

Bioethics in Asia

Fourth International Tsukuba Bioethics Roundtable, University of Tsukuba, Tsukuba Science City, Japan October 31 - November 2, 1998.

The theme of this conference was Bioethics in Asia: cultural or ideological boundaries? Some discussions that were especially relevant to India:

Methodology

Dr Naritoshi Tanida of the Hyogo College of Medicine set the standard of frankness by pointing out that in Japan, the doctor and family decide what is good for the patient "In principle we must inform the patient everything but in practice there is always an excuse for withholding information, especially when the disease is cancer." The Japan Medical Association, argued that informed consent would 'spoil' the doctor-patient relationship: "Whilst informed consent may be practised when the doctor-patient relationship is good, in many cases the patients must just obey doctors."

Dr Jong-Sik Reem from Seoul concurred: "As far as I know, no physician in Korea is truthful with patients' when families request that information (about cancer) be withheld (from the patient)." The question then was: should ethical codes take into consideration local imperatives? Michael Tai from Taiwan and Leonardo de Castro from the Phillipines argued for respect for local tradition and indigenous values. Western concepts must be re-interpreted to make them relevant and acceptable in Asia.

Ms. Vicki Smye, a nurse at St. Paul's Hospital, Vancouver, Canada, 'discussed the refusal of food by victims with anorexia nervosa, often to the severe detriment of their health. She argued that force-feeding such patients was justified: their condition suggests

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that they are suffering from a delusional state, and starvation aggravates the mental imbalance. The University of British Columbia's website describes an ethical framework that permits them to intervene, based on the support of relatives and friends chosen by the patient.

Jens Seeberg and colleagues from WHO/SEARO, South-East Asia, presented preliminary reports on their studies to identify ethical dilemmas as perceived by doctors in six countries including India.

Makina Kato and Darryl Macer reported on a survey of attitudes to persons with AIDS in Australia, Hong Kong, India, Israel, Japan, New Zealand, the Philippines and Singapore. Eighty-five per cent of the respondents felt that information on HIV infection and AIDS must be shared with the spouse.

Kaori Sasaki from Lancaster University, U K, discussed occidental and oriental values. She pointed out that some argued that Japan was steeped in feudalism and that the people needed education to accept modern ethical principles and such concepts as brain death. Others insisted that Japan had its own, treasured culture and did not need the import of Western concepts. Referring to her studies on the Indian subcontinent, she argued that the absence of shared value systems between Hindus and Muslims lay at the bottom of the recurrent conflicts between these two cultures.

John Lizza of Kutztown University, USA, asked an apparently simple question: Is defining death a biological or cultural matter? The US President's Commission on brain death starts out by saying it is a philosophical matter, but soon goes on to define biological criteria for diagnosing brain death. Before the era of organ transplantation, death meant a change in the biological system that made the maintenance of respiration and circulation impossible, leading to an irreversible loss of the ability to maintain internal homeostasis.

Complexities abound now. Is a decapitated body maintained by life support systems alive? Lizza suggests that "the problem of defining death has persisted because we have been unable to reconcile a strictly biological definition of human or personal death with views about humanity and personhood which are not strictly biological."

Is bioethics a love of life?

There were several sceptical voices responding to Darryl Macer's argument that love incorporates the four principles commonly accepted as the basis of biomedical ethics. The responses: there is no universal definition of love; it is used even when talking of 'love of money' or 'love of power'; different cultures may use the word 'love' differently. A doctor asked how he could be expected to love a total stranger who comes as a patient. Robert Veatch, Director, Kennedy Institute of Ethics, USA, felt that love could not have a place in a theory of good action; it cannot provide guidance in the medical treatment of strangers. Godfrey Tangwa of the Cameroons said the essence of bioethics was 'respect or reverence for life'. "Love seems to me to be too complex, generic and diffuse a concept and one with too many problematic associations and connotations to conveniently and economically carry our characterisation of bioethics." He also pointed to the importance given in African culture to consensus rather than convergence on a single belief or principle.

Ole Doering of the Institute of Asian Affairs, Germany, suggested the concept of love could be given added force by using a term proposed by the Chinese philosopher Mo Di. *Jiart ai* combines love with utilitarianism. Frank Leavitt, Ben Gurion University of the Negev, Israel, suggested that love should be a central component of all medical care.

Leonardo de Castro from the Philippines proposed the use of the concept of *Kagandahang loob*

(*kagandahang =beauty; loob=inside*): goodwill manifested in actions beneficial to others, and **characterised** by positive feelings towards the intended beneficiaries, without any thought of reward.

Bioethics education

Tom Buller, University of Alaska, USA spoke of the educator in bioethics as a combination of scientist, lawyer, poet and comedian. The education process must be based on science, derived from observation and experiment; incorporate a legal normative with advocacy for the patient and a case-by-case approach; use narrative poetic skills to reveal the human condition and discuss case histories; and challenge, provoke and use irony to laugh at ourselves and bring forth reactions.

Peter Whittaker of the National University of Ireland tells his students that discussions on right and wrong do not need technological expertise. Students participate actively from the start. Discussions, debates and tutorials are used to instil religious, social and environmental concern.

James Dwyer of New York University pointed out that in undergraduate education, the ethics of speaking up and protesting against all injustice are far more important than narrow discussions such as on cloning. He begins his classes with problems students encounter in the wards. The goal of the teacher, at this stage, is to increase the student's perception of ethical problems. It is best to help the student use his own experience in identifying problems, through examples and discourses. He also advocates getting students to relate problems they experience to larger social issues, and to justify their own solutions. If students end up as cynics, this is a failure of the training programme.

George Agich of the Cleveland Clinic Foundation said bioethics consists of ethical principles and theory, ethical concepts, and discussions on issues,

dilemmas and specific cases. Priority must always be given to practice over theory. The medical student needs information on broad issues: ethical principles and the means for analysing and resolving a problem. Resident doctors may need **focussed** discussions on issues such as advance directives and end-of-life decisions. Finally, the clinical component of education must include discussions on actual cases; simulated situations; and dynamic teaching at the patient's bedside — all within an integrated framework in the given social setting.

Michael Tai, Chungshan Medical and Dental College, Taiwan, quoted an ancient Taiwanese proverb: "A superior physician heals the ills of a nation. An ordinary physician heals the brokenness of his patient. The inferior physician heals only the disease." The current medical curriculum in Taiwan — which includes bioethics, thanatology, the history of medicine, the philosophy of life and of religion, medical psychology, the **patient-physician** dialogue, interactions between the physician and society, rights and responsibilities of patients and physicians and, finally, medicine and the law — enables the student to see the human side of medicine, promotes continuing reflection on the development of the physician, fosters a sense of medicine as a vocation, helps the clinician use ethical principles to resolve dilemmas and, finally, promotes a consciousness of the physician's social responsibility.

Other topics

Most of what Bela Blasszauer of the Medical University of Pecs, Hungary said on corruption in Hungarian health care could be applied to the Indian situation as well. "Corruption has a destructive effect in any field of human endeavour but especially in the area of health care where not only should trust be a principal element of human relationship, but where greed, lies, deception and the likes may result in tragic situations." The chief cause of corrupt practices: a lack of

accountability with poor social and professional control. The solution? "Democracy is not polls every four years but something you feel and act upon every day of your life."

Donald Bruce of the Church of Scotland spoke on merging biotechnology and ethics in Scotland. Science and ethics were worlds apart. Biotechnologists did not feel accountable to the public. Scientists and ethicists had different perceptions on the extent of risk resulting from 'advances', and on the key criteria for judging risks. When ethics was proposed to be introduced into the medical curriculum, the horrified response was: "Then what do we drop?" Bruce suggested that the theology and philosophy faculties of the university weave their activities into those of the faculties of science and medicine.

Chee Khoon Chan of Universiti Sains, Malaysia spoke on the double jeopardy of 'Intellectual property rights'. He pointed out that rather than encourage innovation, **IPRs** encourage theft from third world countries to enrich the already prosperous first world industrialists. "In the midst of such rampant acts of biopiracy, **knowledge-based** corporate entities continue their campaigns against copyright and patent 'violations' in the third world, even as they defeat legislative attempts in the US to declare individual genomic information to be individual private property."

It was a novel experience for a clinician to listen to philosophers and social scientists debate the nuances of bioethics. However, I could not help wishing they were made to participate in real-life clinical events where the exigencies of the situation compel people to do their best even if short of the moral ideal.

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The proceedings of this conference will be published and placed on the Eubios website: <http://www.biol.tsukuba.ac.jp~macer/index.html>