so artistically demonstrated by Plato, if not such use may promote emotional chaos instead of *moral catharsis* in the students. For *this* reason I also believe that a combination of Plato's dialogical insights into the conception of catharsis and Aristotle's poetic insights into the same concept may be of help in developing a *tempered* conception of catharsis, i.e. a conception that insists on evoking in the audience only some sorts of emotions, *not any emotion*.

16.3 Aristotle's Poetic Conception of Catharsis

In doing this I suggest to limiting the investigation to the *Poetics*. There are three reasons for narrowing the scope to the *Poetics*. First, there are reasons to believe that Aristotle's conception of poetic *catharsis* represents "…some sort of response to Plato" (Nussbaum 1992, p. 281). Second, in his definition of tragedy in the *Po-*

etics, Aristotle makes a controversial connection between *catharsis* and the emotions of pity (*eleos*) and fear (*phobos*). Third, there are reasons to believe that an investigation of the emotional potential of Aristotle's poetic conception of *catharsis* may lead to a more accurate diagnostics of the particular didactic challenges involved when training students to cope morally with complex or *tragic* situations of decision-making. These are situations where one is forced to make decisions with potentially disastrous consequences for one or several of the parties involved, while at the same time one is faced with the fact that the possibility of *abstaining* from making a choice or of making a choice not contaminated with some sort of error or guilt (*hamartia*) is non-existent.

My claim is that main stream lecturers in bioethics mainly focus their attention on *instrumental* issues in their teaching, i.e. on conceptual clarifications and purifications, on methodological case study analyses and on rational strategies and theories for resolving moral dilemmas, while neglecting the *cathartic* role that pity, fear, and other painful emotions, such as e.g. anger and embarrassment may play in the process of moral discourse and learning. In this way I also hope to show that the possibilities of developing a *therapeutic* conception of ethics teaching and learning demonstrated in the previous part may be strengthened through the hermeneutics of the Aristotelian conceptions of tragic and comic catharsis.

There is probably no passage in Greek literature more famous than the ten words of the *Poetics* where the notion of catharsis is dramatically depicted as interrelated with the painful emotions of pity (*eleos*) and fear or terror *(phobos)*. The passage which throughout the centuries has given rise to such "a deluge of works" (German: "Flut von Schriften", Gudeman 1934, p. 167), reads as follows (Aristotle, *Poetics* 49b23–31):

> Tragedy is a representation of a serious, complete action which has magnitude, in embellished speech, with each of its elements [used] separately in the [various] parts [of the play]; [represented] by people acting and not by narration; accomplishing by means of pity and terror the catharsis of such emotions. By 'embellished speech', I mean that which has rhythm and melody, i.e. song; by 'with its elements separately', I mean that some [parts of] are accomplished only by means of spoken verses, and others again by means of song.

In the secondary literature no substantial consensus has been reached as regards the exact meaning Aristotle attributes to *catharsis* in his definition. On the contrary, a whole range of seemingly disparate interpretations have been suggested. In the secondary literature it is possible to distinguish between at least six different groups of interpretations:

- *medical* interpretations and interpretations of catharsis as a natural process of *discharge/release* or *outlet* of emotions,
- catharsis conceived of as emotional and intellectual *clarification*,
- *moral* interpretations, including interpretations of catharsis as an *education* of the emotions,
- catharsis conceived of as the experience of emotional *relief*,
- *aesthetic* interpretations or interpretations of a *dramatic* or *structural* nature, and finally
- complex or *holistic* interpretations of catharsis.

I nourish no ambition of being able to settle the old controversy and determine which of the interpretations of catharsis mentioned best complies with Aristotle's definition of tragedy. My aim is of a rather different and more modest nature: to investigate the didactic potential of each interpretation in illuminating the process of moral discourse and learning. In other words, what I hope to achieve is to demonstrate how the different interpretations of the notion of tragic catharsis may be used to uncover and substantiate the variety of forms of *clarification* and *cleansing* involved in the process of moral discourse and learning. In doing this, I also hope to make clear why *tragic* narratives should be considered as the most prominent teachers and sources of ethical wisdom.

16.3.1 Different Interpretations of Tragic Catharsis in the Poetics

We shall now take a closer look at the six different groups of interpretations of *catharsis* indicated in the bullet points above, starting with the different medical interpretations suggested in the literature.

16.3.1.1 Medical Interpretations

One of the most medically minded interpretations of tragic catharsis was launched by J. Bernays, an uncle by marriage of Sigmund Freud. In an influential essay published in 1857 Bernays advances the argument that attending a tragic play may have a direct therapeutic effect on the spectator, in the sense that it may clear and alleviate him from build-ups of undesirable emotions of pity and terror. Bernays draws support for his "pathological standpoint" (German: 'patologischer Gesichtspunkt') from *Politics* VIII 7.1342a4–16 (Bernays 1857, 1979, p. 158). In this passage, Aristotle explains the meaning and role of catharsis in relation to pity and terror by making a comparison with the psychological healing process, which people affected by hysterical outbreaks of emotion (*enthousiasmos*) undergo when cathartic songs are used as therapeutic devices. Bernays takes this comparison to mean that Aristotle conceived of tragic catharsis as a therapeutic device in the treatment of pathological emotions (Bernays 1857, 1979, pp. 159–160).

The main problem with Bernays' psychopathological interpretation is that it makes of the ancient Greek theatre a *medical* theatre, i.e. a forum to which emotionally unbalanced spectators can turn in order to have their build-ups of undesirable emotions of pity and terror aroused and thereby cleared away. Consequently, tragic catharsis emerges as something reserved for emotional lunatics rather than for spectators with a healthy *psychê*.

An alternative approach to the catharsis clause in *Politics* VIII 7.1342a4–16 and consequently to Aristotle's definition of tragedy in *Poetics* 1349b25–30, which appears to do justice to the medical allusions without turning tragic catharsis into a

therapeutic device reserved for emotionally unbalanced people, has been suggested by H. Flashar (Flashar 1956). His alternative is to unravel the medical basis of Aristotle's understanding of pity and terror operative in both clauses. Flashar finds that in prevalent pre-Aristotelian views of the effect of poetry (in particular those of Gorgias and Plato), pity and terror are always associated with a set of *somatic* symptoms: terror (*phobos*), with cold shiverings, tremblings, quiverings of the heart and raising of the hair; pity (*êleos*), with weeping and tears in the eyes.

The implications of this alternative interpretation is not an understanding of *catharsis* wholly different from that advocated by Bernays: What this alternative approach reveals is the abundance of medical conceptions and forms of explanation in the core of Aristotle's *general* theory of emotions. Consequently, tragic catharsis continues to mean *clearing away*, though not any longer in the sense of "emotional *pathology*" (Bernays 1857, 1979, p. 159), but in the *psycho-somatic* sense informed by Aristotle's general theory of emotions, i.e. of a *normal* process of discharge of the emotions.

16.3.1.2 Tragic Catharsis as Emotional and Intellectual Clarification

One of the first scholars to suggest that tragic catharsis means emotional and intellectual clarification was L.A. Post. His translation of the catharsis clause reads as follows: "Tragedy produces its clarifying effect by bringing to bear on the mind imaginary scenes of grief and terror, thus freeing it from preoccupation with similar emotions of its own" (Post 1951, p. 267). L. Golden, the most outspoken representative of a cognitive interpretation of tragic catharsis, argues that this is the reading that best complies with the general line of argument in the *Poetics* (Golden 1973, p. 45). One observation made in relation to Golden's interpretation which I believe is worth taking into consideration, whatever one thinks of catharsis as intellectual clarification, is what D. Keesey calls the "shiftiness" and "fruitful ambiguity" of the word: "It won't stay put"; in the sense that it seems to be operative on several levels and in relation to different instances (Keesey 1979, pp. 201–202). In the last paragraph of this section I shall come back to this observation.

16.3.1.3 Educative and Moral Interpretations of Tragic Catharsis

Since the age of neo-classicism educative and moral interpretations of catharsis have played a central role in the debate on Aristotle's definition of tragedy. A very influential, but somewhat crude variant of this view, insists on a *direct* link between tragic catharsis and ethical teaching (Halliwell 2000, pp. 350–351):

> …tragedy teaches the audience by example—or counter-example—to curb its own emotions and the faults which they may cause: We learn through *catharsis* to avoid passions which can lead to suffering and tragedy.

A more elaborate and refined version originates from G.E. Lessing. In his *Hamburgische Dramaturgie* Lessing states that by tragic catharsis Aristotle simply meant

the *metamorphosis* of strong emotions into virtue (Lessing (1767–1768/1978), p. 380).

For any reader of the *Nicomachean Ethics* it is evident that its author attributed the emotions with a particularly important role in moral education and building of good character. In *Nicomachean Ethics* III.7, for example, Aristotle argues that man may learn to make correct decisions and become good by developing the ability or disposition to face situations with the *appropriate* emotional response, which according to Aristotle always represents the reaction situated in the middle between two extremes. A man who learns this may thus use his emotional responses to situations that occur as guidance in arriving at the good and right decisions. Thereby, he brings himself "nearer to the mean, where virtue lies", and by so doing, he becomes "virtuous in character" (Janko 1987, p. xviii).

A common view among representatives of a *moral* interpretation of tragic catharsis is that Aristotle considered tragedy to be particularly well suited for educating the emotions and for building character; for it offers a way we can learn to know and develop the appropriate emotional responses without having to undergo ourselves in the reality of the dramatic situations represented in a play.

16.3.1.4 Tragic Catharsis as Emotional Relief

In spite of the "overwhelming advantages" of the above mentioned interpretations, J. Lear finds that no version of the "education-interpretation" stands the test. He also rejects Bernays' medical interpretation and other cognate interpretations. His own suggestion as to how tragic *catharsis* should be interpreted is that Aristotle had in mind the special kind of *relief* a spectator of a play experiences when releasing tragic emotions in a safe environment, i.e. of being given the possibility of emotionally experiencing how it is to live through the worst of life situations with intact dignity (Lear 1992, p. 334).

Lear admits, however, that to put the label of *catharsis* on the kind of relief here experienced does not represent a content-full characterization of it, and he remains fairly vague when it comes to any further substantiation of its content. In fact, he restricts himself to briefly mentioning certain "consolations" inherently operative in Aristotle's conception of tragedy, such as the rationality of the world of tragic events, the plausibility of its events and the presence of a certain form of error or mistake (*hamartia*) that makes the fall or misfortune of the tragic hero intelligible (Lear 1992, pp. 334–335). In the last part of this section I shall return to the notion of *hamartia* and its possible role in enlightening the enigma of tragic catharsis.

16.3.1.5 Aesthetic, Dramatic, and Structural Interpretations of Tragic Catharsis

I have chosen to group these three different interpretations together since they differ from the previous ones in that the notion of tragic catharsis does not primarily relate

to the audience of a play, but to the poetic work itself. In other words, tragic catharsis represents a kind of aesthetic ordering of the pitiable and terrible material in the play so that it complies with the end or form of the play (Goldstein 1966, p. 574). Consequently, the kind of pleasure generated from the play is *aesthetic* pleasure (Keesey 1979, p. 200).

16.3.1.6 Complex or Holistic Interpretations of Catharsis

Although Keesey draws attention to the "fruitful ambuigity" and "shiftiness" of the word *catharsis* in Aristotle's definition of tragedy (Keesey 1979, pp. 201–202), Laín Entralgo, is the only scholar, to my notice, who has advocated a complex or holistic interpretation of tragic catharsis. He operates with a four-layered structure of tragic catharsis and attempts accordingly to distinguish between four different stages of the state of mind of the tragic spectator. First, a *religious-moral* layer and state of mind (Laín Entralgo 1970, p. 204). Consequently, the tragic situation around which a play is dramatically organized, forces the spectator to be faced with a conflict which is not only wrapped in religious drapery evoking religious emotions and memories in the spectator; it also originates from a conflict which is basically religious (Laín Entralgo 1970, pp. 231–232). Second comes the *dianoetic or logical* stage, i.e. the stage that gives voice to the spectator's knowledge of what is taking place in the play and at the same time in himself (Laín Entralgo 1970, p. 233). The third stage in the state of mind of the tragic spectator, and notably the one attributed with most prominence in Aristotle's conception of tragedy, is the *pathetic or affective* stage (Laín Entralgo 1970, p. 234). Laín Entralgo labels the fourth and final distinction necessary to make in the state of mind of the tragic spectator the "*somatic or medicinal* point of tragic catharsis." A play does not only make its impression on a spectator's mind and soul; it affects his hair and humors as well (Laín Entralgo 1970, p. 235). Thus, it becomes obvious that the sort of cleaning or clearing up that tragic catharsis imparts, brings order and enlightenment, and thereby pleasure, to the *whole* of one's nature (Laín Entralgo 1970, p. 236).

16.3.2 Tragic Catharsis: Shiftiness Within a Fallible Context

Before I wind up this part of the chapter, it is necessary to pay a visit to a couple of observations made during the analysis: the observation about the shiftiness and fruitful ambiguity of tragic *catharsis* and the observation about the role of some sort of error or fallibility (*hamartia*) in the shaping of tragic conflicts and situations. My suggestion is to take a closer look at the idea underlying the notion of *hamartia* present in *Poetics* 53a13–17 and see whether it may help to make sense of the shiftiness and ambiguity of tragic *catharsis* and of the heterogeneity of existing interpretations. The clause in the *Poetics* involving the notion of *hamartia* insists that in the "finest" tragedy (the example Aristotle here mentions is Sophocles' play *Oedipus Tyrannus*), the fall of the tragic agent into misfortune is not caused by wickedness,

but is due to a great *hamartia* on the part of the agent himself. Since Aristotle wrote these lines the meaning of *hamartia* in relation to Greek tragedy has been subject of a controversy comparable in intensity and size perhaps only to that of the *catharsis* clause in *Poetics* 49b23–31. In a paper published in 2004 I have given a detailed account of this controversy and tried to show how the broad variety of interpretations of the *hamartia* clause, ranging from purely epistemological forms of fallibility such as "mistake of fact", "ignorance of fact", "error of judgment", "error due to inadequate knowledge of particular circumstances" to full-fledged forms of moral failure such as "moral error", "moral defect", "moral flaw", "moral weakness", "defect of character" and "tragic guilt", mirrors the variety of tragic plots and plays Aristotle had at his disposal (Solbakk 2004, pp. 105–112). This, I believe, indicates that Aristotle himself imbued *hamartia* with a very broad meaning and applicability, so as to make his conception of tragedy capable of covering the variety of individual plots and plays he had at his disposal.

These observations about the broad meaning and varying applicability of *hamartia* I believe can now be used to make sense of the ambiguity and shiftiness of tragic catharsis and of the heterogeneity of its interpretations. The inference I propose to draw is the following: If it is true that Aristotle attempts to make his conception of tragedy comply with the variety of tragic plots and plays he had at his disposal, a view which the analysis of the *hamartia* clause strongly suggests, then it seems to follow that the *catharsis* clause must be imbued with a corresponding broadness and variability of meaning and applicability. In other words, as the meaning of *hamartia* may differ greatly from play to play, the kind of tragic *catharsis* evoked by different plays has to differ accordingly.

16.3.3 The Didactic Potentials of Tragic Catharsis

It is now due time to see whether the didactic implications of Plato's conception of cathartic treatment and holistic cure researched may be tempered through the hermeneutics of the Aristotelian notion of tragic catharsis. The didactic implications drawn from Plato's cathartic regimen was that the process of moral learning is not confined to a cleaning or clearing up of the *rational* parts of the soul; it engages the *whole* of the soul; its rational parts as well as its appetites, beliefs, emotions, and desires. The uncovering of the broadness and variability of meaning and applicability of the conception of tragic catharsis makes it now possible to formulate a more differentiated and subtle answer to the question of what students actually experience and learn when they attend classes teaching ethics. For a first, it paves the way for a *psycho-somatic* conception of moral enlightenment and learning; as tragic plays affect the spectator's mind and soul as well as his bodily hair and humors, tragic situations of decision-making have the potential to implicate students in their psychosomatic *entirety* in the learning situation. Second, characteristic of the Aristotelian account of tragic emotions is that they are always displayed as accompanied by a set of somatic symptoms: pity with weeping and tears in the eyes, fear or terror with cold shivering, trembling, quivering of the heart, and raising of the hair. In the first

part of this chapter I made the claim that lecturers in bioethics mainly focus their attention on *instrumental* issues in their teaching, i.e. on conceptual clarifications and purifications, on methodological case study analyses, and on rational strategies and theories for resolving moral dilemmas, while neglecting the cathartic role that pity and fear and other painful emotions, such as e.g. anger and embarrassment, may play in the process of moral enlightenment and learning.

In saying this, I do not deny the instrumental importance of such forms of analysis and clarification; I believe, however, that students of bioethics would be even better off if their teachers began to pay more serious and systematic attention to the cathartic role of pity and fear in this learning process. The Aristotelian notion of tragic catharsis proves here to be particularly helpful, because it provides us with a way of dealing didactically with these emotions and their relation to the most sensitive and perhaps fragile parts of our moral make ups and capabilities. That is, by exposing students to tragic stories—to narrated or represented situations of pity and fear—they will learn to experience, in a safe environment, how it is to live through situations of decision-making that are under a *double* constraint: the necessity to decide, amidst the absence of the possibility of making a decision not contaminated with some sort of error or guilt (*hamartia*). Thereby, they will also learn to acknowledge that such is the nature of tragic choice; when the decision is taken, moral ambiguity and twilight will still remain (Østerud 1976, pp. 75–76). Finally, by giving themselves over to the treatment of tragic catharsis and enlightenment students will also become aware of the limits of their moral competence and capability, as well as of that of their teachers. Hopefully, modesty and ethical wisdom may also grow from this.

16.3.4 The Making and Paideia-Gogics of Tragic Narratives

The uncovering of the broadness and variability of the Aristotelian notions of *hamartia* and tragic catharsis makes it now possible to give a more systematic and differentiated account of what sort of narratives of ethical decision-making could qualify as *tragic stories*. This, I propose to do, by exploiting Aristotle's differentiation in *Poetics* 51a37-b33 of tragedy from history. The first of their distinguishing traits is that history narrates things that *have* happened, while tragedy relates to events or incidents that *may* happen. This is the reason why poetry, in particular tragic poetry, is more *philosophical* than history; it speaks of universals, while history is an account of particulars. "A universal", says Aristotle, "is the sort of thing that a certain kind of person may well say or do in accordance with probability or necessity—this is what poetry aims at, although it assigns names [to people]. A particular is what Alcibiades did or what he suffered" (*Poetics* 51b8–12). The remark about the use of *historical* names in tragedies, and thereby about the representation of events that have actually taken place, is important, because it informs us that not everything in a tragedy is made up. More important, however, is the explanation Aristotle gives for the poet's use of historical material. For tragic accounts to be trustworthy, they must be *possible*, and things which have happened, says Aristotle, are obviously

possible. Consequently, by using events, names or things that have actually existed or taken place, as templates for giving shape to a tragic plot, the poet is free to "invent for himself" a whole that *may* have taken place (*Poetics* 53b23–27). Thereby, out of the creative reconfiguration of the historical and particular, emerge neither *imaginary* accounts nor wild *thought experiments* but accounts that are possible and at the same time of universal relevance and value.

16.4 Tempered Catharsis and Moral Learning

After this attempt at arriving at a *tempered* conception of catharsis through a reconstructive synthesis of Plato's and Aristotle's competing conceptions of the same notion, we are close to reaching a level of conceptual clarification that may prove didactically useful when exposing students to tragic stories—to narrated or represented situations of pity and fear—and to *aporetic* accounts artistically displayed in Platos dialogues, in the ancient Greek theatre and in the modern version of the ancient Greek theatre, i.e. the cinema. The meaning of the Greek word *aporia* is deadlock, impasse, lack of passage, and gives expression to a situation or position from which there seemingly is no way out, thus forcing the conflicting parties involved to come to a *mutual* understanding of their ignorance and helplessness about how to proceed. The message conveyed to the spectators is that *aporia* represents a *preliminary* form of resolution of moral conflicts, in the sense that formerly held beliefs of ill-founded nature have been eradicated by the use of the *elenchus* and agreement has been established between the parties about the need for further inquiry and learning. Thus *aporia* does not necessarily mean full stop; only that the ultimate pages of the story remain to be deciphered, and that further studies would be needed before this eventually could take place.

Finally, the concept of tempered catharsis may be of help in the ethics facilitator's search for bits and parts of theatre plays and movies that may help students to live through—and learn from—aporetic and tragic situations of decision-making, without becoming victims of emotional chaos and moral disruption. Thus, by conceiving of moral learning as a form of tempered catharsis *moral doubt* will not any longer be viewed as a defeat or failure, but as a *therapeutic* device in our attempts at coming to terms with the enigmas of morality.

16.5 The Moral Art of Selecting and Employing Audiovisual Narratives

As already indicated *anything goes* is not a recommendable advice when selecting such narratives for use in the ethics teaching. In the previous sections stories provoking therapeutic doubt and *aporia* have been suggested as forms of narrative dramatization with considerable didactic potential. Likewise, tragic stories evok-

ing pity and fear have been recommended for such use. In addition, a third form of poetic narrative is worth taking into account: the ancient Greek comedy, and its successors—the comic plays of literary figures such as e.g. Ludvig Holberg, Jean-Baptiste Poquelin (better known as Molière) and George Bernard Shaw—as well as comedies cinematically displayed. Also with respect to such forms of narrative dramatization the *Poetics* represents illuminating reading. Tragedies, says Aristotle, dramatize irresolvable moral conflicts infected by some sort of failure (*hamartia*). A comedy, on the other hand, "dares to say the unsayable" (Segal 2001, p. 31), i.e. it deals with the unspeakable things in life, (adultery, envy, frigidity and impotence, greed, ugliness and other shameful things). Furthermore, while the tragic hero is displayed as morally situated slightly above the ordinary citizen—someone to look up to—the opposite is the case with comic figures (Aristotle, *Poetics*, part II, last line). This is also evidenced by the (emotional) effect the fate of a comic figure has on its audience: It is not a reaction embodying the painful feelings of awe and respect; rather it points in a different emotional direction—towards indignation, laughter, ridicule, and towards situating the comic figure in a moral sphere below the spectator herself: "Comedy is, as we have said, an imitation of characters of a lower type—not, however, in the full sense of the word bad, the ludicrous being merely a subdivision of the ugly. It consists in some defect or ugliness which is not painful or destructive" (Aristotle, *Poetics*, part V, first paragraph). Thus it becomes clear that also the comic figure can play the function of a moral paradigm, although in a different way from that of the tragic hero, in the sense that it gives the spectator the possibility of viewing herself in a *positive* moral mirror; i.e. as somebody with a morality of a slightly better kind than that of the comic figure. As is the case with watching a tragic narrative, a moral distance between the spectator and the displayed figure is thus established, something which gives the spectator the possibility of putting her own morality in perspective and reflecting upon herself from the vantage point of a lower morality—i.e. the morality of the comic hero. And as stated by Aristotle in the *Poetics*, the therapeutic effect of both forms of mirroring is some sort of catharsis: purification in relation to the emotions evoked, be it pity and fear (the pure tragedy) or indignation, laughter and ridicule (the pure comedy), or some other sort of combination of these conflicting emotions (plays and movies containing both comic and tragic elements).

16.6 Towards a Moral Methodology of Cathartic Analysis and Learning

This brings me finally to the question how one methodologically speaking should proceed when exploring the cathartic potential of such narratives. Here is a list of questions worth keeping in mind when making use of such narratives. The first four on this list aim at some sort of inter-subjective problem *diagnosis*; i.e. at identifying the different problems emerging from the narrative: What are the core problems of the narrative? What are the *moral* conflicts, dilemmas and problems displayed?

What moral principles are conflicting? Who are the implicated players in the narrative? In addressing these question it is of crucial importance that the didactic facilitator engages in a genuine dialogue with the audience and gives the spectators the possibility to come up with their *own* suggestions for a diagnosis.

The second group of questions turns the attention towards the spectators themselves and their *subjective* reactions to and perceptions of the narrative they have been exposed to: To what extent does the resolution/non-resolution of the dramatized conflicts comply with the moral perceptions of the spectators? Why eventually, are the perceptions of some members of the audience at odds with the resolution/non-resolution displayed in the play, opera or film subject of analysis? Furthermore, to what extent and in what ways were the spectators *moved* by the narrative? That is, what were their emotional reactions to the staged conflicts and the resolutions/non-resolutions of them? Pity and fear? Indignation? Ridicule and laughter? Doubt? Indifference? Why was some members of the audience moved/not moved by the story? How do the spectators morally speaking justify their reactions/non-reactions? What do these movements/non-movements tell about them as moral persons; about the moral convictions and principles they themselves cherish? To what extent and in what ways does this narrative challenge moral convictions present in the audience? What would for each of the spectators be the morally most salient resolution of the narrated conflicts? How would they have resolved the moral conflicts displayed if they were themselves implicated in the narrative? Furthermore, how would they proceed to recraft the story so as to make it comply better with their own moral intuitions?

Finally, while the spectators engage with each other in watching the moral conflicts staged in the play or movie and their narrated resolution/non-resolution, the facilitator can serve as a therapeutic agent or remedy—a *pharmakon*, to use the ancient Greek word—by showing how different ethical positions and theoretical frameworks can be of help in shedding critical light on the moral conflicts displayed, on their narrated outcomes and justifications as well as on alternative exit possibilities and justifications emerging from the dialogue taking place. Hopefully then, out of such an engagement may result the kind of catharsis previously alluded to as the morally most salient; i.e. a catharsis of the *tempered* and *therapeutic* kind.

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