

Eubios Journal of Asian and International Bioethics

EJAIB Vol 20 (1) January 2010 ISSN 1173-2571

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Eubios Ethics Institute World Wide Web: www.eubios.info/index.htm

Official Journal of the Asian Bioethics Association (ABA)

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The deadline for the March 2010 issue is 1 February, 2009.

Original papers, commentaries, news and reviews should be submitted in electronic form to the editor.

Editorial: Twenty years

This issue of *EJAIB* starts year 20 of the journal. Bioethics in Asia has certainly progressed since the first issue in 1991, and the launch of the Asian Bioethics Association in 1997, at the UNESCO Asia Bioethics Conference in Kobe.

This journal also looks at international bioethics, not just in Asia, where cross-cultural issues can be explored. In this issue of the journal the first paper examines the ethics of genetic knowledge. This was an important topic discussed though the past 20 years of the journal also. In this paper, we can see the progress of genetic information to the prospect of individual genome sequences being made in clinical services. Is it part of our responsibility to know our genetic information?

Another familiar topic is in the next paper by Yoshida, which also describes the recent changes to reduce the administrative proof requirements in the organ transplantation laws in Japan, to overcome the decade of few transplants that has occurred in Japan. It also discusses the disposal of Dead bodies, and scattering of ashes.

Next there are papers on basic social issues, including two vulnerable groups – women in India, and elderly in Bangladesh. Fresh water and water ethics is discussed in the next paper. The paper by Cristina Pinto examines debates on end of life care in Portugal. At the end is a translation and dialogue on a Chinese poem from Bing Tang. There are a variety of issues raised in these papers. As can be read from the UNESCO 35th General Conference announcement UNESCO will be working towards feasibility studies of a Declaration on Ethics and Climate Change, which will continue the recent activities in the region on these issues.

We hope to receive proposals of papers for the ABC2010 conference from many readers, as the event looms closer. I wish reader's a happy new year.

–Darryl Macer

Genetic Knowledge is a Civil Right. Towards a New Model of Health Contract as Social Contract

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Abstract

Genetic knowledge is a civil right and a civil obligation. New genetic knowledge in individual health risk prediction and prevention and new pharmacogenetic opportunities for developing more efficacious individualized drugs broaden human and civil rights for better health and health care. Public health policy has yet to develop and provide programs in genetic information and consultation together with other health risk information and health literacy education. Data availability and genetic knowledge will make citizens more competent partners in health risk management. As with all information, abuse and manipulation of genetic information cannot be excluded; but health education as an essential part of public health services will empower citizens to better care for their own and their families health. Existing cultural and ethical principles, laws and regulations need to be reviewed and modified in order to prevent and fight illegal or immoral use of genetic information. The promotion of genetic knowledge allows for a new model of social contract as health care contract between citizens, health care experts, and society.

Key Words: Carrier Ethics, Data Availability, Genetic Knowledge, Genetic Research, Health Literacy, Informational Property Right, Informed Consent, Informed Contract

We are witnessing a scientific, medical, cultural, and ethical revolution of gigantic dimensions brought about by molecular genetics. Genetic knowledge and its application into the inner workings of life forms, including human life and its exposure to inherent or environmental risk, is a new challenge in risks and benefits for humankind and human civilization and quite understandably creates controversies in ethical assessment. On

one side there are the foes of genetics pointing out that genotyping in human genetics will do more harm than good to the individual and to the moral and social fabric of humankind. They present five central arguments: (1) discrimination based on the individual's genetic setup will add to many other already existing forms of discrimination, (2) genetic information cannot be kept confidential and therefore will do more harm to the individual than good, (3) fellow humans with specific genetic setups will find it harder, if not impossible, to gain access to certain jobs or being accepted by health insurance companies, (4) lifestyle regulation in the name of health risk management and cost reduction will be the logical consequence in predictive and preventive medicine, (5) a loss of solidarity towards those with known genetic disorders. On the other side, there are five arguments by friends of human genetics, that (1) individuals will be able to make more educated choices in life based on their genetic risk factors, (2) get guidance for making reproductive decisions giving them for the first time the opportunity for parental responsibility via pre-implantation diagnosis and prenatal screening, (3) get more individualized medication with less side-effects based on their specific genetic setup for drug metabolism, (4) get a better understanding of their individual risk factors in the workplace and in the environment, thus protecting health and quality of life before acute or chronic illnesses occur, (5) improve health risk solidarity as each and everyone will have predictable risks in her or his genetic setup, some more severe than others.

As with all new forms of knowledge and technology, individuals, families, societies, professionals, organizations and governments, locally and globally, have to evaluate the risks and benefits associated with genotyping [1;5;6;7;9]. The revolution in genetic knowledge will have to lead to a revolutionary modification of our concepts of health and disease and of individual and public care for health. A new model of social contract and of contracting in the care for health is feasible and warranted. Health cannot simply be understood anymore as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' [14:459], as the World Health Organization defines. *Health is not just a status; rather the balanced result of health-literate and risk-competent care of one's own physical, emotional, and social wellbeing and well-feeling, achieved in competent understanding, modification and enhancement of individual genetic, social and environmental properties, with the support of health care professionals and through equal access health care services, including information, predictive and preventive medicine.* The old WHO definition of

health has outlived its usefulness as we need a re-evaluation and a re-prioritizing of traditional principles of care, confidentiality, beneficence, informed consent, and harm within physician's ethics and in lay health care competence and ethics. Long neglected lay health care ethics has to become a prime topic for medical research, education and application in the clinical, and in primary care and public health care settings. Also, we will have to focus on modified principles such as duty to inform, duty to be told and to know, health education, health literacy, health care competence, informed request, informed contract, and the ethics of data availability. Century old traditions in medical cultures of dietetics and prudent lifestyle in protecting and improving health have been lost in modern systems of disease management and been replaced by an unfortunate repair mentality in health care matters. Classical interactive principles of competence and compassion, communication and cooperation for experts and lay need to play a more important role in the modern world of health care [12].

Carrier Ethics and Family Health Care

New diagnostic knowledge in human genetics and pharmacogenetics make information-sharing and responsibility-sharing with citizens possible and mandatory. More than previous generations, we know a lot about risk factors from our genetic heritage, environment, and lifestyle. It is a civil right to be educated about those risks and to learn how to deal with them. Based on cultural and moral traditions of responsibility and self-determination and knowledge about one's genetic heritage and its advantages and disadvantages, its risks and uncertainties is a precondition for living a self-determined, risk-competent educated life and for enjoying fullest possible individual quality of life. This civil right requires a public and professional duty to inform, to educate, to counsel, and to support for the health care system and the public health expert. The civil right to genetic information does not include the obligation to follow recommendations or advice in those cases, where others are not impacted negatively by individual self-determination. Coercion is not necessary a result of information and knowledge; on the contrary, information and knowledge empower individuals and societies to withstand coercion and pressure [3;11;12]. There does not seem to be an obligation to tell, if diagnostic findings cannot result in advice or prescription; but one could make the argument that even in these cases of interventional futility citizens have the right to request information anyway, if they want to know [10]. *There is a human and civil right to know and an obligation to tell, if health risks are present*

or predictable. There is, however, only a moral, not a legal obligation to follow health care advice; this obligation becomes more pressing if health care costs are shared in solidarity.

As genetic diagnosis provides potentially important information for family members in regard to health risk, health status, potentially helpful preventive measures and information essential for individual self-determination and quality of life decisions, each and every person diagnosed will need to consider her or his responsibilities towards family. In Western cultures, emphasis is put on privacy of patients or those diagnosed, while even during transitional periods of Asian professional and family cultures there is a high responsibility towards family, filial love, parental love, different forms of love within the wider family. As not only severe genetic disorders, a higher than average risk of hypertension, forms of cancer, metabolic disorders may run in families, information about these risk factors would be extremely important to carriers, so they seek frequent checkups and advice or might use preventive strategies to reduce impact or postpone onset. Interactive family health care ethics still have to be developed, able to adequately deal with issues of family ethics [10;12]. Also, family relations will be influenced by new sources of - unfounded - guilt-feelings, shame, accusations, self-denials, maybe divorce, suicide, and the breakup of families and familial relations. The golden rule must be to not hide behind traditional attitudes towards secrecy and privacy, but to openly and aggressively inform, educate, teach and support dialogue and discourse in families and in society. It should be done, however, not against the grain of traditional familial forms of communication and cooperation or against the will of the diagnosed carrier, but in seeking her or his support and in making the best use of sometimes dormant principles of family responsibility and solidarity.

Various modern cultural and social trends have weakened the traditional concept of the individual as being only a part of the family and not an end and purpose in herself or himself. This cultural trend seems to give the individual more responsibility and weight in a global development. Therefore, in complex issues of family ethics, privacy, disclosure, right not to know, and duty to know, diagnosed carriers would be the prime moral agents to make educated and responsible choices (a) to disclose, (b) to refuse disclosure of all or some information, and (c) to postpone hard choices in informing family members. There will be hard cases, where information might be lifesaving to family members who might be carriers. WHO proposed guidelines [15] on ethical issues in

medical genetics suggest to rather violate the principle of confidentiality in favor of informing and consulting family members; but guidelines of national organizations differ from such a stern position. Additional, responsible parenthood in the future might include decisions whether or not (a) to have children at all, (b) to have prenatal testing and eventually elected abortion following positive testing, or (c) to do nothing and set trust into future breakthroughs in medical treatment of yet untreatable disorders.

Informational Property Rights and Data Profiling

'Data availability' is a core principle in modern medicine and a precondition of good clinical practice; it has to be balanced with the principle of privacy and protection of data. The principle of data availability favors individual health care cards. Since the discovery of blood types, reliable diagnosis of blood types, typing and screening for blood types has become an essential part of emergency medicine and surgery and has saved directly or indirectly millions of lives [9;10]. It is well known that we do not differ only in types of blood but in many other individual properties, such as in cytochrome P450 isoforms, controlling drug metabolism, causing non-efficacy, side-effects, various forms of harm, even death in some types of metabolizers. In hypertension treatment, calcium antagonists are metabolized by the 3A enzyme in the cytochrome P450 isoform system, while beta blockers are metabolized by 2D6, a switch from one to the other without proper drug metabolizing tests would be clinical and ethical malpractice; P450-2D6 enzymes metabolizing codeine for palliative care is absent in 7% of Caucasians, resulting in total non-efficacy in those individuals; P450-2C19 metabolizing diazepam (Valium) and other neuropharmaca is absent in 15% to 30% of Asians, who therefore would require much lower dosages than established in controlled clinical trials on Caucasians [www.drug-interactions.com]. When individual pharmacogenetic profiles for medication-typing can be established the same way we easily can establish individual profiles in blood-typing, personalized drug delivery is possible and ethically required [1;6;7].

The fears that genotyping for drug metabolism will lead to discrimination are not convincing, they are theoretically, culturally, and ethically unfounded. Blood typing did not lead to discrimination, even though some individuals have blood-types which are more rare, at least in certain populations, and therefore might have less access to blood replacement. Blood profiles and metabolization profiles do not describe disorders, i.e. an individual aberration from a general norm,

rather they constitute different types, variations, none of which is the 'standard normal' one. We have a model of variation, not one of order and disorder. It would have been a crime against humanity and an inexcusable wrong towards all fellow humans who would have died and would die of their lives could not be saved by blood transfusion based on proper blood-typing. In drug metabolism as in every metabolic property the concept of normal versus disorder is wrong, as there is no normalcy, only differences in expression and action. Genotyping for drug compatibility causes no significant other ethical concerns than those associated with blood typing: clinical reliability of typing procedures, equal access to typing services, no (medication prescribing) intervention prior to typing. The new scenario of metabolism typing has consequences for the traditional and accepted setup of vaccine development, clinical trials, prescription procedures, and nutrition advice. We are not living in the times of 1948 anymore when HB Hill set up the first model of 4-phase placebo-controlled CCT's. We know more and we know better. Given available pharmacogenetic knowledge and opportunity, it must be considered unprofessional and unethical to not include genotyping into drug development and to establish efficacy, dosage, and side-effects for major types of metabolizers based on cytochrome P450 isoform properties and composition. It is an unfortunate professional deficiency and moral harm to citizens that regulatory agencies have not yet changed the format under which they approve of new drugs. [9;10].

Individuals have a civil right to information about their individual proteonomic and enzymatic properties for metabolizing drugs and nutrition [8]. This informational right would best be served by providing inexpensive individual Drug and Nutrition Cards and access to information and education; also those drug-and-nutrition-cards need to become the golden standard in drug prescription based on metabolizer-type clinical research. Since individuals differ in more than enzymes and protein metabolism, it would only be consequent to provide citizens with individual Health Care Cards containing information on individual genetic or acquired properties, abilities, disabilities and disorders such as risk of hypertension or diabetes. Data availability is the precondition for good diagnosis and prognosis, and subsequently for prevention and treatment. Personal data, including data on health and health care are the informational property of the individual. In other areas of life we share these informational properties with others for our own benefit convenience, such as with credit card providers, supermarkets, libraries, online-merchants, and

insurers of various kind. Of course, we rightly worry about protection of private data. But we already have laws and regulations protecting private data which work most of the time; we accept these risks as we balance risk with benefit. Individual rights on individual health information should not be treated differently than other informational property rights. *Citizens are informational property owners of genetic and other data concerning individual health status and health care. It is in their best interest to have Health Care Cards and to share information with professionals in a protected framework as data availability becomes as important as data protection.*

Genotyping Ethics and Genetic Knowledge

We all know how to live with typing for blood types. Only since 100 years ago the different blood types were discovered and reliable testing became available, are lifesaving blood transfusion possible. We also know how to handle privacy issues when dealing with blood-typing and actually give medical and moral preference to data availability over data protection. Genotyping provides an entire set of new tools for humankind to better understand the human condition, to better care for health, and to fight against and to avoid sickness and disease. But as all tools, new and old, genotyping can be used in a virtuous and in a vicious way. Public discourse and education and the appropriate protection of human and civil rights will be needed to steward and accompany the transition into a new millennium of health literacy and health care and of new avenues in public health and public health genetics. Our charter into the new territories of self-understanding and self-destination, of better health care and improved quality of life for all will not be made easier if we hold on to old models of regulation and control by bureaucracies of various kind intending to protect the people from the dangers of progress, but in fact preventing progress to happen and preventing people from finding their own way to use and to enjoy the new properties of genetic knowledge for more liberty, more justice and for the pursuit of happiness.

Health care professionals cannot provide quality service if denied access to information necessary for providing safe and efficacious service. It would be extremely difficult to argue that those who do not share personal health status data with professionals can ever request those services or will get best possible service. If data are not stored and be made available, rather being generated every time anew, then costs will skyrocket without additional benefit and therefore those who do not entrust personal data to individual Health Care Cards should accept the higher costs of more

expensive procedures. As far as the principle of solidarity is concerned, data availability is not only a prerequisite for good health care, it is also a potential factor to reduce costs.

The new challenges require a new action guide different from rules which were appropriate during periods of limited medical knowledge and lay ignorance. The new world of genotyping calls for new models of interacting lay ethics and physician's ethics in health care matters [11;12]. Better information and knowledge are the preconditions for making educated and competent choices in health care matters. In the coming age of molecular genetic ethics a new moral action guide is required determining priorities for groups of moral subjects and for new priorities of ethical principles, among which health literacy, self-determination and self-understanding, the right and duty to know and to learn about one's own genetic properties and risk profiles, and genetic solidarity with other fellow humans will have to play more prominent roles: *(1) Educated and responsible people and families have a moral duty to learn about their genetic properties and how to make the most out of these properties; they also have a moral duty to help fellow humans in taking care of their individual genetic properties, in particular to help members of their family.- (2) Health care professionals are obligated to not suppress or withhold genetic information from patients; they have the duty to do their utmost to educate their patients and to guide and to accompany them in caring for their health. - (3) Lay persons and health care professional should feel bound by an invisible contract of communication-in-trust and cooperation-in-trust, of competence and compassion, sharing responsibilities, rights, and obligations, also in the care of the less fortunate, less healthy, and less competent. - (4) Governments, national and international institutions and organizations must provide legal, regulatory, and information networks for the protection and improvement of human and civil rights, for the development and improvement of health literacy, and for the protection against exploitation and discrimination; regulatory ethics in human genetics should be based on the ethics of information and education, also the promotion of predictive and preventive services and the protection of privacy.*

Informed Contract and the Ethics of Genetic Research

New areas of research need new models of control and quality assurance. Reforms are urgently needed in clinical trials and human experimentation based on new challenges and opportunities in genetic research, in DNA-

sampling and DNA-storing. The traditional soft-paternalism principle of informed consent has to be replaced by the principle of informed contract, detailing for researchers and probands or patients rights and obligations, liberating probands and patients from their passive role of just consenting to the more appropriate position of being a partner. In particular, issues of research in drug metabolism, DNA-sampling, and disease-specific research cannot be justified without taking into account the probable benefits to the patient or her or his families. Modern medical research finds information about pedigree and family members, which cannot be taken care of by the concept of individual consent only by those who participate in the research.

For genotyping in highly defined populations of patients suffering from certain subgroups of cancer or other diseases and receiving specific medication, it has been debated whether traditional models of informed consent would be enough for multipurpose long-term DNA-banking [8]. It has been suggested that for genotyping only specific informed consent should be requested and that further use should be covered by new specific re-consent. On the other hand generic consent forms - in particular for prenatal and newborn screening - were proposed, but others criticized such an approach as lowering the standards of informed consent.

As the probability of benefits in cross-purpose genotyping and of future yet to be specified re-testing and new-testing is of great importance for the individual patient, patient groups and the progress of clinical research, we need to work within a contract model, describing the obligation of the researchers to inform the patient on all or some of their findings and establish a contract spelling out the obligations towards the patient and her or his family: "We ask you to sign a contract for genetic testing on information and properties which might or might not be associated with your disease and how they are associated with it; this might take along time and we might look for information we don't know yet. We make it our legal obligation to inform about any finding which might benefit your treatment and which might be beneficial to members of your family. Also, at any given time, you or your representative has the right to cancel this contract and to request that your biological properties be destroyed. If you want to share in possible financial gain associated with this particular research, we will provide you with a separate contract" [10].

Within the contract, patients or their legal representatives must be informed on standard data-protection. In order to solve complex issues of privacy and disclosure, the right not to know

and the duty to know, the contract must provide, that patients can make their own choices (a) for mandating disclosure of individual predictive, preventive, or therapeutic knowledge, (b) for refusal of all or some information, and (c) for postponing such a decision for later based on then existing individual circumstances or clinical results. The moral issues of informing and protecting family members similarly will have to be addressed within the contract by allowing the patient to choose among a number of procedures by which family members of various degrees may or not be involved, informed, or invited. It is time to replace an outdated informed consent model totally or in part and replace it by a contract model in which stakeholders such as probands, researchers and sponsors delineate moral and legal contractual rights and obligations.

Some informed consent forms include already such features of informed contracts, but WHO and the European Forum for Good Clinical Practice have not yet addressed these issues or come up with proposals for reform. An excellent example on how the ethics of diagnostic research is changing towards a more appropriate appreciation of individual and family health care competence and decision making as partners in research is a statement by the HUGO international ethics advisory group on choices in data availability within a firm model of data protection and privacy protection: "The choices and privacy of individuals, families and communities should be respected: (a) choices may be with regard to: donation, storage and use of samples and the information derived therefrom (e.g. specific, related or other uses subject to authorization by an ethics committee, etc). Informed consent may include notification of uses (actual or future), or opting out, or, in some cases, blanket consent. (b) Mechanisms should be established to ensure respect for such choices. (c) Participants should be informed about the degree of identifiability of their data (e.g. coded, anonymized, aggregate, etc) and the security mechanisms in place to ensure confidentiality. (d) Participants should be told that samples or the information derived therefrom may be shared with other researchers including those from other countries, with commercial entities and through publication and availability on the WEB" [4].

Individual Choices in Communication and Cooperation

Modern medicine, recognizing the principle of autonomy and self-determination as a most basic human and civil right, allows for clinical research and medical treatment only, of the proband or patient has given free and informed consent based on individual concepts of risk, benefit, values, fear, and hopes. Global recognition of the informed-

consent principle correlates to the vision of universal human rights, as expressed by the United Nations Declaration on Human Rights in 1948 and being a fruit of the processes of emancipation since the European age of Reason. Good as it looks in principle, there are quite a number of well-documented scenarios where the informed consent principle does not work or is used in an abusive and exploitative manner: (1) If people do not clearly understand risks and benefits associated with research and treatment, oral or written consent is void. (2) If people feel an 'obligation' to sign forms, such consent is not given freely. (3) If researchers cannot or do not adequately inform probands or physicians their patients, signed forms are a smoke-screen only to hide that true informed consent is not given; however the legal requirements seem to be satisfied.

The informed consent principle has been developed in Western medicine at a certain historic time under specific cultural and historic conditions during the early 20th century.¹ It was a very useful tool to protect vulnerable persons from abuse; properly used it is the best tool available to protect human dignity and civil rights. However, even if no abuse is intended, there seem to be cultural obstacles associated with its rigid implementation under the maxim 'one size fits all'. We see already standard deviations, exemptions and modifications form the general rule: (1) consent for minors is given by their ethical and/or legal representatives, mostly the parents. (2) competent adults may designate another person to give consent on their behalf, either immediately or under certain conditions in the future. (3) The consent required from psychiatric patients is related to their particular disease and situation at a given time; however, there are well developed treatment contracts signed by patients and their caretakers for possible future situations known to and experienced by the patient [10].

Moral or social communities quite often address ethical issues by community consent, even though only some individuals are subjects under risk. In Western civilization, religious orders and closely controlled religious groups obey and consent to decisions made by their superiors. The fact that different cultural and moral communities have different values, wishes, hopes, and fears, is well used when making proxy decisions in medicine for incompetent persons. Schools of communitarian ethics place great emphasis on supporting and respecting communal values. Ethics committees in

pluralistic societies include neighborhood representatives or representatives from religious or moral or social communities to which the incompetent persons belongs. If a village or province community widely and strongly shares religious, cultural and moral convictions, then most like individual preferences for participation in medical research or for medical treatment would be similar. Also, if this is a part of the specific culture, decisions would made by elders, wise men or women, elected or accepted otherwise. Researchers required to inform and educate and to gain consent, would be well advised to use the existing trust and responsibility structure for information and education and for contracting with the community and/or families and/or individuals [10;12]. Benefits for the community, for the families, and the individuals should be spelled out in detail. In the case of DNA sampling, contacts should be made some time before DNA is sampled, and definitely a long time afterwards information and health care education services should be contracted and provided. The larger and the more complex the community is, the more risky will be a communitarian approach and the more features have to be developed and supported to protect dissenting individuals and groups. There might be situations of communities in cultural transition or under indoctrinating and exploiting elders or oligarchic groups, where the communitarian approach to protect vulnerable individuals and families will not work and cannot work. Community information, knowledge, and culture might support individual consent, but should not replace it. It is only common sense, to recognize that probands expect 'something' in return for their participation; this 'something' can be personal recognition, personal attention, individual or general health care advice, better hygiene, fresh water or nursing care for the community. CIOMS guidelines for medical research in 'populations and communities with limited resources' recommend: 'the sponsor and the investigator must make every effort to ensure that: the research is responsive to the health needs and the priorities of the population or community in which it is to be carried out; and any intervention or product developed, or knowledge generated, will be made reasonable available for the benefit of that population or community' [2:51]. The Nuffield Council on Bioethics [5:116] suggests "that sponsors of research should require that the development of local expertise in healthcare is an integral component of research proposals. Consideration should be given to the extent to which any strengthening of local healthcare facilities can be done in such a way that the

¹ There are reports of similar concepts in several different cultures over time, which is still a matter of further research.

changes are sustainable in the local context once the research is over."

Given the diversity of individual and collective cultures in decision making, one model of consent does not fit all. It seems to be clear, that the late 20th century American (let us call it "classical") model of informed consent has outlived its useful life as a general standard for all, for each and every personal, familial, communitarian, cultural or legal situation. Where the basic cultural attitudes and legal preconditions are not in place to make the classical form of informed consent the preferred and most useful tool, it cannot be made a requirement that medical experts first of all change cultures and attitudes and then proceed with their medical work. It is also not acceptable that medical experts turn a blind eye on the missing of essential prerequisites for making informed consent work.

Everyone has to work on implementing human rights and free decision making by competent and risk-literate adults; this task cannot be put on the physicians alone. Also, there might be true ethical situations where coherent trust-and-responsibility structures within families or communities are well developed, by cultural or religious tradition and in the history of ideas supported and proven to working well in quite a number of cases. In those situations it would be culturally and ethically insensitive and counterproductive to destroy a working network of trust, hope, responsibility, and reliability in order to replace it by a model developed under different cultural and historical conditions. Models of contract with families or individuals rather than one-sided still soft-paternalistic consent might work better in all situations. All culturally sensitive models would need 'escape clauses' or 'conscience clauses' allowing each and every individual to decide for herself or himself on the basis of individual self determination about her or his place in a moral community and in regard to community values and decision making. *Great emphasis has to be laid on developing culturally sensitive tools and procedures for those who do want to make their own choices, even though values and attitudes in their community or family suggest otherwise. Traditional cultures seem to be in transition from community-oriented ethics towards a heavier emphasis on the individual person and her or his personal goals, visions, and lifestyle, which might be different from those of the family.* As medical ethics and health care are not the instruments to change culture nor to prevent culture from changing, health care ethics and individual health competence need to make the best use of existing and accepted models of autonomy and solidarity. Of particular importance is the use of widely available internet sources for health literacy

information, promotion, and consultation. Health policy and public health policy should compete in the market of health information rather than only regulate; they should develop their own health care websites including genetic information and advice [11].

In genetic counseling, it has become the golden standard of modern bioethics to avoid paternalism and directive counseling in favour of non-directive counseling. Given the severity of most renal genetic disorders and the importance of good symptomatic and presymptomatic patient-physician interaction in communication and cooperation, I feel that the controversy between directive and non-directive counseling should be replaced by new and more appropriate models of patient-physician interaction, an interactive counseling model of discourse and evaluation. An interactive model of counseling respecting the patient's or client's self-determination, actually empowering autonomy, would require that the physician (a) inform and educate the carrier, depending on the carrier's capacity to understand information and to make judgments and decisions, (b) assist and support the carrier to make medically important decisions such as compliance with routine check-ups, lifestyle modification, medication, and dietary regimen. Of course, there will be other very personal challenges and decisions related to the carrier status which do not belong into the realm of medical responsibility and involvement.

This new model of neither directive nor non-directive counseling has also been called 'interpretive ethics' [13]. The interactive discourse-and-evaluation based dialogue model will work differently depending on the individual case and the carrier's or patient's quest for guidance or value statements by the consultant. Of course, the discourse model will have to make it clear, as is true of all models of non-directive counseling, that paternalism in decision making cannot be accepted and that carriers have to make final decisions and accept final responsibility for decisions made or not made. It will be a fine line, even in the absence of state-coerced eugenics, that professional genetic counselors do not overstep their obligation to clearly and precisely state facts, issues and prospective problems and dilemmas, but at the same time refrain from providing biased information or assessment on the quality of life of carriers of genetic disabilities. There are and there will be citizens and patients who for various reasons are unable to accept responsibility or to follow a strict regimen. For those patients and citizens traditional forms of paternalism might still be appropriate, but there are factual and moral limits to coercion and to pressure fellow humans into regimens they do not

like and do not want. Individual choices in health care matters require competence and compassion by all partners in health care and public health, the citizen and the health care expert.

Challenges to the citizen include:

(1) *Understand and accept your individual predispositions for health and understand your individual genetic setup, which will allow you to define your very specific individual qualities of life and goals in life, taking your genetic heritage into account.*

(2) *Become health literate and define your individual challenge to happiness and health within the parameters of your genetic heritage and your challenges in the social and natural environment.*

(3) *Live a happy life and protect your health and happiness by appropriate and prudent rules for diet, exercise and relaxation, work and love, social activities and self-determination.*

(4) *Expect from the health care professional and the health care system individualized information on prediction, advice for prevention, guidance in health care and in acute care intervention, and a trust-based interactive professional and personal partnership in dealing with carrier status, chronic illness and suffering.*

(5) *Understand that no health care professional can relieve you from being the prime caretaker of your health, happiness, and life.*

(6) *Discuss your concept of health and disease, lifestyle choices, long term care plans, and advance care documents with health care professionals and with family and friends.*

Challenges to the health care expert include:

(1) *Care for healthy citizens, not just for their medical symptoms.*

(2) *Inform and educate the citizen and/or patient about her or his individual predisposition for health and health risks and help them to understand individual challenges and opportunities.*

(3) *Help citizens to find their individual way to respond to the technical details of dealing with health care risks of various kinds, with the processes of degeneration and the possibilities of postponement of onset of more severe stages of genetic and other disorders.*

(4) *Be a professional expert for your patient and do not discriminate against those patients who do not exercise their right to care for their own health in an appropriate manner.*

(5) *You cannot expect a lay person to become a medical expert; therefore you have to competently and compassionately educate and keep yourself up-to-date professionally with the best available options for prevention and treatment.*

(6) *Help citizens to find their own way to cope with health risks and disorders, to protect and*

improve health, to make health-competent lifestyle choices, and to develop long-term care plans.

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Rights to Dispose of a Corpse: The Japanese Viewpoint

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In this paper I focus on three legal interventions—the 1979 law, the 1997 law and new 2009 Bill. In each case, a critical question concerns who has the final word: the deceased, the deceased's relatives, or neither.

Intention and Consent

In Japanese discourse rights to dispose of a corpse have always been discussed in relation with rights of burial. As far as a corpse is considered as an object of burial, its social value is passive and confined to matters relating to burial. Burial is a duty-based custom rather than a rights-based one. The rights-holder has a responsibility for burial. However, the advent of organ transplantation dramatically altered traditional values. The positive values of use were found in human corpses.

The Japanese general understanding before the advent of organ transplants was that rights to disposal refer not to the dead person's rights but to his/her successors' or relatives' property rights or customary rights to burial. It was very rare in Japan that one makes and leaves one's intention to dispose of one's own dead body while alive. Moreover, even if one does so while alive, the effectiveness of the intention is often limited by moral comparison between the dead's interests and his/her relatives' ones and by the concept of *kōjyo-ryōzoku* (public order and good morals) (for the details on the limitation of rights see William, 1997). This manner was applied to the provisions of the *Law on the Transplantation of Cornea and Kidneys* (Law No. 68, 1979; repealed in 1997).

Article 3 of the Law requires the written consent of the deceased's relatives before transplantation. In addition, some exceptional cases are permitted in which a person gives his/her consent to an organ donation and at the same time the person's relatives do not express an objection to the consent or there are no relatives of the person (Art. 3). The possibility of accepting the deceased person's rights to disposal may be found in Article 3. But even if there is the person's consent and only if his/her relatives express an objection to the consent, the provision prescribes that the removal is not feasible—the person's right to disposal can be rejected. In addition even if the person explicitly rejects the organ donation while alive and if only

the relatives give their consent to the donation, the removal is feasible. Apparently, in this way, this provision gives priority to the relatives' rights to disposal over those of the dead.

On the other hand, the present *Law on Organ Transplantation* (1997) (for a detailed explanation on the law, see Morioka 2001; Kato 2004) generally respects the autonomy of individuals with regard to donating their bodies (Art. 2). More precisely, organ removal from a dead person is authorised if that person expressed in writing the intention to donate, and his/her relatives who were informed about the will do not object to his/her body being donated or there are no such relatives (Art. 6). However, overemphasis of respecting individual autonomy might lead to a dearth (as of November 2009, based on this law, 82 donors whose organs were removed and transplanted have been reported) of transplant providers (Maruyama 2007).

This can happen in the following cases: first, where a person, pre-death, objects to donating his/her organs. Second, where a person fails to make a will despite having expressed his/her intention to donate. Third, where a person expressed his/her intention in writing but the written document has not complied with the formal requirements for testamentary disposal (e.g., a personal note in one's diary or a letter to a friend), this can enable his/her relatives to dispute the request. Thus by the enforcement of the Law an ante-mortem intention to donate is definitely respected more than in *Law on the Transplantation of Cornea and Kidneys*. Even if a person rejects the organ removal in the old law but if the person's relatives give consent to removal, the removal is feasible. But in the present law it is either not feasible or impossible because the person's will is respected by any means by the enforcement of the law.

Also a conflict between a person's right to disposal and his/her relatives' consent is recognised as a clear conflict between a person's intention and his/her relatives' intention. It is suggested that the provision for respecting the autonomy of individuals in Article 2 of the *Law on Organ Transplantation* functions as an *address* of recommendation for all relevant persons including relatives (Utsuki 1997). Even so, however, a conflict is inevitable. This conflict may come in two guises. One is that a person expressed his/her intention to donate and his/her family makes an objection to it. The other is where a person objects to becoming a donor and his/her family intends to donate his/her corpse. This conflict was related to the interpretation of Article 3 of the old law. Although a detailed explanation will be avoided here because of its complexity, the provisions of the Article were insufficient in that the consent of

the relatives is provided as a necessary condition but not as a sufficient condition, which resulted in a conflict of interpretation. It was interpreted that it would be logically possible to remove organs even in a case of the person's objection. However, an opposing view which supports the individual's intention claims that their intention should be respected more in the case of the individual's objection than in that of the consent so that Article 3 of the new law should be interpreted under the condition of the consent of the relatives (Utsuki 1997). Thus the present law can avoid this conflict more effectively than the older piece of legislation.

The *Law on Organ Transplantation* presumes any removal as illegal. Yet the old would suggest that the basic idea embodied in the law, that is, respecting the autonomy or individuals, works inadequately.

Relatives' Power of Overriding

Thus, there is in the practice of Japanese law the possibility that a dead person's right of character may be overridden after his/her death, by *Totensorgerecht* (a relative's right to protect the deceased). In Japanese law where the dead person's intention can be overridden by his/her relative's intention at the time of removing organs, a further problem arises in relation to minors who have limited legal capacities in general and no legal capacity regarding donation of organs. The problem is that even if a minor expresses an intention to donate his/her organs and obtains consent from his/her parent, the removal of the organs from the minor's body is not permitted (see Art. 3 of the *Law on Organ Transplantation*, 1997). When an adult's intention not to donate their organs is overridden by his/her relatives the law respects and prioritises the relative's intention more than that of the deceased's. Therefore, if the justification for this action is acceptable as it would appear to be, then it should also be justifiable to say that in the case of removal of organs from a minor's body, the relative's intention, that is the parents', should be respected by the law. It is illogical that due to the lack of legal capacity, especially, of intention, the minor's intention of consent of the removal cannot be realised by that of his/her relatives or parents.

A perspective seeking to protect a dead person's moral right might object to the suggestion that the relative's moral right (i.e., protecting his/her grief and sentiments of devotion) is relevant, because any relevance attached to a relative's moral right in this example would harm the dead person's moral right (Kanazawa 1984, 94-7). It could be argued that the relative's right to reject the deceased's surviving moral right is not acceptable on the grounds of legal order and

peace (ibid., 96). While the formal making of a will plays a vital role in protecting an individual's pre-death intention, the legal order is frequently inconsistent, for example, if the relative's right to dispose of the body overrides the individual's declaration of intention for potential donation (ibid.).

In the process of seeking grounds for the relative's power of overriding the deceased's intention, S. Hoshino (1984, 114) puts the character and roles of the relatives into three categories from legal and social viewpoints. First is economic disadvantages. The relatives have the economic vulnerability of losing rights to be supported and incomes when their bread winner dies. Second is the care of a corpse. The relatives have a duty to take respectful care of their family member's corpse, have the death registered, hold a funeral rite for the dead person, bury the corpse or the ashes, if any, and manage to maintain the deceased's tomb. Third is deprivation. The relatives such as parents, spouses and children are deprived of close relations with the deceased by his/her death. According to Hoshino's argument of the relatives' consent based on the above three points, the first one cannot be justified. It would be possible to justify the second one because of regarding the consent as a right to dispose of a corpse.

Making much of the third point, Hoshino argues that we have to look not only at the communality that the family members share with their daily life full of diverse domestic activities and tasks but also at the mental interpenetration that they interact with each other as an individual with personality and involve themselves deeply with each others' lives. Such mental interrelations enable the relatives to regard the deceased's body with strong symbolism and to feel deeply attached to and inseparable from corpse (Yoshida, 2004).

The amendments of Law on Organ Transplantation

On 19 June 2009, the House of Representatives passed a bill, among four rival bills, that will make it easier to obtain organs for transplants from brain-dead persons. There are four main points in the bill aimed at revising the Law on Organ Transplantation.

(1) Organ removal from a dead person is authorised even if the person's intention to donate is unknown and if only the relatives give their consent to the donation.

(2) A person can be determined brain-dead as a criterion even if the person's intention to accept brain death determination is unknown and if the relatives give their consent to the determination.

(3) Relatives of a donor can be given priority in

organ transplants.

(4) Organ donations by children under 15 are feasible.

After the approval by the House of Representatives, on 13 July, the House of Councillors passed the revised Law on Organ Transplantation, among three rival bills, which differ greatly in principle from the present law and is expected to gradually expand organ donations.

For removing some obstacles to prompt organ donations, under the amendments, provisions of the present law that forbid organ donation by children under 15 was repealed. The path was opened to donating organs and practicing organ transplants between children within Japan, so that children in need of an organ transplant do not need to have the procedure done overseas. In addition since the new law marks the first time that brain death has been recognised as the legal death of a person in Japan, the increase in the determination of brain death as a criterion expected. Therefore there is an insistent claim that medical reluctance to prolong life after brain death may expand ubiquitously in general medical practice. That is why the bill's sponsor explained that the brain death provisions of the new law would apply only to instances of organ transplantation but not to the definition of legal death generally. As of November 2009, as previously mentioned, there have been only 82 organ transplants from brain dead donors ever since the enactment of the present law. But organ transplantation under the new law will be expected to increase.

In order to enhance the procurement from brain-dead donors, the new law strengthened to some extent the power of the relative's intention to consent, as I previously mentioned. Even if a person expressed in writing the intention to donate and even if there is a case excluding the case where the person expressed in writing the intention to reject the donation, the removal is feasible. Namely even if the deceased person's intention to donate is unknown and if only there is the relative's intention to approve the organ transplants, the removal is feasible. Therefore, in a case where the deceased person's intention to reject organ transplantation is turned out after the removal, there is no relief for the person.

Compromise Views

Thus the grounds for the relative's power which can override the dead person's intention can be argued to lie in the co-operation stemming from the relationships between the dead person and his/her relatives (Hirabayashi 1984, 133-4). Moreover it could be argued that the relatives, as living people, have an autonomous power to

determine their own lives, thus they have a self-determination to autonomously dispose of their next of kin's corpse (ibid., 135). Compromise views may however be possible. Ishihara (1991), for instance, suggests that neither the dead person's intention nor their relative's intention is overridden and that:

'[O]nly in some cases where the explicit intentions of both sides are not contrary to each other and they are in accordance with co-operation for organ transplantation, will the medical practices gain popularity among people and develop as a vital medical remedy for securing recipients of organs based on the donor's good-will' (ibid., 43) [my translation].

In the case, therefore, where the relatives object to organ removal and this objection conflicts with the dead person's intention, this conflict is acknowledged in the present Japanese law and organ removal should not be permitted. On the other hand, in other different cases where the relatives give consent for removal and yet this consent is against the dead person's intention, the present Japanese law can be interpreted to permit removal. However, in terms of legal interpretation, the dead person's objections to removal should not be overridden by the relative's consent for removal.

The *Law on Organ Transplantation* attached importance to the dead person's intention more than the *Law on the Transplantation of Cornea and Kidneys*. Behind the change of the law's attitude is the fact that Japanese society came to accept the definite intention that an individual makes. The Japanese individual's positive attitude to express his/her own intention advances the freedom in disposing of his/her corpse (Rowe 2003). Since in general Japanese have great respect for the ritual act such as laying the ashes in the tomb and its ground and the maintenance of family tombs for ancestor worship, they have been for a long time taking it for granted that ashes should be kept in the tomb. However a recent social movement of scattering ashes would illustrate the awakening of rejecting the idea of 'succession of the family tomb and its ground' (Yasuda 1992). Scattering ashes can be understood as a traditional way of funerals and burial. Emperor Junna ordered his ashes scattered on a mountain in A.D. 840. *Manyōshū* (Anthology of Ancient Poems) has two elegies regarding the scattering of human ashes. Such an ancient custom was related to those of re-burial, but the claim, in contemporary Japan, for scattering ashes can be considered as an expression of an individual's intention to dispose of his/her corpse. By the representation of the intention an individual can claim for rights of self-determinations.

Such a claim based on the freedom of making an intention has been almost disregarded in the traditional debate on rights to burial. Whoever thinks of 'my' corpse should not be 'myself', but 'my' relatives. 'I' do not claim anything about the disposal of 'my' corpse at all. 'I' take the trust of 'my' relatives for granted. This traditional attitude toward posthumous disposal would suggest that the ritual tradition imposes a duty of ancestor worship including 'me' on descendants and relatives and that the *ie* idea confines 'me' to the frame of the maintenance of traditional household.

Conclusions

Said in this way, we can understand that the dead person's right to dispose of his/her own corpse is deeply associated with the society and culture of the times. Scattering ashes in contemporary Japan is based upon the new formation of the individual's consciousness that the individual wants to manage his/her death and posthumous situation involved with his/her corpse. It follows that individuals emancipated from the traditional *ie* system have been claiming their freedom and self even after death. A recent relevant new claim (Mori 1993, 245-7) is one that Japanese housewives do not want to lay their ashes in their husbands' tombs. Mori analyses this trend of dislike as a fact that the idea of rejecting the *ie* system has been steadily spreading among Japanese women. It is an evidence of the emergence of the female's new consciousness that they do not want to be restricted by the Japanese traditional idea *ie*.

When we review the connection between the collapse of the *ie* system and the right to dispose of a corpse, it would be possible to understand that the intention to donate organs is a representation of the intention and freedom that an individual wants to be emancipated from restraint or the like.

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Status of Women in India – A Historical Prospective

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"There is neither Jew nor Greek, there is neither bond nor free, there is neither male nor female: for ye are all one in Christ Jesus" –Galatians 3: 28

The biological fact of sex has created many differences between men and women. Their aims, desires, duties, behavioural patterns, dress styles, roles and statuses are often different. Nowhere in the history of humankind were they treated alike and assigned equal status. In spite of their urge for equality, women could not achieve equal status on par with men. The type of status assigned to women often reflects the nature of cultural richness and symbolizes its level of progress. However, in almost every society, women were subjected to inequality, discrimination and exploitation.

In the ancient period in most cultures, women were subordinates to men and could neither inherit property nor hold any public office. According to predominant social customs, the woman must have a single partner while man can have many choices (with the few exceptions of polyandry). Due to this kind of double standard morality, women remained as widows or committed *sati* (self immolation). Several social practices and

religious formalities made women slaves to men. Not only in India, but also in other countries women experience oppression. According to Plutarch, a Greek writer, the wife is ideally the moral and intellectual equal of her husband and a well ordered home depends on the mutual consent of both the husband and the wife. But in reality, women were tied to their homes and engaged in child rearing and managing homes without any role in the world as men do. Women's education was confined to music, painting, embroidery and household or farm work. According to Manu, the women should never be independent and have to be under the control of father, husband or son. Women were subjected to social evils like child marriage, *sati* and suppression. Even in the same society, the status accorded to women has been changing. In this paper a brief survey of the status of Indian women is described, and it may pave a way for the alleviation of injustice done to them. The status of women in India can be analysed in three stages as ancient, medieval and modern periods.

Ancient India (3000BC to 500AD)

Though the women of ancient India enjoyed an equal status with that of men, they were held in disrespect and positive hatred. During the Vedic period (3000 BC to 600 BC), women enjoyed freedom in education, marriage, economic production, spending money and religious activities. There were instances of polygamy especially in the royal class. The women were bound by patriarchal tradition and the wives were expected to be obedient to their husbands helping them in the performance of their duties. There were disparities between men and women in property matters. Women had no right of inheritance as they were weak. In ancient Tamil Nadu, women lived in social bondage. They did not possess any property rights. They were confined within the four walls of the house, unaware of the events happening around and were actually slaves of superstitious beliefs and unwanted customs. Women were treated as dependent minors and were denied property rights in the earlier society. They were treated as the property of men. In general, the social situation was not in favour of women possessing property, but protection was given to them as daughters and wives. Though women could participate freely in social gatherings, their participation in public meetings and debates became less common in the later Vedic period.

Next to this, during the Epic period, restrictions were imposed on the freedom of women. Husbands were given the status of God for a women, education was totally denied to the womenfolk and social evils like *Sati*, *purdah* (veil)

system and polygamy came into practice. If the wife had the misfortune to survive her husband she had to face a deplorable situation. Either she had to undergo *sati* or she had to lead a cursed life as a widow. Women were forbidden to offer religious sacrifices, prayers, penance and pilgrimages.

Female education was considered as an alien phenomenon in Tamil society. According to Hindu social customs, women need the knowledge about the duties of a household alone. Hence women were always filled with fear, shyness and ignorance. There were several obstacles to female education which was not going to provide any means of livelihood for them as men were considered as the sole breadwinners of the family. Women got married early in their age and hence they couldn't attend schools. Moreover, availability of female teachers and girl's schools was so limited. Women were so conservative with traditional customs and superstitious beliefs. When female education was promoted by the Christian missionaries, it brought many social reforms. It also helped in the removal of caste discrimination to some extent. In boarding schools, the girls were trained to lead a community life. Even girls of high and low castes lived and dined together. The promotion of female education by the British in India facilitated the development of women and their entry into different fields. In Madras, the first missionary school for girls was started on 17 October 1821 by Miss Cooke and Rev. W. Swayer. When caste Hindus hesitated to admit their daughters in mission girl's schools, Sophia Chester started separate caste Hindu school for girls at Dindigul. Later, similar schools were also started at Madurai. During the Buddhist period, women regained a part of their lost freedom due to the Buddhist philosophy which was relatively broadminded.

Medieval India (500AD to 1500 AD)

The medieval period proved to be highly disappointing for the Indian women as their status deteriorated further due to Muslim invasion and the enforcement of strict *Brahmanical* laws. Girl children were considered as a burden or liability and they could not inherit property. Women were reduced to the status of slaves and remarriage of widows was prohibited. As the Muslim invaders started kidnapping the girls, the parents resorted to child marriages. Child widows led a miserable life as they were denied education, public life, and religious activities. They were considered as inauspicious and debarred from all functions and festivals. They had to forgo all the jewelry ornaments and tasty food. It was the Christian missionaries who took special efforts to remove the curse from the widows. They organized

several ameliorative measures for the rehabilitation of widows. The American Madura Mission (AMM) missionaries at Madurai instituted *Widow's Aid Society* in the church congregations for helping widows and orphans. They started schools teaching industrial arts like embroidery, plain and fancy needle work, and stitching, so that the widows can practice them as a livelihood. Though certain reformatory measures were introduced by Swami Vivekananda, Brahmo samaj, and Prarthana Samaj towards the remarriage of young widows, the main impetus was from Pandita Ramabai (1858-1922) who opened Sarada Sadan, a house for the widows. The Widow-Remarriage Act was passed in 1856. The first Widow Remarriage was welcomed in June 1883 at Madras. In 1891, the British government could pass the Age of Consent Bill which prohibited the marriage of women below twelve years of age. Child marriage was prohibited by the Act of 1891. The Indian Divorce Act of 1869 brought relief to Indian women. Their presence on important occasions was considered as disgraceful and they were treated as a symbol of bad omen. Hence some of them led an immoral life or even turned into prostitutes. To avoid such sexual offences, the widows were forced to shave their head and forsake all types of ornaments.

Sati became a widespread practice during this period. In this, the married women used to jump into the funeral pyre of their husbands with the hope of attaining heaven. In certain instances, the women were forcibly pushed into the funeral fire of their husbands. *Purdah* system was common among the Muslims of medieval India. It was a practice found only in the wealthy and royal classes of the Hindus before the Muslim invasion. Later many of them were forced to wear *purdah* to escape from the sexy looks of men. This led to the complete seclusion of women and the denial of education and public life.

Devadasi system grew into a social evil during this period, which spoiled the prospects of many young women. In the name of religion, marital opportunity was denied to women and they were forced to serve God in temples as dancers and singers. They were also compelled by the circumstances to become prostitutes. *Devadasis* (maid servants of the deity) was a category of women dedicated to religious service in temples. They were children dedicated to the temples who married the Hindu gods. *Devadasis* were trained in music and dancing and even sent to schools for education. They used to dress well, put on more ornaments and perform arts. They visited palaces, houses of *zamindars* and attended all public and religious functions. This brought so much of revenue to the temple treasuries. These women

not only served as the servants of god but also satisfied the priests and pilgrims. They were exploited by the kings, religious leaders and other authorities. Enlightened section of the society condemned and criticized the practice of *devadasis* which brought a change in the social outlook of women. Christian women missionaries like Amy Carmichael (1867-1951) did yeomen service in the reformation of devadasis around Tirunelveli. For this she was awarded the prestigious award, Kaiser-i-Hindi Medal.

Like the Hindu women, Muslim women suffered because of male dominance and could hardly get equal rights. Muslim men were allowed to marry four women and divorce any wife at will. As severe restrictions were imposed on the movements of Muslim women, they could not avail educational opportunities and participation in public life, cultural and religious activities.

The *Bhakti* Movement that emerged during the 14th and 15th centuries introduced some relief in the religious and social life of women. Certain Hindu leaders like Chaitanya, Nanak, Meera, Kabir and Tulsidas fought for the right of woman to religious worship. As a result, Indian women could achieve certain social freedom also. The *purdah* system was abolished, and women were allowed to attend religious prayers and festivals. But this could not bring any change in the economic structure and Hindu women continued to remain in their low status in the society.

Modern Period (1750AD to Present)

The modern period can be approached in two stages as the status of women during the British and the status of women in post independent India. Though the status of women remained the same during this period, considerable progress was achieved in eliminating inequalities between men and women in education, employment and social rights. Social evils like child marriage, *sati*, *davadasi* system, *purdah* system and prohibition on widow remarriage were either controlled or removed by suitable legislation. In addition, western culture had resulted in a drastic change in the attitude towards women. The western values, liberal principles, rationalistic approach towards problems, the right to question and criticize, and social equality influenced the Indians. Raja Ram Mohan Roy, who founded the Brahma Samaj played a pivotal role in the abolition of *sati* through the promulgation of the Prevention of *sati* Act in 1829. He also fought against *purdah* system. Rajaram Mohan Roy was able to identify eight social evils corroding Indian society especially women as *sati*, female infanticide, polygamy, infant marriage, *purdah*, absence of education among women, *devadasi* and joint family system.

The Widow Remarriage Act was passed in 1856 by the British Government due to the efforts of Ishwar Chandra Vidyasagar. Arya Samaj started by Maharishi Dayananda Saraswathi advocated equal rights to women. Swami Vivekananda gave importance to the education and self-dependence of women. Later, leaders like Dadabai Navaraji, G.K. Gokhale and Mahatma Gandhi raised their voice for improving the status of Indian women through the Congress movement. Women leaders like Nivedita, Annie Besant, Margaret Cousins, Sarojini Naidu, Pandita Rama Bai, and Ramabai Ranade tried to involve large number of Indian women in political and social activities.

The vast mass of Indian women remained illiterate for more than 2000 years. Education was restricted to only girls belonging to rich and royal classes and to the families of dancers and *devadasis*. During the British rule, the Christian missionaries took interest in female education. Several girl's schools came into existence after 1824. Girls were allowed to go for higher education only in 1882. The literacy percentage among females in India increased from 0.6 in 1901 to 64 in 2001. Women also began to take part in the struggle against the British hegemony. Realising the need of the participation of women in the freedom movement, Mahatma Gandhi persuaded large number of women to take part in Satyagrahas, processions, protest meetings, demonstrations and public meetings. Later women started associating themselves in political movements also. Women came to the forefront and joined in the freedom movement also which elevated their position on par with men in public activities. The promotion of female education by the British in India facilitated the development of women and their entry into different fields. When the womenfolk expected all round help and attention to get rid off the suppression and problems, the welfare measures of the government and the services offered by the Christian missionaries helped them to achieve betterment.

By the end of the 19th century, considerable numbers of women started entering salaried professions. Many of them preferred medical and teaching professions. Though the British adopted the policy of non-interference in the religious and social life of Indians, several laws related to marriage, property and employment were enacted to protect the rights of women like,

- The Special Marriage Act 1872
- The Child Marriage Restraint Act, 1929
- The Married Women's Property Act, 1874 and;
- The Hindu Women's Right to Property Act, 1939.

But these legislations had certain limitations and touched only the fringe of the problem. Hence they

could not effectively wipe out the hardships of women.

Post independent India

Indian independence brought radical changes in the socio-cultural life of women with the reduction in the exploitation of women. The Government appointed several commissions and implemented programmes which brought awareness about the problems of women.

Constitutional and Legislative measures

According to the Constitution of India, all men and women are considered equal and they are equally entitled for individual freedom and fundamental rights. It also provides for equality of sex and favours protection to women against exploitation. The Government also took a number of legislative measures to safeguard the interests of women including:

- The Hindu Marriage Act, 1955 (prohibits polygamy and polyandry, and concedes equal rights to women to divorce and to remarry)
- The Hindu Succession Act, 1956 (provides for women the right to parental property)
- The Hindu Adoption and Maintenance Act, 1956 (gives childless woman the right to adopt a child and to claim maintenance from the husband after divorce)
- The Special Marriage Act, 1954 (fixed the minimum age of marriage at eighteen for females)
- The Dowry Prohibition Act, 1961 (dowry is declared as an unlawful activity)
- The Suppression of Immoral Traffic of Women and Girls Act, 1956 (offers protection to women from being kidnapped and or compelled to become prostitutes)
- The Family Court Act, 1984 (seeks to provide justice to women who get involved in family disputes)

Education and Employment

The educational performance of girl students has been increasing. On a merit basis they join in prestigious professional colleges including medical and engineering institutions. Even though city women are conscious of education and its importance, more than 70% of Indian rural women are still illiterate.

There has been a remarkable increase in the number of women entering employment both in cities and villages. Employment has given them economic independence and self-confidence. The government has also devised socio-economic legislation concerning the right to property, equal wages, working conditions, maternity benefits and job security.

Awareness of rights

The Indian constitution bestowed women with two important political rights, female enfranchisement and eligibility for the legislature. Women could develop sufficient political awareness and some of them could attain high positions in political parties, legislatures and cabinets. In 1937, itself women contested in elections to the local legislative bodies and some won seats. After independence, the number of women voters and women representatives in assemblies and parliament increased. Women started occupying coveted positions in political parties, Legislatures and Cabinets. Mrs. Indira Gandhi served as a powerful Prime Minister for more than a decade. In 1992, according to a constitution amendment, one-third of the seats were reserved for women at the Panchayat level.

Women form one third of the labour force and play a major role in agricultural operations. Hence they play a major role in economic development. In addition to agriculture, they also engage in live-stock production, horticulture, post-harvest operations and house-hold activities. They are involved in the activities of industries, services and mercantile activities.

Even then, most rural women are not well aware of their rights. The majority of the women are not identified as independent individuals but regarded only as daughters, wives, mothers or as family members. Women also did not prefer to have independent identification. Many of them stop careers when satisfied with their family life and do not possess the ambition to take part in political or public life. Working women do not enjoy the freedom in spending the money they earn according to their will and wish. They also are often not involved in decision making process but leave them to their men folk. In the unorganized sector, still the exploitation of women continues as many of them are illiterate and ignored. In many families male children are still preferred over female children. Without a basic change in the minds of people towards women, bringing more legislation to ensure better opportunities to grant more rights and concessions will be futile.

Conclusion

In India, women are not yet equal to men. The main occupation of woman is to bear children, look after her husband and to take care of the household. The working women are doubly burdened as they have to finish domestic work after office duties. Though they have the equal rights of freedom and liberty, they have to obey men. There is no legal or constitutional barrier and women want only their interests to be protected and problems solved. These issues raise a number of

questions about the decision making ability of Indian women for all areas of bioethics.

What the present women need today is greater freedom, better education, self-dependence, decent jobs, and proper treatment by men, and a socio-economic environment free from exploitation. It will not be prudent to restore the rights of the women belonging to the affluent section of the society alone. Therefore, our efforts have to be directed towards holistic development of each and every section of Indian women by giving their due share. It is obligatory to maintain and protect chastity, dignity and modesty of women and it is the need of the hour to give due share to each and every section of Indian women.

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Peoples' Attitudes towards Elderly in Bangladesh

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Abstract

This study on people's attitude towards elderly was conducted at Meherchandi and Dharampur village under Rajshahi District to determine the individual characteristics of the respondents, to assess the relationship and the influence of those individual characteristics on the attitude towards elderly. Data was collected through interviews and were subjected to statistical analysis by the researcher. Results revealed that the mean score of attitude was 12.97 (against the possible score of (-) 40 to (+) 40 with a standard deviation of 5.37. Most of the respondents had positive but weak attitude towards elderly. However no negative attitudes towards elderly were expressed. Only education had significant positive correlation towards elderly which influenced 52% of total variation.

Introduction

Aging is a common phenomenon of human life. One must meet aging in our life if we remain alive. To reach in this stage people become very weak, helpless and become static. Dependency on others is very much increased. A person will want to depend on others to survive, needing more care and attention. In the discussion about the theories of aging, gerontologists said that sometimes aging is static and sometimes it is active. According to the disengagement theory, aged people try to fold themselves from all their activities. On the other hand, activity theorists said, in this stage old people can create a golden era by their past experiences (Kart, 1985: 97).

Thus there are different thoughts about aging among gerontologists and also among the common people. There is a myth that old people are miserable, lonely, have health problems, victimized by crime; live in poverty, unable to manage household etc (Kart, 1985: 1-10). With the changes in personality and interests that come with age, it is reasonable to expect that societal attitudes also change. Throughout their life span individuals have age-related attitudes. Two kinds of attitudes have evolved - (1) the attitude of the individual towards his age group and (2) the attitude of members of his age group towards other different age groups.

From the above it is apparent that 'attitude' is "an individual" characteristic way of regarding an

object, person or process. It involves evaluation, whether one likes/dislikes, approves/disapproves, seeks/ avoids, a particular object, person or process (Chadha, 2003). Previously, elderly people were in a good position in society as well as in their family. There was a proverb in Bangla- "*Teen Matha jar, buddi nibi tar*". The meaning is, if you have problems to solve, go to the aged person. It is believed that aged people were considered as wise. But today that belief has become swing. In most cases we can see that they are oppressed or neglected and being treated as "Buro" (aged), idle or workless, burden etc (Roy, 1996). Our socio-economic and cultural changes are responsible for this.

Social behaviour towards elderly depends on social attitudes towards elderly. Because action depends on the perceived goals in the situation, the affective values of the goals, and the expected probability that is given acts will lead to the goals. We can predict action on the basis of our knowledge of the stimulus situation putting these three categories of action on a continuum that varies in the degree (McKeachie, 1966). Mohsin (1967) mentioned that attitude influences the opinion about the person or group. It may also influence the action in respect to the person or group. If a person have favourable attitude towards a particular person he will be found ready to help him, to form good opinion about him and to welcome his company. Thus he mentioned that attitude has, accordingly, been described as a permanent state of readiness or preparedness to perceive, feel, think and act in a particular manner, to be inclined towards or reject, to be attracted or repelled by an object, issue or person. Mussen *et al* (1973) affirmed that personal factors such as family, self, esteem, intelligence, etc, has a greater role on attitude formation while, Huston's (1983) study found that age, religion, economic status, education also may guide the attitude of a person.

Hence this study was undertaken with the following objectives:

1. To know the peoples attitude towards elderly.
2. To find out the relationship between attitude towards elderly and some selected individual characteristics. and finally
3. To predict the influences of individual characteristics on attitude towards elderly.

Theoretical Framework

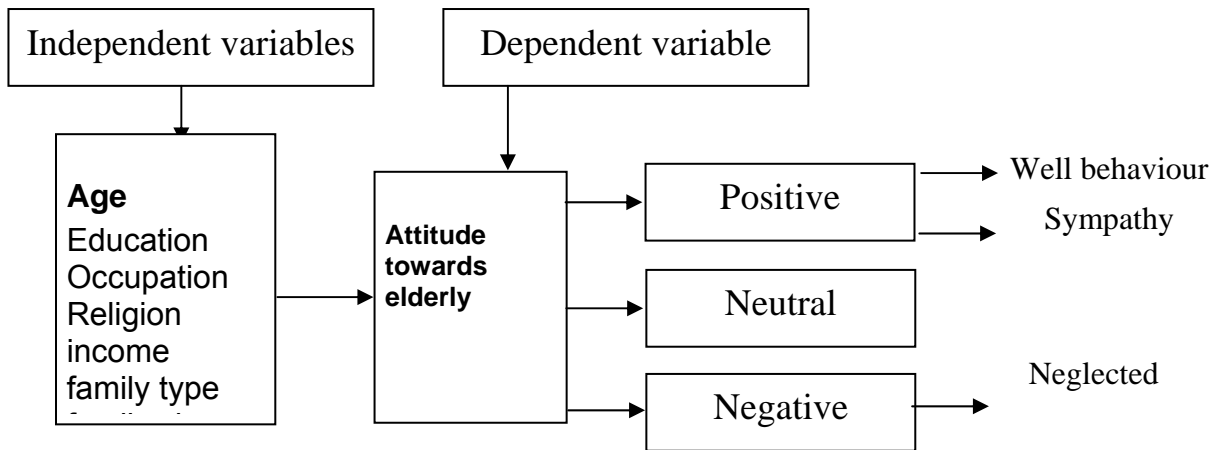


Figure 1: Schematic diagram showing the relationship of the independent and the dependent variables.

Table 3: Correlation matrix of attitude towards elderly and individual characteristics of the respondents

	Age	Education	Family member	Family status	Income	Land holdings	Occupation	Religion	Attitude
Age	1.0								
Education	-.235*	1.0							
F. member	.068	.149	1.0						
F. Status	-.047	.099	-.569***	1.0					
Income	-.019	.495***	.234*	-.149	1.0				
Land holdings	-.027	.289**	.367***	-.115	.289**	1.0			
Occupation	-.014	-.219*	-.100	.067	-.259*	-.158	1.0		
Religion	-.13	.082	.237*	-.206*	.133	.076	.107	1.0	
Attitude	.146	.228*	.111	.032	.121	.082	-.149	-.144	1.0

* Significant at .05 level ** Significant at .01 level *** Significant at .001 level

Table 4: Step-wise regression analysis between attitude towards elderly and individual characteristics.

Variables	Regression co-efficient	Value	Provability	Partial Square	R
(Constant)	--	13.471	.000		
Education	.228	2.142	.035	.052	

Methodology

The study was conducted at Meharchandi and Dharampur village of Motihar Thana under Rajshahi district. The respondents of the study were farmers, businessmen, employees, housewives, day-labourers and many other categories of the society. Of about three hundred matured people of those two villages (Meherchandi and Dharampur) 86 were randomly selected as sample.

A pre-tested researcher made questionnaire was used to collect the data using Likert attitude scales. The researchers also observed and interviewed the farmers for clarification and confirmation of the findings. Data were collected

by some students of the Department of Social Work and the researcher herself on March, 2008

In determining the respondent's individual characteristics, descriptive statistics (means, range, standard deviation, percentage) was employed. In ascertaining the relationship between the variables the Pearson's product moment correlation co-efficient was used. Finally, the influence of independent variables on dependent variables was analyzed through the step-wise regression analysis. The computer package SPSS was used for these analyses.

Results and Discussion

The individual characteristics of the respondents are presented in Table 1 and Table 2. Respondents' age ranged from 20-70 with a mean of 36.86 and standard deviation 10.99. Most of the respondents (41%) belong to the age group 31-40 years. Education varied from 0-16 years with a mean of 5.48 years of school and standard deviation 4.84 years. In the research area 36% of the respondents did not have any formal education. Most of the respondents (38%) had 6-10 years of schooling. In the research area most of the respondents were day labourers (35%) and businessman (34%). A large number of respondents (90%) were found Muslim and rest of those (11%) were Hindu. The annual income also varied from 0-120,000 Taka with a mean 37,510 and standard deviation 20,650. Most of the respondent's income (47%) was belong to the annual group of 26,000-50,000 Tk., followed by 0-25,000 Tk. (31%).

About 60% of respondents had a nuclear family and 40% had joint family. Respondents' family members ranged from 2-11 with a mean of 5.43 and standard deviation 1.7. About 70% of respondents had 4-6 members in their family. Land holdings also varied from 0-22 acres with a mean of 1.49 and standard deviation 4.19. However, most of the respondents (63%) were landless.

Attitudes towards the elderly

The attitude of the respondents varied from 0-24 with a mean of 12.97 and standard deviation 5.37. Possible scores of attitude were -40 to + 40, of which - 40 indicates completely negative attitude and + 40 indicates completely positive attitude towards elderly and "0" indicates neutrality. Most of the respondents (43%) had an attitude score towards elderly between 13 to 18 followed by 7-12 (28%). Only one respondent indicated a neutral attitude towards elderly and none were found to express an negative attitude.

Table 1. Respondents' individual characteristics and attitudes towards elderly

Variables	Range	Mean	SD
Age (Year)	20-70	36.86	10.99
Education (School year)	0-16	5.488	4.84
Income (Tk. in '000')	0-120	37.51	20.65
Family member	2-11	5.43	1.75
Land (Acres)	0.00-22	1.49	4.19
Attitude (Scores)	0.00-24	12.97	5.37

Table 2. Frequency and percentage of Respondents individual characteristics and attitudes towards elderly.

Variable	Range	Freq	%
Age (year)	20-30	29	33.72
	21-40	35	40.70
	41-60	18	20.93
	61-80	4	4.65
Education (school year)	0	31	36.05
	2-5	13	15.12
	6-10	33	38.37
	12-16	9	10.46
Occupation	Business	29	33.72
	Service	13	15.12
	Day-labourer	30	34.88
	House wife	13	15.12
	begging	1	1.16
Religion	Muslim	77	89.5
	Hindu	9	10.5
Annual Income (Taka)	0-25000	27	31.40
	26000-50000	40	46.51
	51000-75000	16	18.60
	76000	3	3.49
Family status	Joint family	35	40.7
	Nuclear family	51	59.3
Land holding	Landless	54	62.79
	Up to 1 acre	14	16.28
	1-3 acres	8	9.30
	4 acres and above	10	11.63
	Up to 3 members	8	9.30
Family member	4-6 members	60	69.77
	7-9 members	15	17.44
	10 and above	3	3.49
	Attitude (score)	0	1
1-6		11	12.79
7-12		24	27.91
13-18		37	43.02
19-24		13	15.12

Relationship between attitude towards elderly and the individual characteristics

To find out the relationship between attitudes towards elderly and the individual characteristics Pearson's product moment correlation was used and showed in Table 3. It was found that education had significant positive correlation with attitude towards elderly. This means higher educated person bear more positive attitudes and lower educated person or uneducated person bear comparatively low attitudes or negative attitudes towards elderly. Age, number of family member, family status, annual income, land holding,

occupation and religion have no significant relationship with attitude towards elderly. In the matrix, a strong (0.001%) positive correlation was found between education and income, and family members and land holdings. A strong negative correlation was also found between family status and family members, because joint families dissolved and produce nuclear families with the increasing number of family members. Thus number of family members in nuclear family is comparatively lower than the number living in joint families.

Influences of individual characteristics on Attitude towards elderly

To determine the influence of individual characteristics on their attitudes towards elderly, step wise regression analysis was employed and the results are shown in Table 4. It appears that 52% variance was influenced by education only and it is significant (.035 level of probability).

Conclusion

It was found that among 8 (eight) independent variables, only education had a significant relationship with attitudes towards elderly. Education also significantly influences the total variance in forming positive attitude towards elderly. Thus in our society we need to expand education to increase the level of positive attitude towards elderly.

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Depletion of Fresh Water Resources

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"There is a river, the streams whereof shall made glad the city of God, the holy place of the tabernacles of the most High" Psalms 46: 4.

Introduction

Water is considered the elixir of life. Occupying two thirds of the earth's surface (71%), it plays a major role in governing our climate. Being a medium, it provides the space for all living processes to occur. As a universal solvent, it dissolves nutrients, helps in the process of thermoregulation and the excretion of wastes. Since water has several unique thermal properties that combine to minimize temperature changes, the range of variation is smaller and fluctuations occur more slowly in water than in air.

About 60-75% of the body of most living organisms is formed of water. One could survive for weeks without food, but only a few days without water. Fresh water is required for agriculture, industries and transportation. It is essential for sculpting the earth's surface and diluting pollutants. The Holy Bible starts with the verse, *"The spirit of God moved upon the face of the waters"* (Genesis 1:1). Water is used to symbolize cleaning of sins in many religions. Worldwide, water is a source of spiritual nourishment and is endowed with a range of mythic and symbolic properties. The qualities that make water so extraordinary are its rambunctious movement, power, uneven distribution and central necessity to life. Because of its countless roles, it is considered as the 'life blood of the ecosphere'. In North America, a team of photographers, writers and editors could observe a historic mismanagement of water, blatant cases of waste and pollution and widespread ignorance of water problems. Such an important resource is often misused, overused abused and mismanaged. In many a situations it is either wasted or contaminated with an arsenal of pollutants and contaminants.

Water resources

The movement of water, its beauty, its support of life makes it perhaps the single most significant recreational resource on earth. The total amount of water in earth is more than 1404 million km³ i.e. about 370 billion gallons. In this, about 97% is in the marine environment which can not be used for drinking or irrigation directly. Even in the remaining 3% of fresh water, 2.997% is locked up in glaciers. Thus about 0.003% of water is available in the form of lakes, streams, rivers, ponds, water vapour, soil moisture and exploitable ground water. But this amounts to a generous supply which is continuously collected, purified and distributed forming hydrological cycle. But damage is caused by anthropogenic activities to both by overwithdrawal and discharge of wastes.² Moreover, this water is unevenly distributed resulting in water related conflicts between nations. Already water has begun to replace oil as a major cause of confrontation in the Middle East. With the increase in population and industrialization water scarcity may intensify. Global warming might also cause changes in rainfall patterns ultimately disrupting water supplies.

Anthropogenic activities

Nearly every human activity requires clean fresh water. Hence its availability determines the center of his activities. We could realize this fact by remembering the development of early civilizations in the river banks. Water is a renewable resource which can be replenished regularly. But human activities carried out with scant regard for its conservation lead to its depletion. Water can be returned to recirculation if it is not contaminated with various pollutants. But it is lost if it undergoes evaporation, absorption and contamination. The average amount of water withdrawn world wide is about 646m³ /person / year. Water use is highly influenced by national wealth and the degree of industrialization.

Agriculture

Agriculture amounts to about 69% of total water withdrawal. In countries like India, almost 93% of water is used for agriculture alone. Much of this water is lost due to inefficient irrigation. The most common type of irrigation is by simply flooding the whole field or running water in rows between crops. In this, 70-80% is wasted through evaporation and seepage before reaching the crops. Sprinkling water is a kind of efficient irrigation but much water is lost through evaporation and also it is an energy intensive

method. Drip irrigation is water-efficient as it delivers measured amounts of water exactly where the plants need and use it. In this, about 90% of irrigation water can be saved and salt building can be reduced. But the installing costs are high. Depending upon wealth, the farmers can adopt a method but with much consideration for water conservation.

Industries

Industry uses about one fourth of the water withdrawals. In certain industrialized countries, about 70% of water is used for industries. Much water is used as cooling water for power plants. When such water is returning, it causes thermal pollution causing damage to aquatic organisms and ecosystem health. With the increase in industrialization, the volume of waste water needing treatment is going to increase enormously.

Domestic use

Domestic water use accounts for about 6% of world water use which includes water used for drinking, cooking and washing. This is influenced by the wealth of the family. Safe drinking water and effective sanitation are necessary for maintaining public health and to prevent communicable diseases. But one fourth of the world's population lacks adequate drinking water and basic sanitation. With the increase in population and urbanization, scarcity of water increases in gravity. According to World Health Organisation, 100m³ (264,000 gallons) of water/person / year is necessary for human health and development. Some of the African countries even cannot meet the minimum essential water needs of their citizens. Rural people are often the most affected. More than two-thirds of the world's households have to bring water from outside the home. This difficult job mainly done by women and children, even takes sometimes two hours a day. In certain countries like Peru, up to one-third of the family's income is spent in acquiring and purifying water.

Ground Water

Ground water accounts for nearly 40 percent of the fresh water used for agriculture and domestic purposes. Overuse of this source dries up wells, natural springs, rivers and lakes. Withdrawal of water from aquifers faster than natural recharge will cause a cone of depression in the water table. Excessive pumping will deplete the whole aquifer and recharging such aquifers will take thousands of years. Aquifer depletion also leads to saltwater intrusion especially in coastal regions and subsidence (sinking of land). Ground water is also prone to contamination from industrial and

² See the ECCAP WG14 report for reflections on water ethics.

agriculture operations, septic tanks and other sources.

Increasing Water Supplies

Though the amount of water on the earth is fixed, efforts have been made to redistribute water resources. To increase water supplies, some have tried to tow icebergs from Antarctica, create rain in dry regions through cloud seeding, desalination of sea water and to have dams, canals and water diversions. Though dams and canals increase the fertility, they can be a source of environmental disaster and injustice. Construction of dams changes the entire lotic ecology of the rivers affecting the aquatic organisms which are adapted for running mode of life. Large dams often flood towns and farm lands. If they are constructed near forests, a large forest area is submerged affecting the forest cover and displacing large numbers of tribal persons who rely on forest produce for their livelihood.

Though dams ensure water supply throughout the year, huge amounts of water is wasted through evaporation and seepage. The salts left after evaporation and agricultural run-off increase the salinity of the river. Siltation is another problem due to dams which decreases the effectiveness of reservoirs affecting water storage and hydel power generation. Due to dams, annual floods can not occur which normally bring rich silt to farm lands, thus making the cultivable lands infertile. Large dams have their own advantages and drawbacks. But constructing small dams may have fewer destructive effects than large dams which can help to trap water for irrigation. Earthquakes, floods, landslides, faulty construction, sabotage or war can cause damage to dams leading to huge loss in lives and property.

Desalination mainly involves distillation or reverse osmosis for the removal of salts from marine, brackish or ground water to increase the supply of fresh water. But desalination is energy intensive and hence the cost of water is high. It also produces huge quantities of brine and dumping such brine is a big problem. If dumped on land, it again contaminates ground water as well as surface water. It is suitable for coastal cities in arid regions if the plants are run on efficient solar powered methods.

Cloud seeding mainly involves injecting a cloud with chemicals like silver iodide to form water droplets as rain. But in dry areas rain clouds are rarely available. Moreover, it will alter snowfall and rainfall patterns affecting regional and global climate patterns. The chemicals employed in cloud seeding will contaminate the soil and aquatic systems affecting living organisms. It also leads to

legal disputes over the ownership of water in clouds.

Conservation

Curbing wastage is a significant approach towards water conservation. It reduces the burden on septic tanks, waste water plants, dams and water transfer projects. This in turn prevents the destruction of wildlife habitats and the displacement of people. In many countries farmers pay by the area of land they irrigate, irrespective of the volume of water they use. Naturally they have little interest to use water sparingly. To meet the scarcity of water, treated urban waste water could be used for irrigation. If this treated waste water reaches aquatic systems, it enhances the process of eutrophication with its high level of nitrates and phosphates. Rather it can be efficiently used to fertilize vegetation as done in Israel successfully.

In farming, irrigation efficiency can be improved by monitoring soil moisture with computer systems and water will be provided when necessary. Switching to more water-efficient, drought-resistant and salt-tolerant crop varieties will lead to water conservation. In industries, processes that can use recycled water can be introduced or the machineries can be redesigned to save water. Water used for domestic purposes can also be reduced by adopting changes in our lifestyles. Taking shorter showers, fixing leaks, using efficient dishwashers and avoiding green lawns which require much water will help in saving water. Low-flush toilets and composting toilets will reduce water use.

Untreated or improperly treated human wastes form the main source of pathogens causing water-borne diseases like typhoid, cholera, dysentery, enteritis, polio, infectious hepatitis and schistosomiasis. In addition water is polluted by the discharge of organic and inorganic chemicals and radioactive materials. Water pollution is often, a major threat to environmental quality. This can be alleviated much by discharging treated effluents and wastes into the environment. Watershed level monitoring and its protection help to maintain water quality. Water pollution control can be achieved effectively through environmental legislation and adopting bioremediation approaches. Proper land-use practices and careful disposal of wastes along with the concern for water conservation will definitely prevent the depletion of water resources.

After the Second World War, problems of public health and water pollution associated with urbanization and industrialization necessitated a modernization of water law in France. Scientific knowledge must be applied in the creation of water laws and policies. With the growing

population and improving living standards the water requirement is increasing and the per capita availability of water resources is reducing day by day. There is a need for proper planning of water resource utilization so that the gap between the water availability and requirement may be minimized. Virtual water trade is one of the alternatives to reduce water consumption. Virtual water refers to the water required in the production of a commodity or service. The virtual water concept has two applications. First, virtual water can be an alternative source of water to achieve regional water security. Virtual water trade can solve geopolitical problems and avoid wars over water. Secondly, the virtual water content of a product tells about the environmental impacts of consuming the product.

Instead of constructing huge dams, watershed management can be adopted to prevent flood damage and to store water for future use. The watershed is all the land drained by a stream or river. Retaining vegetation and ground cover in a watershed lessens floods. Watershed areas can be reserved for water storage, aquifer recharge, wildlife habitat and agriculture.

Water is the most valuable but least appreciated resource. In many places, water policy is based on riparian rights or prior appropriation rights. Charging higher costs to users has helped encourage water conservation. Effective water pricing and allocation policies discouraged wasteful water uses. But they should not be at the cost of environmental, recreational and wildlife values.

Conclusion

Earth being dominated by water is popularly called as the water planet. Water is an essential and the most abundant substance in protoplasm. Though fresh water habitats occupy a small part of the earth's surface as compared to marine and terrestrial habitats, their importance to humankind is far greater. As there is no possibility of existence of life without water, water conservation and the protection of water resources must be given top priority. Curbing water wastage, prevention of water pollution and proper management of water resources will lead to sustainable water supply and the successful existence of life.

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The Vital Testament

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Introduction

Since the beginning of this Millennium, Portuguese physicians are required to consider the patient's decision to refuse therapy, thus incurring into death, or to cease treatment when the clinical setting is irreversible and terminal. Patients have therefore the right to convey directly their wishes to the physician. Likewise the patient's family members may also express the wish for the physician not to perform resuscitation maneuvers in patients deprived of vital functions. Much has been said lately in Portugal about the so-called "vital testament". The vital testament is favoured in the ethical code and has an indicative value. The vital testament of a person's living will is a written document by a person when in full use of his mental capacities by which that individual expresses orientations about the treatment that he or she wishes to receive or refuse in the last moments of life, namely the wish to refuse life through artificial equipment and therefore making an option towards a natural death and discharging a high technology vegetable life!

Needless to say the vital testament may be nullified or altered as many times as needed. However, the knowledge of any nullification or modification should be conveyed to the delegate of person holding the correspondent power of attorney.

A physician may not violate a patient's informed consent even if the decision implies the patient's death. For example, if a patient in full use of his faculties has in verbal or written communication stated that he does not wish for a blood transfusion, the physician cannot decide otherwise even knowing that such a decision may trigger the patient's death!

The 1997 Convention for the Human Rights and Biomedicine was signed in Portugal on the 1st

December 1999, although it was only adopted as a law proposal two years later, thus reassuring the principle of the individual's self determination within the clinical context. Although the Portuguese Association of Bioethics has fought against this legal limitation the political parties represented in the Parliament prefer to focus on "euthanasia"! Euthanasia does not meet with the approval of the national medical class. In Portugal a clear discussion about these issues is highly relevant and urges as pointed out by the Portuguese Association for Palliative Care. The patient's autonomy is accepted in the whole world and reinforced by the now revised Portuguese ethical code. People may and should discharge unnecessary treatment but with due caution! It is important for the Portuguese to discuss the vital testament within the frame shift of human dignity at the end of life but such measures should not be taken lightly.

The adoption of possible over the counter solutions has emphasized in the Portuguese clinicians the spectrum of a vital testament with a compulsive character. The Portuguese Intensive Medicine College rephrases that decisions at the end of life should be assumed with a perfect knowledge of the diagnosis and with a through perception of the prognosis for a certain patient regarding the specific circumstance in which the patient is enrolled meaning that the vital testament may not be reinforced by Law because of its "abstract nature"! The Portuguese lawyers are already arguing about the best way of reinforcing the law. The basic model exacts a written document and two witnesses of the notary's certification in the written document where the patient anticipates the wish regarding medical intervention at the end of life. The more complex model requires a medical consultation and a notarized document allowing the possibility of non fulfilment within the scope of the so called "complex cases". These models are followed in the USA, Spain, France, England, Denmark, Austria, Germany and many other European countries.

Ethical Questions in Terminal Life

The Portuguese Association of Bioethics and the Bioethics Department of the Faculty of Medicine of Oporto have issued during the last two years recommendations which served as a basis for the Socialist Party (holding the majority of the Portuguese Parliament for the last four years) to issue a Law discussed in the Parliament on May 2009. This discussion was not pursued due to the lack of time in the Government Agenda and probably because new elections are due by the end of September 2009. The Portuguese

Association of Bioethics has promoted a general and enlightened discussion of ethical questions disregarding "taboos" of any order or nature. These debates have covered issues such as euthanasia, the vital testament, non-resuscitation orders or palliative care. Regarding euthanasia the Portuguese ethicists argue that such issues should be tackled with "clarity, transparency and determination", although admitting that these same issues may lead to fracture or cleavage of our society and in general of the modern western democracies. The ethicists claim that there is no point in beating around the bush and that the Portuguese physicians should openly assume a gap in terms of public discussion.

The aging of the population, the advances in medicine, the social organization and society plurality are some of the factors that confer pertinence to issues connected with terminal life. Nowadays, death from the social point of view is regarded in a different way compared to bygone days. People die in hospitals where health professionals are not prepared to deal with death. Human dignity should be the compass for all clinical interventions. This type of concept is, however, prone to a flexible interpretation and in practice may lead to a value clash, for example, the holiness of human life versus the right to self determination. Within the same context ethicists are in favour of the exercise of a deliberative bioethics and propose that the opinion of the Portuguese population should be called upon such matters following the mould adopted for the referendum regarding voluntary pregnancy interruption (discussed in *EJAIB* before). There are questions such as whether legalizing euthanasia will lead to greater desire to do it.

In the Netherlands since euthanasia was made legal it kept on diminishing slowly from year to year because the health systems acted to minimize such requests encompassing palliative care and combat terminal pain. In Portugal there are thousands of people who suffer from chronic pain which is pitiful in a country that spends 10% of the PIB in health care; this number is way above other European countries. The ethicists rephrase that with the spiritual assistance and the approval of the vital testament the wish to die before one's time may also slowly fade away ...

If people could exercise their right to auto determination the fear of dystanasia and the scorn for aggressive therapy may be mitigated. It is pertinent to recall that dystanasia regards treatments enduring suffering without a benefit to the patient. It includes the maintenance of artificial vital functions without clinical justification. It regards a patient's death at the patient's request through the intervention of a health professional

meaning that the physician supplies the lethal drug, which is self administered by the patient. This approach is legal in Holland, Belgium, Luxembourg, Germany, and Oregon in the USA.

From the legal point of view, euthanasia, abortion and other life and death issues are difficult situations that not only force people to think but do not meet with a single right answer. People are prone to face certainties but justice may not bestow on people what society is lacking. The principle of holiness in life is at stake when a person is free to choose self determination. This could be similar to suicide which was punished for a long time. In England such punishment came to a halt in 1961. Thus if suicide is not punished the vital testament may be considered "an indirect form of suicide" as claimed by the Portuguese parties which oppose the socialist party. Judicially, it seems pretty much the same if people refer verbally or in writing that they do not wish to be treated. Up from the moment that a person may deny a treatment and die for religious reasons (example, religions that strongly oppose a blood transfusion, notwithstanding the fact that the patient may die without such transfusion), justice will have to admit that this particular person may declare his or hers wish in writing.

Issues Involved In a Vital Testament

Basically the vital testament is meant to serve two purposes. Regarding the person involved in a situation of terminal life, that same patient will have the control over his or her own health, thus releasing family or friends from the burden and anguish of difficult and sometimes painful decisions. The vital testament also avoids conflicts triggering arguments between the various family members regarding the avoidance of certain treatments in a terminal situation. A vital testament implies that its author has enough maturity to understand the nature of the afflicting disease, the clinical evolution of his status and even the complications that may trigger death within the scope of the pathology in course. It seems therefore vital that the patient should exchange opinions or discuss such subjects with the family physician or rather the attending specialist in the course of an aggravating condition. It is desirable that family and friends should have an intervention thus enabling the patient to convey self convictions as well as receiving the necessary feedback from responsible and enlightened people.

A vital testament shouldn't hit the family as an unexpected blow or well guarded secret but rather be regarded as an instrument or means for a sick person to transmit to one's own private and affectionate circle the wish for a dignifying option in a terminal situation. A vital testament is not to

be taken as an instant request. The Portuguese Penal Code (Article 150-1^o) specifies that medical intervention or treatment will not be considered a corporeal offense if such intervention is addressed to prevent diagnose, eradicate or lessen a disease, a suffering, a body lesion or fatigue. By nature a conscious, free and expressed patient's wish is all that it takes to validate a statement with juridical relevance. Such principles emerge from the general law setting (defined in the Portuguese civil code regarding a negotiable statement). A non conscious or non free statement is the shadow of a wish if not a wish mined by a mistake or imposition. Without such mistakes or impositions the individual's wish could have been expressed in a different way! To exact an "expressed" wish means the denial of a tacit or implicit wish. With equal similarity when the Penal Code contemplates a relevant consent (not to mention a presumed consent – article 39 of the Portuguese Penal Code – the statement in question is labeled as "free, responsible and clarified" (Portuguese Penal Code : article 38-2^o). A simple wish or instant request is way out of being considered a valid statement. Therefore the wish in question should be persistent, insistent and repetitive in order to rephrase the Author's determination to stick to such principles.

Discussion

The informed consent did not originate from the sick people but rather from the healthy individuals. The first time that the essence of an informed consent was approved was within the scope of the Nuremberg Code in 1947; other citations followed namely the Helsinki Declaration (1964). The misuse of war prisoners in the experiments of mass concentration camps obviously without any type of consent, is one of the tragic events in the genesis of the concept of an informed consent. It is precisely in the Nuremberg Code that the concept of the informed concept is focused thus reinforcing the patient's autonomy. This code specifies that "*voluntary consent is absolutely essential meaning that the individual in question should have legal capacity to declare his or hers consent, should be in a position to exercise the power of a free choice without the interference of any out force source, fraud, miscarriage or any other form of constraint and also that this same individual should have enough knowledge and understanding to enable him to make a decision with the full understanding of the options involved in such decision*".

An informed consent regards essentially the patient and the physician but may in exceptional cases apply to a donor, to family members (e.g., a clinical diagnosis has its reflection in other family members) or to healthy individuals (for example,

the clinical assays carried on viewing new therapies and performed in healthy individuals that should be informed of the inherent risks). If the principle underlying the informed consent seems "very simple, clear and easy", in clinical practice it is not that simple. No doubt the fact that the importance of an informed consent is undisputable, its nature and the possible way of obtaining a truly informed consent it not that straightforward.

Consensus quotes that the process to obtain an informed consent has three basic elements: information, comprehension and willingness and this reality "ranges from the diagnosis to the therapy and experimentation". For example, a simple diagnosis for genetic predisposition to a certain disease may have ethical implications. The knowledge of how to inform and what to inform are the main difficulties of this procedure especially considering that to unveil information has equally ethical boundaries: it only concerns information that reasonable people would like to obtain in order to make a decision in relation to the therapy options and depends on the perceptions that each physician has through an ongoing relationship with each patient of the type of information that this specific patient may receive considering the patient's individual's characteristics. The respect for autonomy may not be interpreted in an arbitrary way as the patient may not be in conditions to understand the technical evolution and so on... Furthermore the patient psychological status has to be taken in consideration.

An absolute vision of autonomy may have noxious effects leading to the neglect of the patient's care in a terminal condition. "Terminal patients although without autonomy are always entitled to goodness" and should not diminish the health professionals sense of responsibility for their acts. A physician may not be a simple supplier without responsibility in the consumer's choice! The relationship between the physician and the patient is expressed through an affinity therapy between a person that detains the scientific knowledge and another individual that consciously accepts this therapeutic approach as his own. Only then will the patient be fulfilled as a person and the physician will be accomplished as a health professional. The physician of medical team should be obliged to explain the advantages, caveats and consequences of a medical intervention. This information should be sufficient and impersonated and one should never forget the right of **not being informed** silencing whatever the patient prefers to ignore! The principle of therapeutic privilege or immunity enables one, under the circumstances, to withhold relevant information that may harm the patient's

condition. One ought to convey all the truth that the patient wishes for or needs or is in conditions of enduring. As always even this ethical duty has its limits as one may not jeopardize the rights of third parties.

The vital testament doesn't provide a magical solution to all problems concerning ethical dilemmas in a terminal stage of life but is no doubt a means to avoid in many cases a therapeutic stubbornness and to afford a dignifying death. The maintenance of life may lead sometimes to unnatural definitions of life and death! It is within this level that one is faced with the contradiction between the artificial continuation of life, if one may call such condition as "life" and the right to dignity in death or as some may quote "the paradox to live one's own death". The sophisticated techniques of cardiac and respiratory maintenance, the true life engineering through the delirium of medical care and equipment and the acceptance of a real mummifying technology may trigger the risk of human obliviousness, considering the dignity inherent to the real subject of a vital phenomenon. The principle that a subject under the servitude of such flamboyant technology risks to convert the very subject of this phenomenon into the plain object of that same phenomenon!

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Respecting Life and the principles of Bioethics: from a mysterious birth to a carrier

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(Zhou Dynasty: BC 11th century - 6th century. A glance at history shows that no dynasty ruled longer than the Zhou.)

Zhou Dynasty had Houji as its ancestor, Before his birth, his mother was in a mythical labour. □ As far as Houji's inception, it's said that Houji's mother stepped by delusion, on a certain day, more than 3000 years ago, on the footprints of the great Emperor.

She then miraculously became pregnant; gave birth to Houji after being expectant. The home birth took place at a narrow alley; the baby's birth was very unearthly.

The very confused mother as she was would then like to throw the baby away. But with a strong and surviving vitality of the baby, a mysterious force was protecting the baby. Whether the baby was abandoned in the street, Or in the wilderness, or on the top of ice, he all subsisted!

At his age of eight months, when he would had been on all fours just to creep, he was able to find his own food to feed himself.

In the ensuing days, soon, he was able to harvest for what he had cultivated as a very skilled specialist. The amount of crops that he cultivated were plenty, and God had given him a lots of fine variety. Furthermore, he taught people how to worship God; He invented agriculture and the plow for all the people.

He was able in ensuring his people the construction of an affluence line from the original poverty line, as well as in helping his fellows to discover agricultural opulence.

Hence he respected the principles of justice and of altruism**. The latter per se is a foundation of beneficence, which some regard as the most important principle of bioethics.**

He then headed home to settle in Tai for the Dynasty of Zhou, with respect and dignity, and he followed the principle of autonomy. He dedicated his love and respect to God. God, as well, particularly blessed Zhou people with a lot of the products and God's shelter as the secured refuge.

This thus concludes the mysteric birth, child development and carrier of Houji.

As to Houji and his people's homecoming, it is

unlike the following event of devouring the oxen due to a lack of the principle of animal ethics as described by Homer in the Book 1 of Odyssey:

The book 1 of Odyssey (Homer, 800BC-600BC, translated by Richmond Lattimore, 1906 – 1984)

Tell me, Muse, of the man of many ways, who was driven Far journeys, after he had sacked Troy's sacred citadel. Many were the whose cities he saw, whose minds he learned of, many the pains he suffered in his spirit on the wide sea, Struggling for his own life and the homecoming of his companions. Even so he could not save his companions, hard though He strove to; they were destroyed by their own wild recklessness, Fools, who devoured the oxen of Helios, the Sun of God, And he took away the day of their homecoming.

That having been noted, naturally, Poetry just like sky, it's perpetual; On the poet's and their readers' readings, It appears to look like a Zen master's tossing a question rather than giving the answer. Even if the answer were given, others may not even similarly interpreted.

On the Zhou dynasty's Houji, the legendary ancestor, with the attempt to express a concept of respecting Life and Bioethics, Masters may have to answer the issue in history - only if the historians are familiar with bioethical issues on the other hand as well.

For another instance, altruism has been an ethical resource for it has biological, cultural, social as well as spiritual sources.

Wherever it derived from nevertheless altruism and social relationship surely are extraordinarily vital to bioethics.

Otherwise a poem-writer merely can write in the manner of a multi-dimensional meaning. And then let the readers to explain as they wish.

Hence, a fair way of writing epics appears to be as the aforementioned.

Thanks to this issue on life and bioethics that has impacted this writer's thoughts intensifies his soul as well as deepens his mind as well.

Reference

** The editorial.

<http://www.eubios.info/EJAIB32009.pdf> p.33

News in Bioethics & Biotechnology

<http://eubios.info/NBB.htm>

International Bioethics Education Project News

<<http://groups.yahoo.com/group/Bioethicseducation/>>

UNESCO Asia-Pacific School of Ethics

<http://www.unescobkk.org/index.php?id=apse>

In October 2009, the 35th General Conference of UNESCO reviewed the recommendation of the Executive Board on the advisability of preparing a draft universal declaration of ethical principles in relation to climate change. Following intensive debate and dialogue, the General Conference adopted the following Resolution, which will launch a process that could lead to development of a declaration of ethical principles in relation to climate change.

The General Conference,

Recalling 29 C/Resolution 13, paragraph 2.C(d), 30 C/Resolution 20, 31 C/Resolution 21.1(a) and 32 C/Resolution 26, calling upon UNESCO to promote ethical reflection associated to the advancements of science and technology, with the advice of the World Commission on the Ethics of Scientific Knowledge and Technology (COMEST),

Having taken note of 169 EX/Decision 3.6.1,

Considering the UNESCO Strategy for Action on Climate Change, as approved by the Executive Board at its 180th session (180 EX/16 Rev.),

Taking note of the request by the Executive Board, at its 181st session (181 EX/Decision 15), that the Director-General enhance the Plan of Action on Climate Change, in particular through focus on the social and ethical implications thereof,

Taking note of the recommendation made by COMEST at its Sixth Ordinary Session (16-19 June 2009), "In view of the nature and extent of the scientific, social and human challenges of global climate change, which necessitate adoption of policies at the global level to address the pressing needs of the most vulnerable in the face of major uncertainties and the exigencies of international cooperation, it is urgent to determine universal ethical principles to guide responses to such challenges. COMEST therefore recommends that UNESCO should develop an ethical framework of principles in relation to climate change",

Considering that the ethical principles in relation to climate change may be the subject of a declaration and that further study of this issue is necessary,

1. *Requests* the Director-General, following consultations with Member States and other

stakeholders, including relevant United Nations' agencies, further study on the matter by COMEST and the UNESCO Secretariat, to submit to the Executive Board at its 185th session, a report on the desirability of preparing a draft declaration of ethical principles in relation to climate change and to prepare, if found appropriate by the Executive Board, a draft declaration of ethical principles in relation to climate change, taking into account the conclusions reached at the 15th Conference of the Parties of the United Nations Framework Convention on Climate Change (UNFCCC COP-15) to be held in Copenhagen in December 2009, and to submit the outcome to the General Conference at its 36th session provided that the cost of the study can be covered by reallocation within the approved programme and budget for MP III and extrabudgetary funding.

Bandung Declaration of the International Conference of the Coalition of Cities against Discrimination

The members of the Coalition of Cities commit themselves to the ideals of the conference which is called the Spirit of Bandung Two.

The members endorse the UNESCO ten point action plan, and commit themselves to practical plans and actions including:

The members will effect a mass movement through implementing concrete commitments through local regulations;

The Coalition of Cities Against Discrimination in Asia and the Pacific will hold a regional follow-up meeting once a year (in Bandung or rotating around the region);

The Bandung provincial government will host a website for the Coalition of Cities Against Discrimination to share good practices. The members commit themselves to share good practices and lessons learned;

The members will broaden the membership of the Coalition to include NGOs, academics and experts working together to achieve the goals;

The members will adopt broader definitions of discrimination, including all elements that will promote an inclusive society;

The members commit themselves to protection of cultural diversity;

The members will adopt broad definitions of the “city” to encourage better rural and urban management to protect the dignity of all persons;

The members agreed to work as a regional Coalition to evaluate better practical measures to protect human rights, and to promote respect of the integrity and dignity, of persons living outside of their home community, especially migrant workers;

The regional Coalition meetings will always be open to participation of members from other regions in the global Coalition.

30 October 2009

Background: UNESCO Coalition of Cities against Discrimination in Asia and the Pacific

The Coalition of Cities against Discrimination in Asia and the Pacific was officially founded during the “Regional Conference of Cities for an Inclusive Urban Society”, hosted by Bangkok Metropolitan Administration (BMA) and UNESCO which held in Bangkok, Thailand, on 3-4 August 2006. The Coalition remains open for further signature by municipalities in the region. Please refer to www.unescobkk.org/rushsap for details.

The Coalition of Cities against Discrimination in Asia and the Pacific (APCAD) is a network of cities and municipalities interested to meet, discuss, share ideas, experiences, think and act together. In order to develop and strengthen their policies to counter all forms of discrimination that will allow a more efficient implementation of policies for a greater social inclusion of their city dwellers in the full respect of their human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.

A *Ten-Point of Action Plan* relating to the Asia and the Pacific has been developed, covering different areas of competences to local authorities, such as education, culture, housing and employment.

Ten-Point of Action Plan/Commitment for Asia and the Pacific:

- 1) Assessing Racism and Discrimination and Monitoring Municipal Policies;
- 2) Providing Political Leadership at the City and Community Levels;
- 3) Promoting an Inclusive Society;
- 4) Strengthening Support for the Victims of Racism and Discrimination;
- 5) Facilitating Greater Participation and the Empowerment of City Dwellers through Access to Information;
- 6) Promoting the City as an Equal Opportunities Employer and Service Provider;
- 7) Promoting the City as an Active Supporter of Equal Opportunity Practices;
- 8) Challenging Racism and Discrimination through Education;
- 9) Promoting Cultural Diversity;
- 10) Preventing and Overcoming Racist Incitement and Related Violence.

Asian Bioethics Association (ABA)

<www.eubios.info/ABA.htm>

Conferences

For a list of some ethics meetings in Asia and Pacific:

http://www.unescobkk.org/index.php?id=current_and_future_events

Eleventh Asian Bioethics Conference (ABC11), and the Fifth UNESCO Asia-Pacific School of Ethics Bioethics Roundtable, 31 July – 2 August, 2010, Singapore. (In conjunction with the Tenth International Congress of Bioethics, 27-31 July 2010). Please send proposals and abstracts of papers to d.macer@unesco.org

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