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Editorial address:

Prof. Darryl Macer, RUSHSAP, UNESCO Bangkok,
920 Sukhumvit Rd, Prakanong, Bangkok 10110, THAILAND
Fax: Int+66-2-664-3772
Email: d.macer@unesco.org

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

Editorial: Universality of Bioethics

One of the recurrent themes in international discussions of bioethics, and in Asian bioethics, is the universality of descriptions and prescriptions of bioethics. This issue of *EJAIB* includes a series of papers which discuss that theme.

One of the common institutional structures to make ethical decisions is a bioethics committee, and in the first paper Jayapaul Azariah makes a review of the situation of Institutional Review Boards (IRBs) globally and in India. The data he uses is based on the USA OHRP-approved IRBs, which is updated on-line. There have been debates about the way to recognize IRBs, and their function, but they are only one model of bioethics committee. There are several alternative models of ethics committees, and UNESCO in its Assisting Bioethics Committees (ABCs) program is aiding countries who request assistance to establish national policy making bioethics committees. These have a different function to IRBs (See a series of books available in different languages from www.unesco.org/bioethics).

The case studies discussed in India include YRG Care Ethics Committee, an AIDS related organization. AIDS has been a catalyst for reflection on bioethics, in a similar way to genetic technology was. In another paper in this volume AIDS and HIV are linked to the altruism. Altruism itself is a basis for beneficence, which some, including myself, consider to be the most important principle of bioethics.

The second paper in this issue is on "Contextualizing Bioethics: The UNESCO Declaration on Bioethics and Human Rights and observations about Filipino Bioethics" by Lukas Kaelin. This paper discusses some aspects of the UDBHR, though focusing on the principlism implicit in the UDBHR. As a comment, which applies to many analyses of the UDBHR, one first need to consider whether UDBHR is only a prescriptive text, or whether it is also a descriptive text. The context

of the UDBHR was that it was a UNESCO document approved by member countries, however, the correct title is the **Universal Declaration on Bioethics and Human Rights (UDBHR)**. While many see it as a UNESCO document, the official title is UDBHR. UNESCO is a secretariat to member countries, so the Declaration is belonging to countries not to UNESCO itself. Therefore the issue is really how to compare state-level bioethics with the cultural realities of different societies.

In the paper there is absence of referral to the UDBHR article 12 accepting the importance of cultural diversity and pluralism, nor referral to the Convention on Cultural Diversity which UNESCO General Conference accepted at the same time as the UDBHR. A Convention can become legally binding when ratified, unlike a Declaration. All the articles in the UDBHR provide a framework for common dialogue and discussion on bioethics, among different cultures. From this framework our dialogues can become fruitful.

That being said however, there are different frameworks besides principlism on which bioethics can be constructed. However, we can see these frameworks not only in the Philippines, or other Asia and Pacific communities, but also within so-called Western societies as well. The UDBHR does imply principlism, because it has been a useful language for discussion of bioethics and for implementation of policy, and because every state agreed to that framework. Also the common legal framework of protection of human rights, is a starting point that can be used in discussing the universality of ethical relationships between humans and others. This does not mean that we should ignore other approaches to ethical discourse however.

The next paper, "Aesthetics in Ethics: Narrative and Theoretical Dimensions of Moral Evaluation", by Paolo Marino Cattorini, is exploring narratives in bioethics discussions. This is seen around the world also, and in a sense continues the discussions of the universality of human experience. The comparative analysis of narratives is the basis for descriptive bioethics, and there is much left to discover.

The next paper looks at the development of ethics education in Pakistan, with "Perception of Physicians and Medical Students on common Ethical Dilemmas in a Pakistani Medical Institute", by Bushra Khizar and Mobeen Iqbal. There is a need for education in ethics. This leaves us with a question of what to teach. One of the recent developments is the **Core Curriculum on Bioethics** developed by UNESCO, which adopts a series of values to be taught in a core course based on what is accepted in the UDBHR. UNESCO would like to enter into partnerships, and develop MOUs with any institution that would like to trial the Core Curriculum. Please write to me if you are in Asia-

Pacific region as we would like to trial out the course goals. The materials are still being enriched, and a range of case studies and other teaching material are available on UNESCO Bangkok and Paris websites (and in GEObs database 6).

The paper from Nigeria on "Altruism: An Ethical Resource for Dealing with HIV and AIDS", by Helen Kunbi Labeodan, is linked to "Evolution of altruism" by K. K. Verma and Suresh C. Sharma. Altruism has biological, social and spiritual origins. Wherever it came from however altruism and social relationships certainly are central to bioethics.

There is a poem with an ecocentric angle, "The rare plants' lamentation" by Bing Tang, prior to a description of the IAB Arts Bioethics Network (ABN). Finally a paper from Bangladesh on "Human Cloning: Prospects and Challenges in the Asia-Pacific Region" by Shamima Parvin Lasker. Although it can be said that we need to deal with the challenges of social responsibility in bioethics when faced with the high death rates of people across the world, the issue of cloning and ES cell research is one which shows how governance models adopted in each country are diverse. Even if we may have universality at some level, the right of each country to make policies to respond to these issues in their own way is central to our modern international governance structure. Cloning debates in the UN General Assembly led to a Declaration adopted with split opinions, which is in marked contrast to the unanimous agreement with the UDBHR.

This editorial is written after a very successful Tenth Asian Bioethics Conference, held in Tehran, Iran. It is testament to the aspirations of many scholars to understand ourselves and our cultural diversity that the Asian Bioethics Conferences and the Four UNESCO Asia-Pacific School of Ethics Roundtable have been held in many countries drawing together a solid foundation of regional scholarship.

I urge readers to submit papers to *EJAIB*, so that we might be able to engage in deeper reflection of the nature of bioethics, and lessons of real experiences to the frameworks that will shape policy to better outcomes. All the opinions here can be questioned, and debated – that is the essence of bioethics and its universal feature.

Related to these dialogues are some forthcoming UNESCO conferences in the Asia-Pacific region, including Asia-Arab Interregional Philosophical Dialogues on the Crisis of Civilization, 28-30 May in Bangkok. Experts from 30 countries will come together to discuss various themes, including bioethics. I refer readers to the websites to find more information.

-Darryl Macer

Institutional Review Boards, Worldwide (IRBs)

- Jayapaul Azariah, Ph.D.
Founder President, All India Bioethics Association,
New No. 4, 8th Lane, Indiranagar,
Chennai 600 020. India
Email: jazariah@yahoo.com

Abstract

The concept of Bioethics Committees evolved due to mistreatment of human beings during the periods of war as well as to find a medical treatment-cure for syphilis in the USA. Bioethics committees address ethical and moral issues raised due to the advancement of science and technology in the fields of Life Sciences, Biosciences and Medical Sciences. There is also a need to develop a mechanism to address ethically burdened issues and provide an impetus to governments and policy makers for ethical governance. Such a body which provides such logistic mechanism goes by the umbrella term of Bioethics Committees. Bioethics Committees have taken various dimensions such as Institutional Review Boards (IRB), Research Ethics Committee, National Bioethics Advisory Committee, Policy-making Bioethics Committee, Hospital and Health Care Bioethics Committee and Medical –Health professional bioethics Committees. An analysis has been made to record the number of countries which have IRBs – out of a total of 245 countries. A few countries have more than one hundred IRBs and about 99 countries have no bioethical committees. Special attention has been paid to Indian national scenarios, and case studies of YRG Care and ICMR are discussed. The need to address upcoming biotechnological issues in Asian countries, in the context of IRBs, has been pointed out. The importance of recognizing medical ethics and bioethics as academic disciplines has been pointed out.

Introduction - Historical

It is well documented in eastern literature that rudiments of medical ethics existed from the early civilization of the Vedic Period (3000 - 800 BC) (Azariah 2003). However, modern medical ethics and the broader discipline of Bioethics *per se* take their roots from western biomedical and behavioural sciences as well as from western philosophy. Following historical situations provided the ground and formed the compelling reason for the institution of Institutional Review Boards (IRBs). The German-Nazi doctor's inhuman experimentation and mistreatment of prisoners during World War II resulted in the emergence of Nuremberg Code in 1947. The UN brought out the Universal Declaration on Human Rights (UDHR) in 1948.

The Tuskegee Report deals with the case of male Negro (1932-1972) in Tuskegee Alabama. About 399 and 201 healthy human subjects, without syphilis, constituted the control group. These human subjects formed a part of an experiment to find out a treatment-cure for the disease. The research subjects were kept in total darkness as to the nature of the treatment and they were not given the choice to be enrolled in the study (no informed consent). As a result the Tuskegee Syphilis Study came to be known as the "arguably the most infamous biomedical research study in US History".

The Belmont Report was published in 1978 by the US Department of Health and Human Services, explaining the unifying bioethical principles aimed at the protection of human subjects in biomedical and behavioural research. The Belmont Report endorses three core bioethical principles in researches dealing with human subjects, namely respect for human persons / dignity, beneficence and justice. This foundational

statement is the driving force for the proper functioning of all Bioethics Committees.

Provision in the Helsinki Declaration of 1964, revised in 1975, for the formation of an "Independent Committee" laid the foundation for the functioning of the present bioethical system of Institutional Review Boards whose primary function is to oversee the steps taken to ensure the protection of human dignity and human rights. Recognizing the fact that the discipline of bioethics has currently undergone marked cultural and social changes the UNESCO brought out a fresh Universal Declaration on Bioethics and Human Rights (UDBHR adopted on 19.10.2005) which recognizes that "ethical issues in medicine and life sciences and associated technologies may have an impact on individuals, families, groups or communities and humankind as a whole". Therefore, all IRBs, in principle, must function on the basis of bioethical principles of justice, autonomy, beneficence and confidentiality, thus preserving the social stability.

Importance of Bioethics Committees

Bioethics committees concern themselves with the ethical and moral issues raised in the advancement of science and technology in the fields of Life Sciences, Biosciences and Medical Sciences. It is imperative, therefore, to develop a mechanism to address these issues and provide an impetus to governments and policy makers. Such logistic mechanism goes by the umbrella term of Bioethics Committees. These committees function in any institution where research studies are conducted on animals as well as human subjects so as to provide better health care. Providing improved health and enabling the sick to have the access to health care system is the primary aim of the Bioethics Committees. In health care institutions it provides ethical guidance in the area of doctor-patient relationship, protecting human dignity and maintaining confidentiality to patients living with HIV or AIDS. Depending upon the nature and requirement Bioethics Committee has taken various dimensions such as Research Ethics Committee, National Bioethics Advisory Committee, Policy-making Bioethics Committee, Hospital and Health Care Bioethics Committee and Medical –Health professional bioethics Committees.

Bioethics in India

The advent of 21 century has assured in an era of biosciences ethics. Recent developments in new biology and biomedical sciences and their practical application in research involving human and non-human subjects have necessitated the implementation of Institutional Review Boards (IRB). In an Indian context, the discipline of bioethics was introduced for the first time in 1996 by conducting an international bioethics congress at the University of Madras, Chennai.

A national awareness in bioethics was created with the birth of the All India Bioethics Association (AIBA) in 1996-1997. Bioethical maturity of a society deals with the following aspects: (i) how to control the use or misuse of newly acquired biological and medical knowledge and the tools of biotechnologies (ii) to develop a critical frame of mind and (iii) to develop a system of values that prepare us to judge each new biological, molecular and genetic discovery or biotechnology as it evolves as well as to resolve problems with bioethical dilemma and (iv) it insinuates itself into the awesome and broad domains of the life sciences and health sciences (UNESCO, 2005 a).

Therefore, proper governance of IRBs is closely associated with such awareness of core principles of bioethics. Implementation of regulatory bioethical measures through IRBs is to ensure a competent review of all ethical aspects of the research project proposals involving human subjects.

Definition of IRB

A Bioethics Committee otherwise called the Ethics Committee and the Institutional Review Board (IRB) is "a

committee that systematically and continually addresses the ethical dimensions of (a) the health sciences, (b) the life sciences and (c) innovative health policies. A bioethics committee is typically composed of a range of experts, is usually multi disciplinary and its members employ a variety of approaches to work out toward the resolution of bioethical issues and problems, especially moral or bioethical dilemmas. Moreover, the members of these committees not only become more sensitive to ethical dilemmas but also, in time, develop the knowledge and skills required to deal more effectively with them, frequently finding ways to resolve what may at first appear to be intractable dilemmas." (UNESCO, 2005, a).

Bioethics committees generally have no legal authority to prosecute or take legal action against any erring institution. To a larger extent, it protects the Principal Investigator (PI) from any pitfalls in his research which may trigger legal proceedings and it also ensures the protection of human dignity and human rights of the human subjects. Just as it is protecting the investigator against legal proceedings it also safeguards public trust.

World Scenario

IRB - Office for Human Research Protection

In the United States of America (USA) the Office for Human Research Protection (OHRP) maintains a Registry of IRBs of the world (<http://www.hhs.gov/ohrp>). On a national and international basis, it caters to the interests of human subjects in clinical trials and provides infrastructural support in bioethics by way of strengthening and providing leadership in the national system for protecting volunteers in medical research. It plays a role in capacity building of IRBs in terms of assisting in solving bioethical dilemmas, providing clarification / guidance to research institutions as well as academic inputs in curriculum development in bioethics and for the education of committee members in bioethics. It is recommended that, in every country, similar national organization must be instituted with their own National Registry containing the names of IRBs, ID of website information, if any, information on the area of interest and a list of expert members.

The registry of OHRP provides information on the IRBs of the world, from which information regarding the number of IRBs (that they recognize) in all the countries listed in its registry was culled out to construct the following Tables. Table 1 lists the name of countries with the total number of recognized IRBs, in an ascending order. From this source information Tables 2 and 3 were constructed.

Countries with no OHRP-recognized IRBs include: Albania, Algeria, Andorra, Anguilla, Antarctica, Antigua / Barbuda, Aruba, Bahrain, BassasDIndia, Bermuda, Bhutan, Bissau, Bosnia / Herzegovina, Bouvet Island, British IOT, British VISS, Brunei, Brunei Darussalam, Bulgaria, Cape Verde, Cayman Island, Central African Republic, Christmas Island, Clipperton Island, Cocos Keeling Islands, Comoros, Cook Islands, Cyprus, Djibouti, Dominica, Equator Guinea, Europa Island, Falkland Islands, French Guiana, French So/Antarctic lands, Gaza Strip, Gibraltar, Glorioso Islands, Greenland, Grenada, Guadeloupe, Guernsey, Guinea Bissau, Guyana, Heard/Mcdonald Islands, Iraq, Jan Mayen, Jersey, Juan de Nova Island, Kiribati, Kuwait, Libya, Liechtenstein, Macau, Marshall Islands, Martinique, Mauritania, Mayotte, Micronesia, Montserrat, Namibia, Nauru, Netherlands Antilles, New Caledonia, New Guinea, Niger, Niue, Norfolk Island, Oman, Paracel Iss, Pitcairn Islands, Qatar, Reunion, Saint Helena, Saint Kitts/Nevis, Saint Vincent/Grenadines, San Marino, Sao Thom/Principe, Solomon Islands, Somalia, Spratley Islands, Suriname, Svalbard, Swaziland, Togo, Tokelau, Tonga, Tromelin Island, Turkmenistan, Turks/Canicos Island, Tuvalu, Unknown, Vanuatu, Vatican City, Wallis/Futuna, West Bank, Western Sahara, Yugoslavia, Zaire

Countries with one OHRP-recognized IRB include: Afghanistan, Angola, Azerbaijan, Bahamas, Barbados, Belize, Benin, Botswana, Burma- Myanmar, Burundi, Chad, Cuba,

Faroe Islands, Fiji, French Polynesia, Gambia, Guinea, Iceland, Korea Peoples Republic, Laos, Lesotho, Liberia, Luxembourg, Maldives, Mauritius, Monaco, Mongolia, Mozambique, Palau, Panama, Rwanda, Saint Pierre/Miquelon, Seychelles, Sierra Leone, Sudan, Syria, Tajikistan, United Arab Emirates, Uzbekistan, Yeman,

Countries with two OHRP-recognized IRBs include: Madagascar, Congo, Gabon, Honduras, Ivory Coast, Jordan, Kosova, Kyrgyzstan, Lebanon, Macedonia, Mali, Papua New Guinea, Paraguay, Senegal, Slovenia, Tunisia,

Country list of IRBs

It can be inferred from Table 3 that the concept of IRB has not taken roots in almost half the countries of the world. The number of IRBs present in a country may be governed by the degree of advancement in Science and Technology, its per capita income as well as by its land area. For instance, Italy (100) and Australia (106) are countries with less land mass when compared to Canada (175) and Mainland China (159). But they are relatively, thickly populated with IRBs. A critical analysis of the Tables may indicate that more education in Bioethics and in house training in establishing IRBs and its functional features are to be introduced in all these countries where Bioethics Committees have not taken roots or not functioning to solve ethically charged issues – Ethical, Legal, Social Issues (ELSI).

Table 3: Number of countries and the Number of OHRP-recognized IRBs

N. IRBS	N. Countries
Zero	99
One	40
Two	16
Three	13
Four	07
Five	06
Six	06
Seven	02
Eight	05
Nine	08
Ten	04
11-20	16
21-30	08
31-40	05
41-50	03
51- 99	05
100 & Above Hundred	06

Countries with 100 or more IRBs

Table 2 provides data on the number of countries which have one hundred and more IRBs. There are only six countries which fall under this category. It may be noted that India is one among them having a total 137 IRBs. Canada tops the list, followed by Mainland China and United Kingdom,

Table 2: Number of Countries with 100 or more IRBs

Nr.	Country	IRBs
1	Canada	175
2	China Mainland	159
3	United Kingdom	153
4	India	137
5	Australia	106
6	Italy	100

A complete country wise listing was prepared (Table 2). Out of 245 listed countries almost 99 countries do not have a single functioning IRB. About 40 countries have only one IRB. In about 13 countries there are just 3 IRBs. About 16 countries have a few IRBs, i.e. between 11 and 20 (See Tables 1 and 3 for details)

Table 1 Country wise Distribution of ORHP-recognised IRBs:
Total Number of countries = 245 (countries with 0,1 or 2 IRBs
are listed in text) Source link <http://www.hhs.gov/ohrp/>

Nr.	Country	Nr. Of IRBs
156	Burkina	3
157	El Salvador	3
158	Haiti	3
159	Latvia	3
160	Lithuania	3
161	Malawi	3
162	Moldova	3
163	Nepal	3
164	Nicaragua	3
165	Saudi Arabia	3
166	Sri Lanka	3
167	Zambia	3
168	Zimbabwe	3
169	Austria	4
170	Bangladesh	4
171	Croatia	4
172	Estonia	4
173	Serbia /Montenegro	4
174	Trinidad/Tobago	4
175	Venezuela	4
176	Cambodia	5
177	Ethiopia	5
178	Iran	5
179	Kazakhstan	5
180	Morocco	5
181	Slovak Republic	5
182	Cameroon	6
183	Ghana	6
184	Greece	6
185	Jamaica	6
186	Norway	6
187	Uruguay	6
189	Belarus (7)	7
190	Kenya	7
191	Armenia	8
192	Bolivia	8
193	Costa Rica	8
194	Dominican Republic	8
195	Malaysia	8
196	Bulgaria	9
197	Guatemala	9
198	Romania	9
199	Ecuador	10
200	Indonesia	10
201	Tanzania U Republic	10
202	Uganda	10
203	Philippines	11
204	Turkey	12

A detailed list is provided in Table 1 for countries with more than 2 recognised IRBs. Most countries, which do not have an IRB are the underdeveloped or developing countries. In such countries e.g. Albania, other human rights related problems such as human trafficking of young girls may have to be addressed along side with the establishment of regulatory measures like IRBs. It is likely that a new strategy may have to be followed which will build these countries economically, upgrade their present state of art in of Science and Technology and simultaneously helping them to establish IRBs.

Nr.	Country	Nr. Of IRBs
205	Denmark	13
206	Pakistan	13
207	Portugal	13
208	Singapore	13
209	Georgia	14
210	Ireland	14
211	Egypt	15
212	Switzerland	15
213	Czech Republic	16
214	Netherlands	16
215	New Zealand	17
216	Taiwan	17
217	Vietnam	17
218	Chile	20
219	Finland	21
220	Israel	25
221	France	26
222	Ukraine	26
223	Peru	27
224	Colombia	28
225	South Africa	28
226	Sweden	28
227	Belgium	32
228	Hungary	33
229	Thailand	34
230	Nigeria	38
231	Poland	40
232	Germany	45
233	Mexico	45
234	Argentina	46
235	Spain	52
236	Japan	54
237	Korea Republic of	55
238	Brazil	90
239	Russia	92
240	Italy	100
241	Australia	106
242	India	137
243	United Kingdom	153
244	China Mainland	159
245	Canada	175

In this context, it may be mentioned that a National Conference "On Alternative IRB Models: Optimizing Human Subjects Protection" was conducted during November 20-21, 2006 at Washington DC, USA. This conference sought to solve emerging future sophisticated bioethical problems. It will be highly contextual if an alternative model to the existing American model of IRB is developed to build these countries from the scratch, both economically and bioethically.

As pointed out earlier, UNESCO advocates the formation of different types of committees to suit different needs and requirements in formulating the ethical guidelines dealing with research on human subjects such as 1. Policy making and Advisory Bioethics Committee 2. Health professional Associations' Bioethics Committee, 3. Health care and Hospital Committee and 4. Research Ethics Committee. But in reality, most hospitals and medical institutions have mostly a single type of IRB to oversee diverse aspects of research projects.

Indian National Scenario: IRB distribution in India

There are about 137 IRBs spread across the nation of India (Table 4). There are 28 States and 7 Union Territories in India. Out of these, only 14 States and 2 Union Territories have IRB. Maharashtra tops the list with 28 IRBs, followed by Tamil Nadu (20), Karnataka (18), Union Territory National Capital Delhi (18) and Andhra Pradesh (10). States like West Bengal, with a big city like Kolkata (Calcutta) has only 6 IRBs (Table 6).

A city wise breakup of figures is given in Table 5. Mumbai stands highest with 19 IRBs followed by New Delhi (18), Bangalore (12), Chennai (12) and Kolkata (06). It is interesting to note that in an ancient and thickly populated city like Kolkata (Calcutta) there are only 6 IRBs. In major cities like Trivandrum, Pune, Jaipur, Mysore, Ahmedabad, Kochi and Goa, the number of IRBs is between five and one. Although there are about 12 IRBs in Chennai, the total number of IRBs for Tamil Nadu State amounts to about 20. Only two cities, Kochi and Trivandrum, in the state of Kerala, have a total of 7 IRBs. In Orissa State there are only five IRBs, all of which are located at the capital city of Bhubaneswar.

Following areas have been mentioned as areas for which IRBs exist, namely biomedical, hospital ethics, scientific/biomedical, bio-psycho-social, biological, bioethical and epidemiological. Most of the Institutions have not mentioned their area of specialization. Such information should be included in the National Registry of IRBs, which is yet to be created.

Table 5: Number of IRBs in different Indian Cities

Location	State	Total IRBs
Mumbai	(Maharashtra)	19
New Delhi,	(Union Territory)	18
Bangalore	(Karnataka)	12
Chennai	(Tamil Nadu)	12
Kolkata	(West Bengal)	06
Trivandrum	(Kerala)	05
Pune	(Maharashtra)	04
Bhubaneswar	(Orissa)	04
Jaipur	(Rajasthan)	03
Mysore	(Karnataka)	03
Ahmedabad	(Maharashtra)	03
Kochi	(Kerala)	02
Goa	(Goa)	01

Table 6: Number of IRBs in Indian States

Nr.	Indian States	Nr of IRBs
1	Maharashtra	28
2	Tamil Nadu	20
3	Karnataka	18
4	New Delhi (UT)	18
5	Andhra Pradesh	10
6	Kerala	07
7	Uttar Pradesh	06
8	West Bengal	06
9	Orissa	05
10	Punjab	05
11	Gujarat	04
12	Rajasthan	04
13	Madhya Pradesh	03
14	Goa	01
15	Mizoram	01
16	Chandigarh (UT)	01

UT = Union Territory

Regional Scenario: YRG CARE - A Case Study

Incidence of AIDS was recorded at Chennai during 1980s by Dr. Sunithi Solomon and her team of research workers. She heads a non governmental organization (NGO) 'The YRG

CARE'. This Centre for AIDS Research and Education (CARE) is part of YR Gaitonde (YRG) Medical, Educational and Research Foundation, (YRG CARE). YRG Care as a NGO, works among people living with HIV and AIDS. The IRB of YRG Care, was instituted in 1998 and functions on a local level. i.e. at Chennai and it inducted the President of All India Bioethics Association as one of the IRB members at its very inception.

Its Institutional Review Board (IRB) is a registered body of experts (January 1999). In accordance with the International and National (The Indian Council of Medical Research - ICMR) guidelines on research protocols for conducting research on human subjects, it has a Federal Wide Assurance (FWA) (March 2001) with the Office for Human Research Protections (OHRP)..The tenure of the FWA is renewed after a three-year period.

Composition of Experts

Experts who are IRB members are drawn from diverse fields. They include scientific researchers in biological, social sciences and medical fields. With the primary aim of enforcing protection of the rights and welfare of the human subjects, the IRB has microbiologists, legal advisor, development consultant, social scientists, ophthalmologists, HIV /AIDS activists for women, psychiatrists, economists, bioethicists and general medicine. At one stage there were members who were living with HIV (PLHIV). Its IRB members are dedicated to the health of PLHIV and especially to ensure their easy access to health care. The Board members are required to undergo a course of training/workshop and pass an online test on the prescribed background resource materials. Such academic climate equips IRB members to identify the unethical use, if any, of new developments in biological and medical sciences. The IRB meets usually once in a month, on a Saturday agreed by the members in the previous meeting. The regularity of the meeting is governed by the arrival of new research proposals for review, as well as on going projects. Although the IRB members serve on an honorary/voluntary basis provision has now been made to cover their conveyance expenses to attend the board meetings.

Fixing IRB meetings is meticulously managed by the Coordinator who is specially appointed for this purpose. All Principal Investigators (PIs) are required to submit their proposals well in advance to the IRB Coordinator who finalizes the agenda and distributes the study material to all the IRB members well in advance. One of the difficulties in having continued interest of the IRB members in attending review meetings is that of time. Everybody is too busy during the working days and/or on Saturdays they may be out of city. Yet they find time for this important job. The Coordinator telephones each member, a few days before, and confirms their availability since all are busy. Very rarely a meeting is cancelled due to lack of quorum. Usually meetings are postponed for another Saturday when the members are free and available. All meetings are chaired by the Chairman who is elected by the committee members.

Review Procedure

All PIs, including foreign researchers, are required to present their proposals within the allotted time slot, usually done with power point slides. The IRB scrutinizes the proposal without any fear or favour. Suggestions are made for any improvement with respect to methodology, sample size, and the correctness of the questionnaire to be administered in studies that involve a survey. All PIs of such projects are required to state the objection that was pointed out in the earlier review along with the remedial steps taken to concur with the earlier remarks. All revised proposals are finally submitted for approval. No research project is approved without the collective decision of the IRB members. The IRB coordinator electronically records the proceedings and distributes the minutes of the meeting one week prior to the meeting and maintains all files and

correspondence. All IRB approved projects are submitted to the Central Ethics Committee of ICMR for its review and approval.

Effective functioning of the IRB has ensured that "all research conducted by YRG CARE is in compliance with the highest ethical standards". For fulfilling the primary purpose of the IRB which is to ensure the protection of the rights and welfare of human subjects in research at YRG CARE each proposal is reviewed as to its content and protocols such as the inclusion and exclusion criteria, informed consents and reports.

The IRB mainly concerns itself with the research proposals of YRG Care. The IRB is fully apprised of the plan of research, the aim of research and its impact and possible risks and ensures the principles of informed consent and voluntary participation, privacy and confidentiality. It also takes into consideration the existence of regional and cultural variations in India. It safeguards the rights and welfare of the human subjects who will serve as the candidates for the research work. Due to the tendency of stigmatisation of HIV/AIDS candidates, extreme care is taken to keep the case history of each candidate as confidential reports. Secondly, researchers who use the case sheet of patients (medical records) for obtaining data for publication purposes are extremely careful to keep such data confidentially and maintain the anonymity of the patients. Similarly blood samples of infected patients would not be allowed to be subjected to another research proposal, if there is no clear statement permitting blood samples obtained under one research proposal to be used in another new research proposal. Such multiple uses of blood samples should have been clearly stated in the informed consent form. If not, no permission is granted to swap blood samples.

Informed consent – A Living Document

In accordance with The Belmont Report and the Indian (ICMR) Ethical Principles and Guidelines for the protection of Human Subjects, greatest emphasis is given to informed consent. Informed consent is a difficult preposition in an Indian context. Illiteracy is one such problem. Secondly, the role of family members and of the Head of a village community can not be underestimated! Rarely the patient is involved in signing an 'informed consent form'. Generally it is the family that takes the final decision.

YRG CARE caters to the medical needs of people with HIV/AIDS within a multilingual community – the Tamils, The Telugus and the English speaking South Indians. Hence, all the informed consent documents in English language are translated into regional languages, Tamil and Telugu languages. Each translation is back translated into English to verify the accuracy of translation by a third person. Translation is redone if there are wide deviations from the meaning of the original English document. Therefore IRB considers the process of obtaining informed consent as of crucial importance. Hence, it considers the signed informed consent form not as some mere piece of paper but as a living document which to be preserved and referred to till the end of the research program. IRB of YRG CARE does not permit oral informed consent. Therefore, meticulous care is taken to enforce the principle of informed consent either by electronic means or by oral explanation, if the patient is illiterate. In the latter case, thumb impressions are counter signed by a witness.

Protocol Deviations

Entrusted with the responsibility of not only the initial review of the research-proposal- protocols, prior to the initiation of the projects but it also has a continuing responsibility of regular monitoring for the compliance of the ethics of the approved program still the completion of the project. Further, if there are any deviations from the reviewed protocol procedures that were earlier approved by the IRB then the PI of the project is required to present his/her proposal again with reasons for the deviation. IRB reviews the proposal again and then approves. As part of continuing review, all the PIs are required to update

the IRB members of the progress made in their research project from time to time.

Finally, every PI presents a completion-presentation of their project. Such reports are published in reputed journals and a copy of the reprint of the research paper is posted to all IRB members. Such activities are part of the continuing education of the IRB members. Since, not all IRB members are well versed with the terminology used in AIDS research such repetition helps the education of the members.

Community Development

YRG CARE has two ethics committees. The Community Advisory Board (CAB) provides the needed impetus to design research projects ethically, especially those under the HIV Prevention Trials Unit (HPTU), as well as to enhance benefits for and participation of the community. The IRB members and community workers meet together over a meal to get to know the field work.

ICMR – Central Ethics Committee

All IRB approved projects are submitted to ICMR's Central Ethics Committee (CEC) for its review and approval. The seventeen members of the CEC of the ICMR are experts in the fields of medical sciences, pharmacology, law, social science, as well as heads of different religious groups and others. Inclusion of representatives of different religious groups as well as philosophers has always been a problem due to the fact of different ideological stand taken by different groups on a common bioethical problem. The members meet to review and to sanction clearances to proposals referred by the Department of Biotechnology, the mother-to-child transmission studies referred by National AIDS Control Organization (NACO) and Ministry of Health and the preventive AIDS Vaccine trials being conducted jointly by ICMR, NACO and International AIDS Vaccine Initiative (IAVI). It has also the responsibility of providing clearances to all the proposals referred by the 137 local IRBs. Such a load of work on CEC there is always enormous delay in obtaining ICMR's clearance. As a result, research projects that are funded by foreign funding agencies suffer loss of financial support. Due to such inordinate delays in obtaining the final sanction, there is also the possibility to swap (plagiarism) a research project submitted by one IRB by another.

The Unethical Side

Instances of plagiarism have been reported from time to time. The Society of Scientific Values (SSV) serves as a watchdog to spot any unethical practices in science and technology. Recently SSV has brought to light two instances of plagiarism and data swapping. In one instance is related to a "prominent government report" and the other is a research publication of a nationally reputed National Centre for Cell Sciences. (NCCS) (Padma, 2007). The "horns of bioethical dilemma" is that two different committees - The Institutional Enquiry Committee at NCCS and an Independent Committee - came to contradictory conclusions and recommendations. On this very issue of conflict of interest, the SSV demands immediate creation of "an independent ethics body with sufficient legal powers to enforce integrity in Indian Science"

In the United States of America, besides regular IRBs attached to a recognized institution, there are many other commercial IRBs which work mainly as profit making organizations. Such commercial IRBs have been under the scrutiny of Food and Drug Administration (FDA) of USA. And yet "no governmental agency has systematic data on commercial IRBs" (C-IRBs) (Lemmens and Freedman, 2000). The root cause for the emergence of C- IRBs is the insistence by federal funding agencies and the FDA for the approval by an IRB to qualify a PI or an institution to secure funding. Therefore, the following recommendations have been made. "Within the

regulatory setting, procedural conflict-of-interest rules are essential because of the absence of clear substantive rules in research review and the reliance on the fairness and good judgment of Institutional Review Board members. Current guidelines and regulations lack adequate conflict-of-interest rules and provide insufficient details on the substantive rules... However, conflict of interest rules are essential to safeguard public trust." (Lemmens and Freedman, 2000).

In an Indian context, it may be recalled that at one stage, the UGC introduced the guideline that it was necessary for an academic to qualify for the Ph.D. degree. Then many commercial 'Thesis writing shops' sprung up. In order to prevent the reoccurrence of such a phenomena it must be made mandatory for all Indian IRBs to be registered with a Central Government Agency in India which will have systematic data on infrastructural details of a given IRB.

The Divide between Developed and Undeveloped Countries

When bioethics was introduced into India mindset during 1996, it was widely commented that it is a luxury for India. After a decade of activities, it is now felt that it is a necessity for social stability. Similarly, Coleman and Bouesseau (2006) argue that "the structure of the American IRB system is poor fit for African countries". However, fifteen African countries have jointly formed a networking called the Networking for Ethics on Biomedical Research in Africa" (NEERA) to survey the participating countries' existing systems for ethics review of research involving human participants and develop a strategy for strengthening it" (Coleman and Bouesseau, 2006). Two issues are involved. Will the American regulatory system of IRB work in the countries listed in Table 1 which do not have a single IRB? Secondly, existence of some such regulatory system is better than having none! However, there is a need to adopt the American system of IRB with suitable modifications to suit local conditions.

International Collaboration

The ICMR has provided "Guidance for International Collaboration for Research in Biomedical Sciences" which is regulated by the International Health Division (IHD). Research projects in the major area of Science and Technology have an implication in biomedical research and Human Health. Hence, both the Government of India and the ICMR have signed specific bilateral agreement with other countries. Such a general agreement includes areas such as exchange of scientific personals and information, joint execution of scientific projects, procurement of infrastructural equipment and for organizing conferences and seminars. However, applications for carrying out research projects in India with foreign funding in biomedical / health research are to be submitted to ICMR (IHD). All such research proposals have to be approved by the Government of India, Ministry of Health's Screening Committee (HMSC).

It may be noted that the procedures /instructions and the application format vary from country to country. For instance, in any INDO- US collaboration, applications have to be submitted to NIH Grants for their approval as well as the approval of the respective IRB. The NIH application format may be downloaded from the website <http://grants2.nih.gov/grants/funding/phs398/phs398.html> . All NIH approved research proposals are submitted to the Indian counterpart agencies for the approval of their respective IRBs. In the case of research proposals involving human subjects with HIV/AIDS all proposals that are approved by their respective IRBs need the approval of ICMR's Central Ethics Committee and by the Ministry of Health's screening Committee (HMSC) whose secretariat is in the office of ICMR as well by the National AIDS Control Organization.

In this context it may be pointed out that the National Bioethics Advisory Commission of UK considered 'there are legitimate reasons to question the capacity of host countries to support and conduct prior ethics review' of collaborative

research. Nuffield Council on Bioethics is of the opinion "strengthening the ethics review capacity of low and middle-income countries is therefore, an important goal of international bioethics and human rights (Coleman and Bouesseau, 2006).

Influence of Philosophers in the Committee

It has been pointed out earlier that Indian IRBs, unlike the American/European counterparts, may not have a philosopher on its board (Azariah, 2005). The influence of having a philosopher on the Board and in other advisory or legislative body or not having one, can be illustrated by two historic instances.

The U.S. House of representatives recognized that a federal crime against a pregnant women claims two victims, passing the Unborn Victims of Violence Act (H.R. 1997), also known as "Laci and Conner's Law," by a vote of 254-163. The bill would recognize as a legal victim any "child in utero" who is injured or killed during the commission of a federal crime of violence. Two areas need to be addressed. (1) it is good that it recognizes the rights of a "child in utero". 2) The usage of the world child indicates that the unborn fetus is a person. It remains to be seen how such an implication will be taken by an American philosopher, who may not generally recognize a foetus as a person.

The Great Divide

It is interesting to note that, in the Western Civilization, it is rare to find any bioethics committee without a philosopher. In fact most of the bioethical dictums are influenced by philosophical undercurrent. Socio biologists thought that such a domination is not always good and hence "Scientists and humanists should consider together the possibility that the time has come for ethics to be removed temporarily from the hands of the philosophers and biologized" (Wilson, 1975). On the contrary, it is interesting to note that in the Indian context, bioethics was introduced to the Indian intelligentsia by biologists. Hence many natural scientists have become expert-bioethicists. Indian philosophers are immersed in the varied shades of Indian philosophy and hence it is very rarely a philosopher is interested in Ethical Legal and Social Issues (ELSI). Biologists can speak philosophy but it is hard for an Indian philosopher to speak bioethics based on biological concepts since they have no exposure to biology in their collegiate education.

The Unbridgeable Divide

As a result, it has been pointed out in an earlier paper that the Ethical Committee which formulated the Indian Ethical Guideline of Human Subjects in Biomedical Research of 2000 didn't have philosophers on its Board. In consonance with the Indian belief system (cultural/scriptural) it made a statement that the fetus is a person (Azariah, 2005). In this context, the recent judgment of an Indian judge is interesting. An Indian state consumer court (MUMBAI, India, March 7, 2007) has delivered an unprecedented ruling in favour of a woman seeking an insurance claim on the death of an unborn child--the court determined that the unborn baby was a living human being entitled to personhood and required the insurance company to pay the claim (Personal email communication with Prof Bing Tang, NY, USA).

Difficulties in implementation

Guidelines advocated by the ICMR have no legal bindings on any research institutions and hospitals in India. As there is no provision for compulsory enforcement of ICMR ethical guidelines, they are to be adhered to by voluntary compliance. Although these guidelines have been released by a national organization like the ICMR it has no regal authority to take any action against those who violate the rules.

Therefore, one of the greatest difficulties is that of implementation and monitoring. The following question was

asked to Dr. Vasantha Muthuswamy of ICMR "Is there a monitoring mechanism to ensure ethical processes such as informed consent, recruitment and compensation are carried out during the clinical trials?" She replied "There is no proper mechanism in position at present. It is recommended that Institutional Ethics Committee take up the monitoring role by site visits to ensure compliance. It will take some more time to make these things really happen" (IAVI 2007). Even though there is a law preventing the misuse of organ transplants, especially with reference to kidney transplants, enforcing the law is far too difficult.

If the task of monitoring the enforcement of ICMR guidelines is left with local IRBs it is far more difficult. Recently, about thirteen hospitals were deprived of their licenses to perform kidney transplants due severe malpractice in kidney trade (Kannan, 2007 a, b., Azariah, 2007). Following are the names of hospitals, in the state of Tamil Nadu, involved in kidney racket: 1. Vedanayagam Hospital (Coimbatore), 2. PSG Hospital, (Coimbatore) 3. Kovai Medical Centre, (Coimbatore), 4. G. Kupuswamy Naidu Hospital, (Coimbatore) 5. Kavary Medical Centre, (Trichy), 6. Ramakrishna Nursing Home, (Erode) 7. Galaxy Hospital, (Tirunelveli). 8. Devaki Hospital, (Chennai), 9. Chennai Transplant Centre, Madras Medical Mission, (Chennai), 10. ABC Hospitals, (Chennai), 11. Chennai Kaliappa Hospital, (Chennai), 12. Apollo Speciality Hospital, (Madurai) and 13. Meenakshi Medical Mission, (Madurai). Apparently, in all these hospitals of refute there is no IRB or Hospital Ethics Committee!

Enormous Delay in Future Hopes

Although the ICMR guidelines for biomedical research on human subjects were circulated as a consultation paper as early in 1997 it was finalized only in 2000. However, it was only recently it has been given the shape of a Bill. As on date, the Bill awaits that it is passed as a Law by the Indian Parliament (IAVI, 2007). Almost it has taken seven years to reach this stage, during which the ground realities and cultural and social norms change drastically. ICMR hopes that once the Bill becomes a law then it becomes "mandatory for all clinical studies, conducted by both physicians and non-physicians, to follow the guidelines. Currently, there are laws governing research in India. Under the Drugs and Cosmetics Act all trials in the country should follow the ICMR guidelines. Medical Council of India Act amended in 2002 states that all research in India carried out by physicians has to subscribe to the ICMR guidelines. This is an indirect legal support to enforce our guidelines but we need more teeth!" ICMR also hopes that all researchers in biomedical sciences may undergo a course of training in ethics before taking up a research work. The proposal that all postgraduate theses should go through IRB clearance may not be a reality due to time factor.

Ethics Committees and the Future

There is a need to establish ethical guidelines in animal rights where animals are employed in toxicological research. Technological universities and pharmaceutical companies connected with drug and cosmetic research invariably animals are used. There is an appropriate Scientific Ethical Review Committees which looks into this matter.

Development of human resource to solve our common future bioethical issues and concerns, in newer areas of biotechnological research in genetic engineering, IVF, human embryonic stem cells (hESC) research and human egg donation are areas of exploration and exploitation. Hence, these sophisticated newer fields definitely need safeguards and laws to confer human rights to vulnerable humans. Currently, The Indian Council of Medical Research (ICMR) located at New Delhi takes the responsibility of approving all research projects involving human subjects nationwide and to enforce the principle of non violence in biomedical research by assessing

the risks and benefits of these new advancements in science and technology.

One Central Bioethics Committee may not be effective to govern newer areas of research involving human subjects. Afore mentioned national (USA) conference "On Alternative IRB Models: Optimizing Human Subjects Protection" foresaw such a problem. The two main objectives of the conference were the following: (i) To optimize and facilitate institutional access to appropriate ethical and scientific expertise for reviewing increasingly sophisticated projects and (ii) To optimize institutional resources to review such projects.

It is recommended to create a National Bioethics Authority or National Bioethics Commission so as to bring regulatory measures in research involving human subjects as well as non-human subjects. More importantly, regulatory mechanisms, which restrict scientific research in grey areas, are to be considered. These are two aspects which need current attention.

Educating the IRB

Successful Bioethics Committees usually begin the process of education slowly, introducing the process of self-education when they first begin to convene as a group. Bioethics is complex and multifaceted discipline, drawing on philosophy and law as well as science and medicine. Most committee members will lack special training and experience in bioethics, and though they typically have significant expertise in other fields, will be willing to devote some time to this multi-disciplinary field.

In the world of Bioethics Committees the horns of bioethical dilemma are ever changing. With the advancement of new scientific discoveries and new biotechnologies, governments all over the globe are introducing new bioethics-related-policies and regulations with new judicial rulings. With the changing culture new worldviews evolve in a society. Professional attitudes to these new ethical legal and social issues change dramatically. Hence, committee members are to be equipped with bioethical infrastructural cementing factors which will enable them to address the new forms of horns of bioethical dilemmas effectively. Since the issues are multidimensional in nature IRB members need to undergo intensive education. UNESCO advocated self education and long-term intensive education in fields like biology, biosciences, biotechnology, medicine and law. It remains to be seen how effective will be the process of intensive self- education in an Indian context!

It may be recalled that bioethics was introduced in India as early as 1996 through the creation of All India Bioethics Association (AIBA) in Chennai. And yet it has not taken roots into Indian academic curricula. As far as the Tamil Nadu medical curriculum is concerned there the subject of Medical Ethics has not yet been introduced (MCI, 2008). Currently bioethics has not been recognized as an academic discipline in medical schools in Tamil Nadu, of which Chennai is the capital. Hence universities have no Departments of Bioethics. And 'Medical Ethics' has not been taught as a major subject in the medical curriculum. Consequently students are not expected to undergo any university terminal examination to obtain their Degree Certificates in Medicine. If Indian IRBs are to have qualified members on its Ethical Review Committees then it is mandatory that medical students and students of other related subjects as well as IRB members should be well educated in the many areas of bioethics so as to be qualified to serve as members of IRBs. Creating human resource in bioethics is a prerequisite for the good and bioethical governance of research involving human subjects through IRBs. Education in intervention bioethics is an area for immediate concern of crucial importance, if Indian IRBs is to function on internationally accepted norms (Azariah, 2006). It is the recommendation of the UNESCO (2005, a, b) that every country has its own IRBs both at the National and Regional levels. However, in comparison with the extent of the land of

India and number of health-care institutions, there are just a few local IRBs catering to the ethical needs of a given area.

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Contextualizing Bioethics: The UNESCO Declaration on Bioethics and Human Rights and observations about Filipino Bioethics

- Lukas Kaelin, PhD
Institute for Ethics and Law in Medicine
University of Vienna, Austria
Email: lukas.kaelin@univie.ac.at

Abstract

This paper examines the question of the universality of bioethical norms by contrasting the UNESCO Declaration on Bioethics and Human Rights (UDBHR) with aspects of Filipino bioethics. Starting with an exploration of the vagueness of the concept and scope of bioethics, this paper will in turn discuss the UDBHR and distinguish it from key notions in Filipino bioethics. The outlook of Filipino bioethics that I have observed differs significantly from the UDBHR emphasis on the principles autonomy and justice. This discrepancy leads to some reflections on the culturality of bioethics and on the nature of bioethics in the Philippines. Filipino bioethics as a test case shows the embeddedness of bioethical questions in the cultural context as well as the Western biased scope and content of the UDBHR. This conclusion, however, does not rule out a universalistic approach to bioethics, but it asks to reconsider the culturally biased outlook of its presumably universalistic principles.

1. Introduction

The January 2009 issue of *EJAI*B focused on the ultimately philosophical question about the nature of bioethics. This paper will attempt to provide a contribution to this topic connecting as well the issue raised by Karori Mbũrgua about the existence of a genuinely African bioethics as well as the relation between normative and descriptive bioethics discussed by Jon Vegar Hugaas in the same volume. However, this paper will focus on the Asian context (specifically the Filipino context) in relation to the hegemonic Western bioethics discourse. This paper attempts to provide a contribution to the ongoing discussion about whether there can be a normative global bioethics without falling into a form of moral imperialism. Filipino bioethics is used as a test case in contrast with the UDBHR in order to examine the extent of the universality of bioethical norms.

The UDBHR (2005) explicitly argues in favor of a global bioethics, thus – after an introduction into the problematic term “bioethics” (2) – I will provide a short recapitulation of this declaration. I will argue that the UDBHR attempts to bind together the different understandings of bioethics, but that it remains Western in its main orientation (3). The problematic of such an understanding of bioethics is explored in the next paragraph, which deals with the problems of implementing such a notion of bioethics in the cultural context of the Philippines (4). This brings me to a more general point, namely the roots of science as such as well as specific scientific disciplines in a social, cultural and historical context (5). A last paragraph will offer some general remarks about bioethics in the Philippines (6).

2. What is Bioethics? A tentative approach

The literal understanding of bioethics does not provide much guidance in grasping the concept of bioethics: Life-ethics. All forms of ethics are dealing with life in one way or another: If we ask for example with Aristotle what the good life is, or if we ask with John Stuart Mill how we can maximize utility, or if we apply Immanuel Kant's Categorical Imperative, we always deal with

human (and non-human) life. A simple etymological analysis of the concept of bioethics will not provide a sufficient answer in order to understand the concept. Thus, we have to look elsewhere in order to grasp the meaning of bioethics.

A description of the discourse in bioethics might provide an adequate understanding of what bioethics is. Looking at the debate about bioethics in Europe (especially in Germany), one finds different questions that are discussed under the topic of bioethics: Is cloning ethical? Should research on human embryonic stem cells be allowed? What are the implications of preimplantation genetic diagnosis (PGD)? What are the benefits and dangers of genetic engineering in plants? These are the questions that are mainly discussed, when the word "bioethics" is used.¹ Quite often these questions are accompanied by far-reaching speculations given that these technologies are either brand-new (embryonic stem cell research, PGD) or not yet possible (cloning). Other questions that deal with the protection of the environment or technologies concerning contraception are hardly considered to be part of bioethics. In all these cases, we deal with ethical questions arising from new technologies, in particular with the morality of genetic engineering. A further look at the recent history of science and the origin of the concept of bioethics might give us a more concrete idea about it.

Bioethics was first widely discussed in the late 1960s and early 1970s. As all concepts that make their way into the scientific discourse, they are a concrete reaction on questions in a field of society.² Bioethics was commonly conceptualized as an answer to the innovations in the realm of medicine, which give rise to new questions. Tom Beauchamp and James Childress' book on the *Principles of Biomedical Ethics*, firstly published in 1979, is still considered the standard textbook in the field of bioethics, especially in the medical field and in the USA. It bases bioethics in the medical context on four principles: autonomy, non-maleficence, beneficence and justice. Under the topic of autonomy, for example, informed consent, confidentiality and privacy are crucial. The focus of the book is slightly wider than the questions discussed under the topic bioethics in Germany. It lies on ethical issues that arise from modern medicine in general.³

Bioethics in the narrow sense can be understood as a collective term for various questions that spring from technological innovations in the fields of medicine, biology and life-sciences: Ethics of health care answers questions genuine to the different types of health care institutions, medical ethics tackles ethical issues related to modern medicine, the ethics of biotechnological research such as embryonic stem (ES) cell research and cloning, and lastly environmental ethics deals with the potential damage of modern technology to the environment.

¹ For a philosophical discussion of these bioethical issues in Germany, see my article: Bioethics: A view on the contemporary discussion in Germany compared to Asia. *EJAIB*, Vol. 16 (4), 2006, 125 – 130

² Concepts do not pop up by chance in a certain societal and historical situation. Rather, they are the consequence of it. From the perspective of the Critical Theory of the Frankfurt School, one might well understand bioethics (Life-ethics) as a reaction to the institutionalization of life in general and a fear that life as such is subordinated by instances that are more powerful such as the economic, industrial and administrative system. Bioethics, then, would emphasize the importance of human life *against* the power of these institutions. But that would be an entire different issue.

³ An interesting understanding that slightly deviates from the above, is provided by the US American *President's Council on Bioethics*: "To do bioethics properly, I suggest, means [...] undertaking fundamental inquiry into the full human and moral significance of developments in biomedical and behavioral science and technology. We must strive to understand the meanings of the intersection of biology and biography, where life as lived experientially encounters the results of life studied scientifically."

(http://www.bioethics.gov/background/council_second_term.html accessed on March 28, 2008)

Bioethics as the general term is subsumed under ethics, i.e. it is a branch of applied ethics.⁴

The notion of bioethics encountered in the Philippines is significantly wider in scope. Three books – by a medical doctor, Dr. Alora, by a theologian, Fr. Miranda, and by a philosopher, Dr. Timbreza – will show that. In a small handbook in bioethics Alora states bluntly: "Bioethics is the division of Ethics that relates to human life or the Ethics of the life science and healthcare, both delivery and research."⁵ Reading this definition, one ponders about two things: Firstly, about the equation of "human life" and the "Ethics of the life science and healthcare". Depending on how one understands bioethics, the scope will be very different. Secondly, the above understanding makes clear that there is not a single understanding of bioethics, but that it strongly varies in different cultures.

Another book, entitled *Pagkamakabuhay. On the Side of Life* written by Dionisio M. Miranda, attempts to offer a Filipino notion of bioethics.⁶ Bioethics is not understood as an application of principles to a certain situation, rather it is understood as a form of life embedded in its socio-cultural context that covers all aspects of life. Bioethics, understood as our attitudes towards life in general, is rooted in a concrete culture:

"Filipino bioethics may therefore be seen as that part of human reflection which explicates in a holistic way the significance of illness and health within the Filipino culture and context, the values involved in the threats to corporal existence, and the principles which must guide one's activity in the affirmation of personal life as embodied."⁷

This notion of bioethics is quite far away from the abstract principles and its differentiations suggested by Beauchamp and Childress. The common Western understanding of bioethics as a branch of applied ethics becomes arguable.⁸

A last example refers to Florentino T. Timbreza's bioethics book that is praised in the foreword as "the first full-length textbook of bioethics in the Philippines."⁹ A quick glance at the table of content shows that it covers a wide range of issues from abortion to suicide, from contraception and sterilization to the mankind old questions of human sexuality. A range of topics that goes well beyond what is in public and academic discourse in Europe: neither contraception and sterilization nor the whole range of human sexuality would be considered to be part of bioethics as these questions are not arising from the progress in science.

I do not claim that these books are representative of the Filipino understanding of bioethics. However, it is worth to ask what these different accounts have in common that distinguishes them from the Western perspective as described above: Firstly, the scope of all of these books is considerably

⁴ The focus of this paper will be medical ethics. For a discussion of the structural difference between medical ethics and environmental ethics see: O'Neill, Onora, *Autonomy and Trust in Bioethics*, Cambridge: CUP, 2002, p. 4ff. O'Neill points out, among others, that medical ethics focuses mainly on the individual, while environmental ethics is concerned with public harm and benefits.

⁵ Alora, Rosario Angeles Tan: *A Handbook in Bioethics*, Makati City: Bookmark, 1999, p. 8

⁶ Some clarification is needed when discussing "Filipino bioethics". I am certainly aware of the danger of cultural essentialism. When discussing the Filipino notion of (bio-) ethics, I refer to a certain way of interaction with reality that is dominant in the Filipino peninsula as described in the books quoted and some limited personal experience. I am especially aware of the danger of the nation as a group concept.

⁷ Miranda, Dionisio M. *Pagkamakabuhay*, p. 328

⁸ Helga Kuhse and Peter Singer for example clearly point out that bioethics is a branch of applied ethics. (Kuhse, Helga and Singer, Peter (eds.), *Bioethics. An Anthology*, Oxford: Blackwell, 1999, p. 1. I will later return to this "Prolegomena for Bioethics from a Filipino-Christian Perspective" (the subtitle of Miranda's book) as it sheds light on the culturality of bioethics.

⁹ Andrew Gonzalez in this foreword to: Timbreza, Florentino, *Bioethics and Moral Decisions*, Quezon City: C&E Publishing, p. xi

broader. Secondly, there is significant less emphasis on abstract principles or institutions, and lastly bioethics is not understood as a distinct scientific theory but – especially in the case of Miranda – rather as a form of life. These differences show the cultural relativity of the concept of bioethics. However, the philosopher – who cherishes nothing more than clear and distinct concepts – cannot be satisfied with a blurry meaning of bioethics and attempts to identify a workable notion.

3. The UNESCO Universal Declaration on Bioethics and Human Rights (UDBHR)

Having such difficulties in understanding the term, one is looking for guidance of international bodies such as the UNESCO, which recently under much ado adopted a resolution on bioethics.¹⁰ The declaration, published in 2005, is entitled “Universal Declaration on Bioethics and Human Rights”.¹¹ UNESCO understands her role as one of “identifying universal principles based on shared ethical values” (Preface). Stating that, UNESCO commits herself to a view of ethical universalism, i.e. that there are universally shared ethical values, which she attempts to identify and turn into universally binding principles.¹²

Quite surprisingly, a definition of bioethics is not provided in the declaration; not surprisingly given the above discussion of the different understandings of bioethics. A look at the scope of the declaration, however, gives us a clearer idea of what bioethics is: “This declaration addresses ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions.” (Art 1.1) Bioethics, the declaration suggests, deals therefore with ethical questions that arise from (new) technologies within the scientific disciplines concerned with human life in its biological function.¹³ Moreover, the second and third paragraph of the preamble are emphasizing the “rapid development in science and technology” and “rapid advances in science and their technological application” respectively, which change “our understanding of life and life itself” and give raise to ethical questions. Looking at the UNESCO homepage, the focus of bioethics gets even more concrete.

“Stem cell research, genetic testing, cloning: progress in the life sciences is giving human beings new power to improve our health and control the development processes of all living species. Concerns about the social, cultural, legal and ethical implications of such progress have led to one of the most significant debates of the past century. A new word has been coined to encompass these concerns: bioethics.”¹⁴

In other words, according to the scope of the declaration and this short description, bioethics is a field of ethics that reflects on the development of new technologies in the field of science and technology. The scope of the UNESCO understanding of bioethics is therefore akin to the Western understanding

sketched out above and does not mirror how bioethics is understood for example in the Philippines.

Looking at the content of the declaration, we can find different principles mostly formulated along the line of Tom Beauchamp and James Childress’s *Principles of Biomedical Ethics*. A glance at Article 3 to 17, which deals with the principles of the declaration, can illustrate this. (The latter part, Articles 18 to 25, is concerned with the application of the principles.)

Articles 5 to 9 deal with the principle of autonomy under different headings: Art. 5 states that the autonomy of a person has to be respected, Art. 6 and 7 deal with informed consent and the provisions concerning persons unable to consent. Art. 8 demands respect for personal integrity and Art. 9 put forward the principles of privacy and confidentiality. Thus, the principle of individual autonomy and its different subprinciples like informed consent, privacy and confidentiality is given extensive place.

The next group of articles, 10 to 16, is concerned, in one way or another, with the principle of justice. These principles demand for equal treatment of human beings regardless of culture or religion (Art. 10-12), ask for solidarity and cooperation (Art. 13) and demand for equal access to the life-necessary resources such as water and nutrition in general and to health care in particular (Art. 14-15). Finally, Art. 16 deals with the issue of intergenerational justice.¹⁵ In summary, the principles of the UNESCO declaration are concerned mainly with autonomy and justice. Incidentally, these two principles are the ones that face difficulties when implemented in the cultural and social context of the Philippines for different reasons which will be dealt with in the next paragraph.

Before turning to that question, a glance at the application of the principles dealt with in the latter part of the declaration merits attention. It can be read that bioethics in the declaration, is mainly understood as institutional ethics. The scope of the declaration makes that clear: “This Declaration is addressed to States.” (Art 1.2)¹⁶ When it comes to the application of the suggested principles, the main actors are again nation-states. The declaration calls for “independent, multidisciplinary and pluralistic ethics committees” (Art. 19) to work towards the implementation of the principles. Rules of conduct are given for transnational practices (Art. 21) and international cooperation is encouraged (Art. 24). In short, it is considered the task of the States to ensure a responsible handling of new technologies in the field of the life sciences.

In the following paragraphs, I will first show the problematic of such a narrow understanding of bioethics in the context of a developing country like the Philippines and then tentatively show how a broader notion of bioethics can challenge the narrow notion.

4. Filipino Bioethics’ contrast to the UNESCO Declaration

Bioethics, in the “Western” sense, is mainly based on principles. Especially the already mentioned principles of Beauchamp and Childress play an important role. As demonstrated in the above paragraph, the UDBHR has to be considered in scope as well as in content as part of the Western type of bioethics: an institutional ethics which is guided by abstract principles. This claim to universality, put forward among others by the UDBHR, will be examined through some aspects of Filipino bioethics. At the center of this examination is the significance of autonomy and justice as well as the scope of the declaration.

¹⁰ In the drafting process, there have been encouraging and criticising views expressed about the content of the declaration. John Williams laments its lack in scope in health care somehow falling in between an ethical, educational document for individuals and a legal document addressed to states. (Williams, John R., “UNESCO’s Proposed Declaration on Bioethics and Human Rights – A Bland Compromise, *Developing World Bioethics*, Vol. 5 (3), 2005, 210-215). A different view takes Ruth Macklin who hails the political force of the document although she criticizes that it might be too restrictive. (Macklin, Ruth, “Yet Another Guideline? The UNESCO *Draft Declaration*”, *Developing World Bioethics*, Vol. 5 (3), 2005, 245-250)

¹¹ http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html (accessed on Jan 27, 2009)

¹² UNESCO is a secretariat to 194 member countries of the world, who adopted the UDBHR unanimously. The term “United Nations” however implies a commitment to an ethical universalism.

¹³ Further should be noted that the scope given by the declaration is anthropocentric. The welfare of animals and the biodiversity of nature are only of importance as long as human beings are concerned.

¹⁴ www.unesco.org/shs/bioethics (retrieved on Dec 1, 2007)

¹⁵ The last article that is dealing with the principle (and not its application) demands the “protection of the environment, the biosphere and biodiversity” (Art. 17)

¹⁶ In full, Art 1.2 states: “This Declaration is addressed to States. As appropriate and relevant, it also provides guidance to decisions or practices of individuals, groups, communities, institutions and corporations, public and private.”

Autonomy

There are mainly two cultural aspects in the Philippines that undermine the Western notion of autonomy: the emphasis on family and the Filipino view of the patient. As Angeles Tan Alora and Joseph M. Lumitao put it in their critique of Western bioethics: "The focus of Western bioethics is individual; elsewhere it focuses on social units."¹⁷ Certainly, the Philippines is part of *elsewhere*: The family is considered the basic unit of society. The importance of the family is reflected as well in the Constitution of the Philippines.¹⁸ This strong notion of family fundamentally undermines autonomy and informed consent, which is crucial for Western bioethics.

A second aspect that is at odds with the notion of autonomy is the understanding of the patient. The family needs to take care of the patient and to spare him from all sources of stress. The family is the primary caregiver; sometimes the patient is even exempted from deciding about the adequate treatment.¹⁹ "The sick family member accepts a role of dependency and passive tolerance."²⁰ A consequence of the importance of the family and the understanding of the patient is for example that the physician "talks to the relatives first [...] as if the patient were not present at all."²¹ The notion of autonomy, informed consent as well as privacy and confidentiality are either marginalized or nonexistent at all.

One way of harmonizing the emphasis on autonomy in the UDBHR and the lack of individual autonomy in the context of the Philippines, is to apply the notion of autonomy to whole families instead. Not the individual's autonomy is considered, but the familial autonomy. However, this attempt of rectification stands in apparent contradiction with the declaration's emphasis of the person's autonomy.²² Moreover, the traditionally vertical structures of Filipino society together with a trust in (for example medical) authorities run counter the very notion of autonomy.²³

Justice

While in the case of autonomy, the inadequacy of the concept can be shown clearly, it is not that straightforward when dealing with justice. The most-promising way of understanding the difference in the Western notion of justice and the Filipino notion is to look at the different understandings of morality.

¹⁷ Alora, Rosario Angeles Tan and Lumitao, Josephine M.: An Introduction to an Authentically Non-Western Bioethics, in: Angeles Tan Alora and Josephine M. Lumitao (ed.): *Beyond a Western Bioethics: Voices from the Developing World*, Washington D.C.: Georgetown University Press, 2001, p. 4

¹⁸ "The State recognizes the Filipino family as the foundation of the nation. Accordingly, it shall strengthen its solidarity and actively promote its total development." (Art. XV, Sec. 1)

¹⁹ Lumitao and Kuan describe the case of a 75 year-old active diabetic female patient, who needs amputation of her right leg. The daughter knowing about her mother's opposition to the surgery urges the surgeon not to inform the mother, and gives consent to the operation in place of her. A proceeding, as Lumitao and Kuan rightly say, that is completely opposite to Western bioethics. (Lumitao, Josephine M. and Kuan, Letty G.: *The Family and Health Care Practices*, in: Angeles Tan Alora and Josephine M. Lumitao (ed.): *Beyond a Western Bioethics: Voices from the Developing World*, Washington D.C.: Georgetown University Press, 2001, p. 23)

²⁰ Alora/Lumitao, *An Introduction*, p. 15

²¹ Lumitao and Kuan, p. 25

²² "The autonomy of persons to make decisions ... is to be respected." (Art 5). "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned." (Art. 6.1)

²³ Kuan and Lumitao put forward a case study about a stroke patient treated by a orthopedic surgeon, a family friend, who is chosen not because of his medical expertise in the field, but rather because of family ties. The surgeon himself feels insulted when a nurse, noticing the worsening condition of the patient, suggests to refer him to a specialist. (Kuan/Lumitao, *The Family and Health Care Practices*, p. 29)

"Filipino bioethics as a lived ethic does not focus on individual consent to health care, individual confidentiality, or individually articulated concerns with beneficence, caring or truth-telling. The focus is on family – a social reality that sustains a communal morality."²⁴

In this quote Alora and Lumitao construct an opposition between an individualistic principle-based Western type of bioethics and a person-oriented Filipino Bioethics.²⁵ This understanding of bioethics, which we find as well in Miranda's *Pagkamakabuhay*, affects the principle of justice. The responsibility towards people is perceived as much stronger, than the ethical demand to follow an abstract principle. This notion of mutual responsibility or gratitude undermines Western egalitarianism.²⁶ This notion of responsibility or indebtedness towards the concrete other affects, for example, the allocation of scarce resources: A bed in an ICU will rather be to a person to whom the physician feels indebted than to the one that needs it most.²⁷ On a more abstract level, we can see that the social web takes preference over abstract principles.²⁸

Scope of the declaration

The above discussion about autonomy and justice have shown that the principle oriented bioethics, which is put forward also in the UDBHR, has a universality deficit and is culturally biased. Not only its content, but also its scope is culturally biased in two regards: The scope "addresses ethical issues related to medicine, life science and associated technologies as applied to human beings" (Art 1.1) and it "is addressed to States" (Art 1.2). In article 14 however, social responsibility includes access to food, water, and health care. Regarding the ethical issues addressed, a quick glance at the social reality of the Philippines shows that the bioethical questions most face relate more to social responsibility than to other issues raised on the UNESCO homepage like stem cell research and cloning.²⁹ However, the topic of bioethics still appeals to people

²⁴ Alora/Lumitao, *An Introduction*, p. 15

²⁵ "Filipino culture is person-oriented: Persons take precedence over abstract, impersonal issues or ideas." (Alora/ Lumitao, *An Introduction*, p. 9) That is of course a wide ranging statement and for the Western outsider, who attempts to understand Filipino culture, still a source of bewilderment.

²⁶ Alora and Lumitao argue even more decisive: "In short, instances of a mutual show of gratitude fail Western notions of egalitarianism. Issues of fairness and justice may never become relevant, let alone decisive." (*An Introduction*, p. 13)

²⁷ Alora/Lumitao, *An Introduction*, p. 18

²⁸ Concerning the issue of the allocation of scarce resources, a lot more could be said. In an unfortunately very short article about the allocation of resources Alora and Lumitao writes that "the maldistribution of health care [...] is magnified in the Philippines." (Alora, Rosario Angeles Tan and Lumitao, Josephine M., "Allocation of Scarce Resources: Macro-, Meso-, and Micro-Level Concerns", in: *Beyond a Western Bioethics*, p. 103) Moreover, they point out: "This situation [of the maldistribution] may be considered unfair and unjust, or it may be regarded as the unfortunate outcome of more than moderate scarcity and the limits of any moral approach to allocation." (p. 104) On a personal note, I would be critical with this type of defaultism. Given the resources of the upper class spent for cosmetic surgery, further mechanisms of redistribution could be put in place in order to alleviate scarcity in the health system of the Philippines. However, this is ultimately a political question.

As a side note: Discussions with Austrian students at the University of Vienna showed that the social web occasionally takes precedence over impersonal principles in the Austrian health care system too. However, in the bioethics discourse the distribution of scarce resources according to the social web is unanimously seen as unfair and a form of corruption by these students.

²⁹ Teaching issues such as stem cell research, PGD and cloning in my bioethics elective at the Ateneo de Manila University (2006/07), I realized how far these issues are from my students. They pointed out that there are much more pressing social issues, then questions concerning the legitimacy of stem cell research or artificial reproduction methods can be ignored.

as the literature covering bioethics shows. Just the issues addressed are different.

As pointed out earlier, a common Western understanding of bioethics is one of an institutional ethics based on principles. Not surprisingly therefore also in the context of the role of UNESCO is that the UDBHR is addressed to States, and calls for ethics committees, international cooperation and regulation of transnational practices. Such an institutional ethics is at odds with the Filipino notion that bioethics is expressed "in lived moral virtues."³⁰

5. The Double Nature of Science and the Contextuality of Bioethics

Having pointed out the points in the UDBHR, some general remarks about the nature of science are needed to understand the relativity of the concept of bioethics on and to prepare the ground for what a Filipino bioethics could be. Science, first and foremost, has a double nature: On the one hand it claims to have universal validity, it attempts to establish truth. On the other hand, it is rooted in concrete cultural situations; scientific disciplines are reflections in a literal sense of questions arising in a concrete social and historical context.

The discipline of bioethics might be a good example for this double nature of science.³¹ It is an example moreover that shows a certain temptation inherent in science. The term bioethics, as pointed out at the beginning, has its origin in academic discussion in North America and Europe. It can be understood as a reaction to the rapid progress in medicine that gave rise to new questions; more generally, bioethics, as it appears to be, is a scientific *discipline* that attempts to solve problems (or give guidelines) these problems that arise from a certain type of interaction with reality or a certain way of life.

But is bioethics a discipline at all? Onora O'Neill denies that: "*Bioethics is not a discipline, nor even a new discipline; I doubt whether it will ever be a discipline. It has become a meeting ground for a number of disciplines, discourses and organisations concerned with ethical, legal and social questions raised by advances in medicine, science and biotechnology.*"³²

O'Neill's understanding of bioethics is culturally sensitive as it does not understand bioethics as a discipline with a fixed content, but rather as a formal meeting ground for different disciplines. Depending on the issues in question, this meeting ground can have different locations in different cultures. However, she understands bioethics still as a basically scientific discourse (although it is influenced by media, politics and lobbyists as O'Neill points out³³), which arises from progress mainly in medicine.

However, referring back to the initial account of the understanding of bioethics in the Philippines, O'Neill's understanding does not cover that. Moreover, given the health situation the large majority of the Filipinos are in, questions arising from technological progress in medicine do simply not matter. In a country where "seven out of every 10 [people] die without ever seeing a doctor"³⁴, where people in rural areas have hardly access to medical care, technological progress is

not the main issue that merits attention.³⁵ Putting it more bluntly: "Where people die of tuberculosis and leukemia and can hardly afford the hospital bill (if they have access to a hospital at all), ethical questions concerning stem cell research or genetic testing can be neglected in good faith. Indeed, in such a context the "ethics of biotechnology" has to give way to an "ethics of poverty."³⁶ But what, then, could a bioethics in the Philippines look like?

6. Remarks concerning Bioethics in the Philippines

Miranda formulates in *Pagkamakabuhay* the necessary condition for a Filipino bioethics: "The test of bioethics as a discipline lies in its responsiveness to the ethical problems of Filipinos today."³⁷ With the above general remarks about science in mind, we indeed have to look at the questions and issues that arise from life in the Philippines.

One attempt repeatedly made by Miranda as well as by Alora and Lumitao, is to look at the Filipino language in order to provide a genuine approach of a Filipino bioethics. Concepts such as *loob* (the within), *hiya* (embarrassment, timidity) and *pakikisama* (the seeking of harmony with others) are brought into play to understand the distinctness of Filipino culture and lay the ground for a genuinely Filipino bioethics. Indeed, language is the house of being, as Heidegger would say, and an exploration of language might help in reconstructing Filipino anthropology. However, cultural anthropology is different from bioethics. Although an ethics might have extensive anthropological foundations such as Aristotle's or Spinoza's, it must retain some normative elements. If the term bioethics should not become devoid of any content, then a certain normativity – based on principles or virtues – is required.

Such bioethics is structurally different from the Western bioethics I am familiar with. In the West, the driving force of technology brings about ethical questions that need to be answered. We do not find this type of problematic here. Bioethics – forced to give answer to concrete questions arising in a concrete culture – would rather have to tackle more basic issues about the fair access to medical services taking into account the Filipino understanding of health and sickness. Bioethics is not the constant attempt to put technological progress within limits; rather, it should address cultural and social challenges.³⁸

7. Conclusion

The starting point of this paper was a certain conceptual confusion about what *bioethics* is. Bioethics in the West, as

³⁰ Angeles/Lumitao, *An Introduction*, p. 4. To argue that the declaration can be ignored as there will hardly be a tool to enforce it, fails to see its main function. Declarations on the international level will decide about how to allocate resources, which type of research will be funded and more generally in which way science develops. In its regulative and directive function the UNESCO declaration thus plays an important role.

³¹ Another example that comes to my mind is postcolonial studies. Having studied in Germany, I did not even know that such a discipline exists. It is a discipline that clearly arises out of concrete questions that arise in a postcolonial setting and that cannot be answered by the standard range of existing discipline which bring about the need for this new discipline.

³² O'Neill, *Autonomy and Trust*, p. 1

³³ O'Neill, *Autonomy and Trust*, p. 1

³⁴ Ombion, Karl G. and Azue, Ranie, *The 'Corporatization' of the Public Health System*, in: *Bulatlat*, Vol. 5, No. 39, Nov. 6-12, 2005 (Online accessible on: <http://www.bulatlat.com/news/5-39/5-39-health.htm>, accessed Mar 28, 2008)

³⁵ It sounds like a very bad joke, if a webpage that promotes tourism in the Philippines writes the following: "Hospital expenses in the Philippines are a lot cheaper compared to many other countries. Filipinos have the privilege to get quick access to their medical needs without spending so much every time they come and visit a doctor." (<http://www.wowparadisephilippines.com/> accessed on Mar 28, 2008)

³⁶ Sahai, Suman, "The Bogus Debate on Bioethics", *Biotechnology and Development Monitor*, March 1997. Online accessible on: www.agbioworld.org/biotech-info/articles/biotech-art/bogus.html on Jan 27, 2009. Although I agree with Sahai to give priority to the pressing problem of poverty and that an echoing of the Western bioethics debate in the Third World context is indeed bogus, I would be anxious to conclude that ethics is thus superfluous. For a thoughtful critique of Sahai's text see: Shiva, Vandana, *Bioethics – A Third World Issue*, July 30, 1997, online accessible on: <http://www.ratical.org/globalize/bioethics.html> accessed Jan 27, 2009)

³⁷ Miranda, *Pagkamakabuhay*, p. 57

³⁸ Critics might say that English is the wrong language to formulate such a bioethics. However, in an international discourse, it will still be the only way to make it heard. The books quoted above show as well that successful attempts were made to show the cultural bias of Western bioethics and to work towards a different understanding of bioethics. However, whether one wants to use the term *bioethics* for that discipline (whether it has to be a scientific discipline at all) or not, that remains open. (The advantage of calling it „bioethics“ to relate to an international discussion and scientific trend. The disadvantage is the confusion it creates as bioethics becomes an equivocal terms with very distinct meanings.)

commonly discussed³⁹, is a result on the one hand of accelerated innovations in the realm of medicine and biology and of the institutionalization of the field of medicine in the so-called First World. The UDBHR remains largely within the boundaries of a Western understanding of bioethics propagating a principle-based form of bioethics centered on autonomy and justice. Such an understanding is culturally biased as seen in the discussion on Filipino bioethics. Bioethics as understood in the Philippines focuses less on principles and does not give precedence on autonomy compared with cultural values such as seeking harmony with others and the dominance of the family over individual interests. Thus, bioethics in the Philippines has to reflect on its rootedness in a concrete cultural tradition, which is significantly distinct from the Western principle-based bioethics. This conclusion, however, does not rule out a universalistic approach to bioethics, but it asks to reconsider the culturally biased outlook of its presumably universalistic principles.

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Aesthetics in Ethics: Narrative and Theoretical Dimensions of Moral Evaluation

- Paolo Marino Cattorini, Ph.D.

Full Chair Professor of Bioethics,

State University of Insubria, Varese, Italy;

Former member, National Committee for Bioethics (Rome) and

National Commission for the Fight against Aids (Rome)

Email: paolo.cattorini@uninsubria.it

Postal address: via Vigorelli 2, 20090 Segrate (Mi), Italy

Abstract

A narrative ethics takes into account the biographical plot of a moral agent, and the background stories, that lead the hopes and offer the behaviour paradigms to daily choices. Ethical theories take root in the visions and tales of a just and good life. Visions that we trust, without having the previous, incontrovertible, intellectual evidence that they are true. Both conceptual and emotional intelligence cooperate in understanding and evaluating the meaning of an action or the dignity of an existence, just like the art criticism tries to grasp the beauty of a work of art and to show the reasons why it looks well done. The ethical discernment intertwines logical analysis, symbolic interpretation, affective insight, literary creativity.

Key words: Ethics, aesthetics, narrative, medical dilemma, moral evaluation.

The silence of the story teller

In the novel by Joseph Roth, *Beichte eines Mörders erzählt in einer Nacht*, a murderer confesses his guilt, during one night. Golubcik, who is telling in a restaurant his worrying experience, makes a pause, a long pause⁴⁰. He does not speak, drink, even move. One listener (the narrating voice), who reports that mortal silence to the readers, records a strange anguish. Golubcik had been bringing the audience out of the time, introducing them in an eternally valid story, upon the eternally wavy waters of an endless sea. Now they were all left to the mercy of that nocturnal silence.

Something like that happens to ethics, when the flow of the narrative thinking stops and you feel the risk of playing the moralist, i.e. of applying abstract and simplistic categories to the reality. Even worse, ethics, amputated and detached from narrative, loses its own identity, trying to arrogantly reach an impossible geometric exactitude. When something does not fall

³⁹ There are of course exceptions seen in many authors.

⁴⁰ *Joseph Roth Werke*, Bd. II, Verlag Allert De Lange, Amsterdam, und Verlag Kiepenheuer & Witsch, Köln, 1975 (Ital. transl. Milano, Bompiani, 1987, p. 90).

under a general law, Aristotle says⁴¹, it is the law which must be corrected, and a decree has to be written following the nuances of the case, as the flexible list, mad of lead, used in the construction of the city of Lesbo. Such a measuring list adapts itself to the shape of the stones and it is not blocked in a rigid form. Narrative is like this architect's tool, mentioned by Aristotle. It is the word we need, to confess faithfully our crimes.

Narrative in Ethics.

The French philosopher Pascal has once distinguished the *esprit de finesse* from the *esprit of géométrie*. It is unfortunately an awkward geometrical deduction that goes into action, when the famous principles of biomedical ethics (autonomy, beneficence, non maleficence, justice)⁴² are applied in a mechanical way, like a magic chemical formula, that could transfer the diamond clearness of a theory to the anarchic, chaotic and dirty world of living situations, where moral dilemmas emerge from.

Here is the *géométrie* of the reasoning: in the major premise of the moral syllogism stand theoretical principles; in the minor one stands the historical description; the conclusion harvests the safe moral truth. For example: stealing is morally bad (the major premise taken from the pure heaven of some philosophical intuition); Peter is stealing (the minor premise); Peter is doing evil (the conclusion).

The purity of simple, fixed, ahistorical, impersonal, universal, comprehensive theories on one side; the confused and changing field of individual stories, on the other side. Is this the real relationship between these *two domains*? We would give a negative answer for several reasons.

First of all, there is a simple proof of the strict kinship (rather than separation) and mutual belonging of the two dimensions. The perennial aim of ethics is looking for a theory so generally sound that it might solve each single dilemma. This means that individual stories have a special evaluating power: they are the test bench of theories and force them to revise concepts, ideals and rules. Every ethicist knows that in applying ethics there is a sort of *rebounding* from the reality, to which the principles are brought down, to the theory from which the principles originate. This rebounding is such that the deformation stamped or conveyed from the reality to the principles may result in the modification of the theory itself. This phenomenon can be explained in just one way: the two levels of understanding have the same root and nature⁴³.

Furthermore, the *description* of the action, to be evaluated, needs a narrative, to understand its *meaning*. Only if we know the premises, the cultural background, the moral agent's intention, the historical consequences of a gesture, we can perceive the moral dimensions of what's happening. An action

is like a text, that can be interpreted just within its *context* and that is why narrative, as Paul Ricoeur has written, is the first laboratory of moral judgement⁴⁴. The narrative perspective is exactly the right point of view to see the whole identity of an action. As an ethics consultant for health care staff, I am used to advising my colleagues: before asking me if an action is good or wrong, I ask you, please, to tell me the story, where that action takes place⁴⁵.

Against the naive separation between description and prescription, between facts and values, in ethics we have to recognize that every narrative (which entails a description of details and a course of events) is an *interpretation*. Who tells the novel, decides what to say and what to omit, what deserves larger or less attention, and the decision reflects the *moral stance* of the observer, narrator or author and his ideal of a worthy vision⁴⁶. A value framework always orientates our sight and attention, so that we can see different things even if we look at the same object. As a moral evaluation implies an historical account of the events, so this depiction implies an ethical perspective. No dissociation is possible between the objective and subjective side of our sight⁴⁷.

The necessity of tale-telling has not only to do with the minor, but also with the major premise of the ethical argumentation. Ethical theories, concepts and abstract forms of reasoning are rooted into visions of the world (*Weltanschauungen* in Karl Jaspers's words⁴⁸), visions shaped as *original or germinal stories*, as myths (in the richest sense), that tell the beginning and the end, the genesis, destiny and role of the human beings in the universe. We see the ethical myths as a plot linking together the symbols of good, we believe in. Reciprocally, we see such symbols as narratives, which are compressed and condensed, like a skein of cotton, that a story-teller might unravel again. Now, stories connect moral symbols and ethical cyphers (cyphers of good, cyphers of evil) as a music that binds notes and melodies, we love. Stories, that we trust, without having the theoretical, incontrovertible, undoubt evidence that they are true. Stories that give us the *vocabulary* to describe, interpret and evaluate the meaning of our biography and of our choices and deeds. Stories that offer the criteria to balance, weigh and measure the different effects, produced by an action (in a teleological approach), or to compare and rank the conflicting duties and rights (in a deontological approach).

The distinction between pain and suffering is a good example of this narrative reasoning. Pain can be measured,

⁴¹ *Nicomachean Ethics* 1137 b (Ital. transl. *Etica Nicomachea*, Milano, Rusconi, 1979, p. 256).

⁴² The famous book *Principles of Biomedical Ethics*, by T.L. Beauchamp and J.F. Childress, Oxford, Oxford Univ. Press, 1979, 2001 (5th ed.), has raised several disappointments over the last years. See for example E.R.DuBose-R.Hamel-L.J.O'Connell, Eds., *A Matter of Principles? Ferment in U.S. Bioethics*, Valley Forge, Trinity Press Int., 1994. Beauchamp himself, *Principles and 'Principlism'*, in AA.VV., *Le radici della bioetica*, Milano, Vita e Pensiero, 1998, 47-59, writes: "Principles, in the prima facie conception, should be understood less as norms that are applied and more as guidelines that are interpreted and made specific for policy and clinical decision making" (p.55). The "specification" of the principles is defined (quoting Richardson and De Grazia): "the progressive filling in and development of the abstract content of principles, shedding their indeterminateness and thereby providing action-guiding content" (p.55). We would ask: where comes from the material with which we fill the principles, if not from stories and existential metaphors? See also H.S.Richardson, "Specifying Norms as a Way to Resolve Concrete Ethical Problems", *Philosophy and Public Affairs*, 19, 1990, 279-310.

⁴³ The theoretical presumption of building a rational, self-sufficient system of norms, based upon some a priori principle or truth, has been criticized since the '50s: see G.E.M. Anscombe, "Modern Moral Philosophy", *Philosophy*, 33, 1958, 1-18.

⁴⁴ For the notion of action as a text, see Paul Ricoeur's philosophical researches, for example P. Ricoeur, *Du texte à l'action*, Paris, Seuil, 1986 (Ital. transl., *Dal testo all'azione. Saggi di ermeneutica*, Milan, Jaca Book, 1989) and *Soi-même comme un autre*, Paris, Seuil, 1990 (Ital. transl. *Sè come un altro*, Milano, Jaca Book, 1993). See also P.Kemp, "Per un'etica narrativa. Un ponte tra l'etica e la riflessione narrativa in P.Ricoeur", *Aquinas*, 31, 1988, 435-458.

⁴⁵ This is also the incipit of my book *Bioetica e cinema. Racconti di malattia e dilemmi morali*, 2nd ed., Milano, FrancoAngeli, 2006.

⁴⁶ S. Chatman, *Story and Discourse*, London, Cornell Univ. Press, 1978 (Ital. transl. *Storia e discorso. La struttura narrativa nel romanzo e nel film*, Milano, Il Saggiatore, 2003).

⁴⁷ See H. G. Gadamer's hermeneutic lesson in *Wahrheit und Methode*, Tübingen, Mohr, 1972 (Ital. transl. *Verità e metodo*, Milano, Bompiani, 1983); D.C.Thomasma, "Clinical Ethics as Medical Hermeneutics", *Theoretical Medicine*, 1994, 15, 93-111; P. van Tongeren, "The Relation of Narrativity and Hermeneutics to an Adequate Practical Ethic", *Ethical Perspectives*, v.1, n.2, June 1994, 57-69; R.A. Carson, "Interpretive Bioethics: the Way of Discernment", *Theoretical Medicine*, 11, 1990, 51-59; R.A.Carson, "Interpretation", in W.T.Reich, Ed., *Enc. Bioethics*, New York, Simon & Schuster, 1995; R.A.Carson, "Medical Ethics as a Reflective Practice", in R.A. Carson-C.R.Burns, Eds., *Philosophy of Medicine and Bioethics*, Dordrecht, Kluwer Acad. Publ., 1997, 181-191; T.S.Chambers, "The Bioethicist as Author: The Medical Case as Rhetorical Device", *Literature and Medicine*, 13, n.1, Spring 1994, 60-78.

⁴⁸ K. Jaspers, *Psychologie der Weltanschauungen*, Berlin, Springer, 1925 (Ital. transl. *Psicologia delle visioni del mondo*, Roma, Astrolabio, 1950).

suffering has to be narrated. *Pain* is not exactly *suffering*, even if pain always causes human beings to suffer. Like all symptoms of somatic illness, pain has a physical dimension and it is affected by psychological factors. But when pain is felt by a person, it is always “suffered” and therefore it has also an ethical meaning, because it is always interpreted as part of a narrative: pain as punishment or blessing, revelation or disaster, moral challenge or absurd event. Suffering is, precisely, a feeling and a vibration of the whole person, and it challenges the reasons of hope and the myths of justice, which our moral life is founded on⁴⁹.

Therefore applying ethics requires *narrative work*. The task is to establish a relationship between two stories: the ideal of a good life and the events of our concrete life. In other words, the aim is to build a bridge between the paradigm of a just society, the trusted myth of a peaceful proximity, on one side, and, on the other side, the concrete promise of caring for other persons. A promise that we have made in our history and that constructs our moral identity, because it represents the *ipse*, the *self* we have decided to be⁵⁰.

The moral agent goes to and fro between *two* narrative levels: background tales (stories representing the destiny of mankind and describing the features of a just, peaceful society) and individual tales (stories of our personal development, of whom we have been, we are, we dream to become). Great tales give universal light and offer reasons of hope to the little ones. Little tales test the great ones, compel them to expand and to encompass new variations. This kind of effort resembles a literary exercise and requires, as we shall say further, some aesthetic competences. As Ronald Dworkin has exactly written, when we take a bioethical decision, we do not simply consider which behaviour (out of the range of alternatives) maximizes pleasure and minimizes suffering, nor which behaviour adheres most to impersonal rules of conduct. Instead, we ask what the most beautiful action is, that is, whatever ensures the most coherent progression or conclusion of our human experience. It happens as if we were writing, as authors, the next chapter of our story, moving toward a good end, looking for a nice conclusion and wondering how to connect the narrative unity of our life with the original story, that guides our last hopes⁵¹.

⁴⁹ E.J. Cassell, *The Nature of Suffering and the Goals of Medicine*, New York-Oxford, Oxford University Press, 1991 commented by P. Cattorini, *La morte offesa. Espropriazione del morire ed etica della resistenza al male*, Bologna, Dehoniane, 2006 and P. Cattorini, “Narrating Pain: The Role of Medical Humanities”, *Eubios Journal of Asian and International Bioethics*, v. 16 (6), Nov. 2006, 177-181.

⁵⁰ In Ricoeur’s terms, it represents our *selfhood*, notwithstanding the changes of our body, character, biological features, social positions, i.e. the changes of my *sameness*. See also J. Verstraeten, “Narrativity and Hermeneutics in Applied Ethics”, *Ethical Perspectives*, v.1, n.2, June 1994, 51-56; M.H. Waymack, “Narrative Ethics in the Clinical Setting”, *Making the Rounds*, v.1, n.15, April 8, 1996, 1-4; R. Zaner, *Ethics and the Clinical Encounter*, Englewood Cliffs, Prentice Hall, 1988.

⁵¹ R. Dworkin, *Life’s Dominion. An Argument about Abortion, Euthanasia and Individual Freedom*, New York, Knopf, 1993 (Ital. transl., *Il dominio della vita. Aborto, eutanasia e libertà individuale*, Milano, Edizioni di Comunità, 1994): we worry about the effect that the final stage will have on a person’s entire life, just as we would worry about the conclusion of an artwork, an artistic text, or the final scene of a play. Life is to be evaluated as though we were criticising a bad ending that ruins an entire piece of literature that we had enjoyed until then. See also A. MacIntyre, *After Virtue. A Study in Moral Theology*, Notre Dame, Univ. Notre Dame Press, 1984 (Ital. transl. *Dopo la virtù. Saggio di teoria morale*, Milano, Feltrinelli, 1988); P. Cattorini “Introduction”, *Bioetica e cinema*; and J. Good Byron, *Medicine, Rationality and Experience: An Anthropological Perspective*, Cambridge, Cambridge University Press, 1994 (Ital. transl., *Narrare la malattia. Lo sguardo antropologico sui rapporti medico-paziente*, Torino, Edizioni di Comunità, 1999). It is interesting J.D. Lock’s article, “Some Aspects of Medical Hermeneutics: the Role of Dialectic and Narrative”, *Theoretical Medicine*, 11, 1990, 41-49.

Narrative and Ethical Theories.

We could make several examples of the role played by stories and narrative metaphors in *philosophy*. There is the story of the war of all against all behind Hobbes and some libertarian versions of modern contractualism⁵². There is the myth of care behind some feminist ethical critiques of the biomedical principlism. There is the Jewish memory of the liberation from Egypt behind the ideal of covenant used to describe patient-physician relationship⁵³. Generally speaking, there are some dimensions of the ethical truth, that can be caught and express only in this kind of narrative and symbolic language: the Enlightenment believed in the victory of the reason over the past obscurantism, as a sun rising over the power of a night that has been making a slave of free person; even Hegel’s *Phenomenology of the Spirit* may be viewed as a romanced story of the conscience⁵⁴.

Ethics is moral philosophy and what we discover in applying ethics reveals a truth, that regards the whole Western theoretical enterprise⁵⁵. As Nietzsche once said, the newborn Greek philosophy has embarked once forever the preexisting wisdom of myths upon the Platonic boat, even if the theoretical thought presumed to get rid of symbols and narratives.

Some comments on Plato’s works may be useful and especially on his “non written doctrines”, that dealt with the “Good” and, as the most precious thoughts, were reserved for the personal oral education of the disciples⁵⁶. Plato’s teaching does not authorize to interpret philosophy as a one-way passing from *mythos* to *logos*, as a transformation, that does not leave rejects and that undervalues the former kind of discourse as pre-philosophical or even anti-philosophical. Actually “Plato regarded all his writings as forms of myth”⁵⁷ as any writing, because of its inherent limits, cannot keep and express every kind of truth. The rigorous dialectic concepts, coined for the pure *noesis* of the unchangeable and eternal being, do not fit the singular, becoming, hystorical and ethical contents of life.

Logos and *mythos*, which perform different, complementary functions and which are the two sides of the same passion for truth, have to be understood as “the systole and the diastole” of the Platonic philosophy⁵⁸, and generally as the two wings and ways of the same research about the sense of life. Research each time takes the form of thinking through images (myths, symbols) or through concepts (theories). The myth requires an interpreter, who could analyse it and translate in concepts; the concepts need the work of rediscovering their mythical core⁵⁹.

Bioethics itself recognizes its debt toward both narrative and theoretical thinking, as two aspect of the same effort to *give reasons* why an action is good or wrong, just or unjust. There are narrative elements in moral theories, as there is logical coherence and evaluative criteria in stories. Every side corrects and integrates the other one, just like literary criticism judges the likelihood, the coherence, the originality, the significance of a novel, and on the contrary a good novelist opens new narrative worlds, styles, atmospheres, that break and renew the

⁵² W. T. Reich, “Alle origini dell’etica medica: mito del contratto o mito di cura?”, in P. Cattorini – R. Mordacci, Eds., *Modelli di medicina*, Milano, Europa Scienze Umane Ed., 1993, pp. 35-60.

⁵³ W.F. May, *The Physician’s Covenant*, Philadelphia, Westminster Press, 1983.

⁵⁴ J. Hyppolite, *Genèse et structure de la “Phenomenologie de l’Esprit” de Hegel*, Paris, Aubier, Montaigne, 1946 (Ital. transl. *Genesi e struttura della “Fenomenologia dello Spirito” di Hegel*, Milano, Bompiani, 2005).

⁵⁵ We have deepened these aspects in P. Cattorini, *Un buon racconto. Etica, teologia, narrazione*, Bologna, Ed. Dehoniane, 2007.

⁵⁶ G. Reale, “Platone”, in: Fondazione Centro Studi Filosofi di Gallarate, *Enciclopedia Filosofica*, Milano, Bompiani, 2006, v.9, pp. 8670 ss..

⁵⁷ Ivi, p. 8696.

⁵⁸ Ivi, p. 8697.

⁵⁹ For the notion of blank metaphor, hidden between the lines of theoretical concepts, see J. Derrida, *Marges – de la philosophie*, Paris, Minuit, 1972 (Ital. transl. *Margine della filosofia*, Torino, Einaudi, 1997).

old philosophical definitions and the aesthetic criteria of literary elegance.

Coming back to what we said about myths, visions and symbols of a good life⁶⁰, we could precise that theories function as intellectual *translations*, abstract *summaries*, written in a clear, simple, impersonal language, of the narrative *Weltanschauungen*, that we believe in. These visions attract our desire and motivate our own moral behaviour⁶¹. They are the good breeding ground, where our key moral words bloom⁶² and where we have to return, whenever a concept, *prima facie* unequivocal, is interpreted and employed in opposite manners. It happens for example when the terms "mercy" or "dignity" are used both to defend and to oppose voluntary euthanasia; it also happens when two neo-Kantian philosophers fight each other regarding autonomous suicide, even if both try to apply the same rule: treat the humanity in yourself and in others always as an end and never only as a mean. To understand what you intend by a theoretical key-word, you need to tell the story from which you have taken it out.

By reemploying the distinction made by Hadot⁶³ between philosophy (philosophical life) and philosophical *discourse*, we would say that applied ethics, the art of applying ethics, entails the skill of imaging, interpreting, evaluating and realizing good actions, while the theoretical ethics is the intellectual reflection aimed to build a logically coherent structure where rules, principles and general theories keep their own places and establish justified relations. Now, from our bioethical point of view, the abstract discourse is and has to be at the service of the concrete dealing with moral problems and with the crisis of human existence. Theory comes from a living experience and helps the *life*. If life is lost, theory itself ruins. But the two things are not separate circles. Making philosophy and philosophically living, defending an ethical theory and evaluating a fragment of life are two dimensions of the same enthusiasm for a true life.

Faith and reason

One of the consequences of our thesis is the collapse of another abused dissociation: that one between faith and reason. We would rather suggest that every ethical theory is to an original story or vision what a concept is to a metaphor and what logical justification is to faith. The abused distinction between religious and secular ethics, between sanctity and quality of life, between ethics-with-absolutes (based upon some faith) and ethics-without-absolutes (based upon the reason) should leave room for the recognition that faith is an essential element of the moral experience and of everybody ethical decision, if faith is defined as the *credit* given to the narrative vision, that offers the value framework of our daily life perceptions and that represents the paradigm to which we compare the specific situations of our biographical journey.

⁶⁰ A. MacIntyre, *After Virtue. A Study in Moral Theory*, Notre Dame, Univ. Notre Dame Press, 1984 (Ital. transl. *Dopo la virtù. Saggio di teoria morale*, Milano, Feltrinelli, 1988).

⁶¹ It is useful the distinction between categorical imperatives and desires made by B. Williams, *Moral Luck. Philosophical Papers 1973-1980*, Cambridge, Cambridge Univ. Press, 1981 (Ital. transl. *Persone, carattere, moralità*, in *Sorte morale*, Milano, Il Saggiatore, 1987, pp. 9-31).

⁶² As R. Rorty, *Contingency, Irony and Solidarity*, Cambridge, Cambridge Univ. Press, 1989 (Ital. transl. *La filosofia dopo la filosofia*, Bari, Laterza, 1990) has clearly stated, once we have chosen our moral vocabulary, the theoretical game is already decided. The key, moral debate does not entail ascribing an unequivocal theoretical foundation to an assertion; it lies in comparing different vocabularies, expanding the range of perspectives, identifying new moral ties and showing the ability to identify and take a liking to the actors involved. Given that anything can appear bad or good after a new, different description, an opposition between assessment and narrative, moral and aesthetic, is not very useful.

⁶³ P. Hadot, *Exercices spirituels et philosophie antique*, Paris, Albin, 2002 (Ital. transl. *Esercizi spirituali e filosofia antica*, Torino, Einaudi, 2005).

As there is no reason without a vision, and concept without a metaphor, that lies behind it, then the task of ethics is to *reflect upon* the visions and metaphors, that seem trustworthy. Ethics is not a knowledge that is intellectually pure and void of assumptions. It is rather the critical analysis of the cyphers and novels, that interweave our life and give us a sense for living well and doing good.

Jaspers, who affirmed that everyone, religious or not, read the transcendence (the principle of being) through existential cyphers, distinguished between a *revealed* and a *philosophical* faith (*philosophische Glaube*). The two stances are not each other in a brutal confrontation (as it seems when pro-life and pro-choice positions fight in the moral arena), but are connected in a common research and cultural challenge. Who believes in a Revelation should admit that his faith is not essential for all the human kind; he may announce a Gospel, but he cannot wait for others following his belief. The philosophical believer, on the other side, should recognize that the faith (which he feels so alien to his areligious nature) is for someone else a choice of truth coming from an unknown origin⁶⁴.

It happens as all of us were marching, in a tiring and risky exodus, toward an happy and worthy land, toward a liberated home, that lights our hope and demands our trust in a promising destination, in something valuable, belonging to this earthly human life, that has to be faithfully embraced, even in the most complete ignorance of the consequences⁶⁵.

Narrating the emotions and affections

Clinical bioethicists run several risks to meet with a disappointment, when they try to *apply* some spreading ethical concepts to bedside situations. We have in mind, first of all, some emphasis on *autonomy*. Some streams of contemporary bioethics, especially in the Anglo-analytical stream, have described a moral agent that does not exist in the real world: an *isolated*, atomistic individual, who looks for solutions for all people and implements the (presumed) best decision, in an impersonal nowhere place, hidden behind a veil of ignorance, free from passions, affections, traditions, relevant relationships⁶⁶. The so-called autonomous person tries to follow coherently a detached, intellectual reasoning, aimed to fulfill general principles, or to maximize benefits and minimize evils for all or to reach the largest consent among mature, individual, self-conscious subjects⁶⁷.

⁶⁴ K. Jaspers, *Der philosophische Glaube angesichts der Offenbarung*, München, Piper, 1962 (Ital. transl. *La fede filosofica di fronte alla rivelazione*, Milano, Longanesi, 1970, pp. 726-77).

⁶⁵ B. Williams, *Morality: An Introduction to Ethics*, Cambridge, Cambridge Univ. Press 1972, Canto Book Series 1993 (Ital. transl. *La moralità. Un'introduzione all'etica*, Torino, Einaudi, 2000, p. 78).

⁶⁶ In this perspective, Bernard Williams (in his criticism of T.M. Scanlon and J. Rawls) has rightly written that contemporary ethics needs a moral psychology: see B. Williams, *Problems of the Self*, Cambridge, Cambridge Univ. Press, 1973 [Ital. transl. *Problemi dell'io*, Milano, Mondadori, 1990]. We would add that contemporary clinical bioethics has almost completely lost one aspect of its generating soul. An emotional soul represented by pioneers like W. Gaylin, *Talking is Not Enough: How Psychotherapy Really Works*, Brown, New York, 2000; Id. *The Meaning of Despair*, New York, Science House, 1968 (Ital. transl. *Il significato della disperazione*, Roma, Astrolabio-Ubalini, 1973); Id. "Nondirective Counseling or Advice: Psychotherapy as Value Laden", *Hastings Center Report*, v.30, n.3, May-June 2000, 31-33. Eric J. Cassell, *Talking with Patients* (Cambridge-London, The MIT Press, 1985, 2 voll.) is another brilliant example of this attitude.

⁶⁷ For a counterproposal, see the following P. Cattorini's articles: "The Desire for Children and the Experience of Illness. A Christian Ethical Perspective", *I supplementi di Tumori*, v.3, n.3, S171-S175, 2004; "Application or Interpretation? The Role of Clinical Bioethics Between Moral Principles and Concrete Situations", *Analecta Husserliana*, LXXII, 2001, pp. 99-115; "Clinical Bioethics. Identity, Role, Aims", *Medicina nei Secoli - Journal of History of Medicine*, 13/1, 2001, pp. 187-197; "Moral Norms and Hermeneutics in Clinical Bioethics", *Medicina nei Secoli - Journal of History of Medicine*, 13/1, 2001, pp. 199-209.

This rationalistic attitude undervalues what actually moves people to act, i.e. motives and passions:

*"It treats the rational content of speech and argument without regard to the engaged concerns that incite both speech and action. It by and large ignores mores and customs, sentiments and attitudes, and the 'small morals' that are the bedrock of ordinary experience and the matrix of all interpersonal relations. It by and large ignores real moral agents and concrete moral situations, preferring the abstraction of the hypostasized 'rational decision maker' confronting the idealized problem needing to be solved [...] Though originally intended to improve our deeds, the reigning practice of ethics, if truth be told, has, at best, improved our speech"*⁶⁸

Little attention is paid to the real *phenomena of the moral experience*, to the stories we live and believe in, to the symbols of good that make the history of my life my moral history, to the emotional turbulences (like the sense of guilt, of debt, of shame) that give birth to and accompany one's own personal ethical conflicts. Little importance is given to the signs of the mutual dependency that in childhood has marked once forever and that everyday marks one's own moral attitude.

From a narrative point of view, this perspective has to be severely criticized. First of all, if "*individual*" moral agent means someone not divided inside himself and divided from everyone else, this model of individualism is nothing but an illusion, not only because we grow up and survive thanks to others' helps, voices, gestures⁶⁹, but also because we keep an ethical arena inside ourselves, an arena where different voices, affections, thoughts, emotions hold a dialogue each other. An internal theatre, where diverging characters play their roles in search for a true, happy solution of the adventure of their and our own life. They are (using the title of a famous Pirandello's theater *pièce*) *characters looking for an author* and for a convincing plot. In other words, the ideal of mental democratic and interdependent *integration* seems to be more realistic and fundamental than the abstract request of *autonomy*⁷⁰.

Second point. "Affections blind the reason", said an old and wrong sentence, that consequently condemned as irrational the emotional waves of the literary genre and privileged the imperturbable, detached style of a philosophical treatise. Unfortunately for these intellectualistic premises, *interpreting our desires* and affections is the only way to catch which might be our good action. Consequently, empathizing with others' emotions is the only way to understand what they feel, hope, want and to collect useful elements to ethically evaluate their behaviour.

This hermeneutical attention requires a narrative attitude, because desires and *emotions* are not arbitrary and irrational explosions, but are the proper reaction to a personal situation, where our reason grasps something true or false, meets an enchanting or a disgusting revelation, encounters a benevolent or a cynic face of the world. The emotions are turbulent opinions as the moral opinions are emotions expressed in general statements. A reason lies inside the desire, even when it is ambiguous, opaque, savage. A vision of good lies inside an

emotion, even when it is wrongfully directed, misinformed, unripe⁷¹.

A person looking for what to do in a dilemma and investigating what kind of agent (of father, mother, or citizen) he (or she) wants to be, is committed to listen to his emotions, just to decide which gesture fulfils in the same time his desire of happiness and of justice, so that the good action, that he and only he must do in that situation, could honour his aspiration to enjoy his life and to promote the wellbeing of all the others. As ethicists, we have been wrong to leave the topic of desires and affections to psychologists. The most important moral decisions in our life (to marry or not, to have child or not, to terminate one treatment or not) are not taken, balancing consequences in an impersonal way, but opening and promoting the *good side of our desire*, letting new textures of existence and new narrative ways flourish from the emotional waves that suprisingly drive us from behind.

Narrating is one of the most powerful thinking tools for taking out the meaning of feelings, for showing their generating motives, for imaging an authentic destiny of them⁷². By help of narratives we can ask the main question: what do emotions and desires actually disclose to us? What people, witnesses, proxies, creditors or betrayers do they summon? What gesture do they claim? What world do they dream? Emotions are essential elements of a moral life and of a sound ethics, because they are symbols of a whole moral attitude and fragments of a story, that has still to be completely imaged, understood and realized.

Aesthetics in ethics

We have assimilated the *moral action* to a text, who needs a context to be understood and evaluated. Now, a literary text like a novel is but an example of a *work of art*. Therefore the final step of our discourse intends to assimilate the applied ethics (bioethics, for what it concerns us) to a sort of *art criticism*, that is the intriguing enterprise which tries to perceive the quality of an artistic production and to give reason of its level of beauty.

Why do we need aesthetics in ethics? Because the good action has an intrinsic *individual feature*: it is a concrete gesture, that asks *that* moral agent to be done in *that* way, in *that* specific context, in the light of *that* existential story. It is something that we, and only we in such a manner can make, because it is the deed that honours and expresses our personal desire of justice and good, giving an original sense to the emotions and affections, that suprisingly has enchanted our will.

When we decide to implement a good action, we don't obey an external, impersonal, abstract order, but we take the decision to mould in the best way *our personal identity*, to shape our biographical unity, to embody our ideal of dignity, love, society. An ideal that we feel worthy of praise and we trust as a vision, a narrative, that deserves the credit of our whole life. From this point of view, the ethical decision looks like a literary exercise: to put together and coherently interlace the story, we are, and the guiding story, we esteem worthy of our commitment.

We don't know what goodness is, before perceiving it into the concrete, historical figures of deeds, that *symbolically* represent an entire attitude towards our life, others' rights, the hope in a better world, the sense of living. We can escape the appeal of these practical choices or we can consent to them, image their development, reflect upon them and, in positive

⁶⁸ L.R.Kass, "Practicing Ethics:Where's the Action?", *Hastings Center Report*, 20,1, Jan.-Feb. 1990, 5-12. See also the comment by R. Hamel in *Bull. Park Ridge Center*, Sept. 1990, 42-43.

⁶⁹ For these reasons, feelings of gratitude and responsibility are the living core of our moral awareness. We depend on others and *dependency* does not lead to heteronomy, but instead to the only kind of autonomy one can build and enjoy. The borders among persons are not so complete and definite as some moral theories guess. "The opposite of autonomy [...] is *not* dependency but *heteronomy*", write J.Holmes and R. Lindley, *The Values of Psychotherapy*, London, Karnac Books, 1998, p.7.

⁷⁰ See this proposal by R.D. Hinshelwood, *Therapy or Coercion?Does Psychoanalysis Differ from Brainwashing?*, London, Karnac Books, 1997.

⁷¹ M.C. Nussbaum, *Poetic Justice. The Literary Imagination and Public Life*, Boston, Beacon Press, 1995 (Ital. transl. *Il giudizio del poeta. Immaginazione letteraria e vita civile*, Milano, Feltrinelli, 1996).

⁷² This is true also from a psychoanalytic point of view. See A. Ferro, *La psicoanalisi come letteratura e terapia*, Milano, Cortina, 1999 and R. Schafer, *Retelling Life. Narration and Dialogue in Psychoanalysis*, New York, Basic Books, 1992, commented by P. Cattorini, *La morale dei sogni. Lo statuto etico della psicoanalisi*, Bologna, Dehoniane, 1999.

case, we can decide to implement them and go to see what kind of truth they open.

This *discerning work* is not so different from the engagement of an artist, who has felt a fascinating promise in the sequence of colours, lines, words or musical notes, he has perceived. The beauty, he is searching, is hidden right there and for no reason he would lose its *traces*. Therefore he starts listening carefully to those signs and obeying the meaningful world, they keep inside. The creative efforts test new ways, perspectives, attitudes and forms of relationship between the artist and the material elements, he can reshape⁷³.

Now, if making a good action is like producing a work of art, then the ethical evaluation is quite similar to the art criticism, that tries to discover the reason why a work is well done. When we reflect upon the reasons why a kind of existence is morally worthy or why a deed is ethically good, we cannot avert our eyes from the individual object of evaluation, because *intelligence and emotions*, sense and sensibility (to quote the title of a famous Jane Austen's book) cooperate to catch this value dimension. We can use general criteria of discernment, often obtained and extracted from the aesthetic tradition, like the concept of *proportion*, but their meaning cannot be fixed once for all a priori, and it has to be referred to the individual issue, which is the focus of the judgement⁷⁴.

In other words, something is good if it satisfies the *exigencies of both* our intellect and desire. The former gives universal laws, but it cannot reach the individual. The latter grasps the individual but does not possess certain and complete rules, that guarantee a firm deduction. If an ethical law exists, it has to be the law of that individual person and action. At the same time, each moral agent makes use of intellectual principles to distinguish in front of all the just and the unjust, the good and the wrong. Like the "finality without a specific aim" (*Zweck-mässigkeit ohne Zweck*) in Kant, a norm exists and seduces us, but it inextricably lies in concrete, individual and historical situations and cannot be translated in univocal, universal concepts.

Our effort of moving the *good* closer to the *beauty* and to accord the good gesture to the well done picture has several authoritative precedents⁷⁵:

⁷³ L. Pareyson, *Estetica. Teoria della formatività*, Milano, Sansoni, 1974 has written that the artist follows obediently an idea in deciding what to do with the first shapes of the concrete work he is realizing. Where comes this idea from? From the same work that does not yet exist and that notwithstanding attracts his desire. Therefore we may talk of a stringent *legality in artistic action*. It is true that a successful work is "fitting to itself" and nothing beyond itself, but it is also true that artistic invention is guided by the same form which, if it succeeds, produces. The piece of work acts even before existing, it is formed and it is forming together and it does not reach being formed if it has not been forming. The piece of work therefore summons to itself the action of the artist, action which could remain inferior to the summoning, if it does not follow faithfully the rigorous internal legality which will constitute the beauty of the work. Such a law, which is produced with the work, and which together counts as a judging criterion of the artistic gesture, can therefore be said to transcend the concrete action, since the artist does not invent it despotically, but also discovers it, brings it to light and obeys it.

⁷⁴ The Neoscholastic aesthetics recognized that this double element is at work, when we employ terms like *proportionate*, that is one of the classic features of the beautiful work of art (*integritas, claritas, debita proportio*) and it is, not surprisingly, one of the most frequent adjectives in bedside ethics, when we talk, for example, of proportionate forms of care. For the Neoscholastic position see S. Vanni Rovighi, *Elementi di filosofia*, Brescia, La Scuola, v.II, cap. XII "Il bello", pp. 201 ss. For contemporary aesthetic criteria (like originality, meaningfulness, coherence, wholeness, materiality, vitality, truthful dissonance) see A. Ferrara, *L'eudaimonia postmoderna. Mutamento culturale e modelli di razionalità*, Napoli, Liguori, 1992 and A.C. Danto, *The Transfiguration of the Commonplace. A Philosophy of Art*, Cambridge-London, Harvard Univ. Press, 1981.

⁷⁵ The term "well done" fits better than "beautiful" the contemporary artistic sensibility, because several "intractable" artists have reminded us that beauty is not their aim and it has not always been the essential feature of a excellent work of art. See A.C. Danto, *The Abuse of*

*"the idea of an identity or of an affinity of the beauty with the good, probably present already in Socrates' thinking, predominant in Plato [...], rejected by Aristotle [...], reaffirmed by Plotinus [...], shows such a strong vitality that it appears again in Shaftesbury's ethics or aesthetics, and that it influences Schiller's ethics or aesthetics and the Romantic poets' and thinkers' concepts"*⁷⁶.

Linguistic and etymologic studies have underlined the relationship of the beauty with the ideas of moral greatness and perfection and viceversa of the ugliness with the image of what is morally shameful or base.⁷⁷

We can guess an immediate objection: the fall to a blind *subjectivism*⁷⁸. We would reply that our hermeneutical, aesthetic and narrative stance does not condemn us to an empty *relativism*, because both aesthetic and ethical judgements are not simply irrational, excited, sensorial reactions. They are *not a mere preference of taste*. On contrary they both deal with values, that claim universal approval. It is true that, when we admire a picture or a tale, which are masterpieces, the reasons of beauty come out from those particular objects. But their beauty forces everyone to recognize it and their brightness claims a general approval.

Kant said that *reflecting judgements* are at work in the aesthetic field, where it is given only the particular and the universal is to be sought not in laws a priori of the intellect, but in the reflection upon objects for which a preconstituted law is lacking⁷⁹. The beautiful object demands a universal recognition, because beauty is something which tends to please universally, but its value is to be found in the intrinsic quality of such an object and not in relation to abstract criteria defined externally. The successful work of art itself supplies the criteria of judgment which should be given, since the artistic creativity has as its own law the individual inherent rule of the piece of work. An Italian philosopher has called "formatività" the character of doing which, while doing, invents the way of doing. Pure "formatività" is the nature of art, since it is a forming just for a forming (and not forming for any other reason or function), so that in art the norm cannot be but the inherent norm of the individual artistic piece of work⁸⁰. In producing a work of art, together with the method of application, the rule or norm which should be applied is also invented.

Well, we think that something like that happens also in the *moral sphere*: a general ethical norm exists, but it is widely undetermined and to be "filled", specified and connoted through the specific norms that the particular situation, with its historical context and characters, reveals to the interpreter. Just as the

Beauty. Aesthetics and the Concept of Art, Chicago, Carus Publ. 2003 (Ital. transl. *L'abuso della bellezza. da Kant alla Brillo Box*, Milano, Postmedia Books, 2008).

⁷⁶ A. Caracciolo, "Bello", *Enciclopedia filosofica*, Milano, Bompiani, 2006, p. 1139.

⁷⁷ R. Bodei, *Le forme del bello*, Bologna, Il Mulino, 1995, pp. 13-14. There have obviously been important exceptions: S. Hampshire, *Logic of Appreciation* (1952) in W. R. Elton, Ed., *Aesthetics and Language*, Oxford, Maxwell, 1954, 161-169 (Ital. transl. *Logica e fruizioni*, in AA. VV., *Estetica e linguaggio*, Roma, Armando, 1977, 190-198, cit. a p. 198), recommended not to follow this misleading analogy, because an artist does not need an aesthetics and when in aesthetics we pass from the particular to the general, we are moving in the wrong direction.

⁷⁸ We use the adjective "blind" because it is true that moral judgments are unavoidably linked to the subjective perspective of a moral agent, but it is not demonstrated that this fact deletes any intersubjective validity and leads to a complete relativism, where moral visions have no worthiness but a particular, individual, situational one. For Williams' strategy to "defuse" this bias, see *Morality* (quoted above) and *Ethics and the Limits of Philosophy*, Cambridge. Cambridge Univ. Press, 1985 (Ital. transl. *L'etica e i limiti della filosofia*, Roma-Bari, Laterza, 1987).

⁷⁹ The importance of the reflecting judgements for the political and moral thinking has been studied by E. Vollrath, *Die Rekonstruktion der politischen Urteilskraft*, Stuttgart, Klett-Cotta, 1977 and E. Pleines, *Praxis und Vernunft. Zum Begriff praktischer Urteilskraft*, Würzburg-Amsterdam, Königshausen Neumann-Rodopi, 1983

⁸⁰ We are referring again to L. Pareyson, *Estetica. Teoria della formatività*, Milano, Sansoni, 1974.

beautiful work of art, so the good action cannot be imaged, chosen and produced by simply applying general laws, that are known a priori, to a rough, shapeless material. The just gesture, like a living being, takes progressively the form, revealed and moulded by the moral agent's biography, desires, promises, relationships, ideals, supreme values.

Conclusions

Camus once wrote: "You can think only through images. If you want to be a philosopher, write novels"⁸¹. The sense of this provocative sentence regards particularly the ways we do ethics and history of ethics. We can no more think of philosophy as a self-sufficient conceptual enterprise, for the same reason that prevents us from reconstructing the old Greek philosophy, without considering what Aeschylus, Phidias, Euripides, Pericles have done. Therefore the historian of philosophy has to become historian of literature, art and religion⁸². Plato regarded the poets as dangerous competitors, because their tragic or epic works were reputed so morally serious and meaningful as a philosophical treatise⁸³.

In ethics both conceptual and emotional intelligence cooperate in understanding and evaluating the meaning of an action or the dignity of an existence, just like the art criticism tries to grasp the beauty of a work of art and to show the reasons why it looks well done. The ethical discernment intertwines logical analysis, symbolic interpretation, affective insight, literary creativity.

Perception of Physicians and Medical Students on common Ethical Dilemmas in a Pakistani Medical Institute

- Dr Bushra Khizar

Assistant Professor Medicine, Shifa College of Medicine
H-8/4, Islamabad, Pakistan
Email: Dr_bushrabu@hotmail.com

- Dr Mobeem Iqbal

Professor of Medicine, Shifa College of Medicine
Islamabad, Pakistan

Abstract

Knowledge about medical ethics is limited in Pakistan. The teaching of ethics in both under and postgraduate education is generally not formal. The aim of the survey was to assess the knowledge, attitudes and practices among the medical professionals in relation to medical ethics in an attempt to identify the medical ethics learning needs of Pakistani doctors. A self-administered structured questionnaire about knowledge, attitudes and practices regarding some common bioethical issues was devised and distributed among medical students and doctors attending a one day medical ethics workshop held at Shifa College of Medicine. The issues included clinical rationing of care, abortion, medical futility, and conflict of interest

⁸¹ A. Camus, *Carnets*, Paris, Gallimard, 1962 (Ital. transl. *Taccuini*, v.1, Milano, Bompiani, 1992, p. 14).

⁸² C. Diano, *Il pensiero greco da Anassimandro agli stoici*, Torino, Bollati Boringhieri, 2007, p.68.

⁸³ M.C.Nussbaum, *The Fragility of Goodness. Luck and Ethics in Greek Tragedy and Philosophy*, Cambridge, Cambridge Univ. Press, 1986 (Ital. transl. *La fragilità del bene. Fortuna ed etica nella tragedia e nella filosofia greca*, Bologna, Il Mulino, 1996, p.62).

A total of 110 medical personnel completed the survey. There were 34 physicians with postgraduate diploma, 48 physicians who were either trainees or did not have any postgraduate qualifications, and 28 medical students. There were 56 males and 57 females. The mean age of respondents was 32±12 years. Most doctors disagreed to deprive elderly with expensive technologies. 91% agreed for legal abortion where congenital defects or mother's life is in jeopardy. There was a strong perception for not allowing parents to discontinue medical treatment in infants with severe physical or mental impairment. Similar pattern of disagreement was observed in elderly with terminal disease, vegetative state or at risk of severe physical or mental impairment. 95% agreed to disclose errors during surgical procedures to the patient.

There seems to be strong element of beneficence in the perceptions of the physicians while making decisions in ethical dilemmas. Physicians also had trouble accepting discontinuation of medical treatment in infants with severe physical or mental impairment or elderly at risk due to terminal disease or vegetative state.

Introduction

Physicians come across ethical issues almost daily during their routine practices. The ability to identify, understand and resolve these ethical issues is a core competency, which should be part of all under and post graduate medical curricula and training.

Traditional medical training offers little help in resolving the ethical dilemmas encountered by healthcare professionals due to lack of exposure and training in this important area of medical practice. However, on qualifying, they are expected to have not only knowledge of medical ethics but also be equipped with necessary skills to adequately deal with them.

There have been many reports stressing the importance of incorporating ethical and legal issues into medical curricula. Ethics teaching needs to be strategized in a direction that it is implemented in accordance to the needs of the particular society in which it would be relevant (1-3).

Teaching medical ethics as a scientific discipline is not advisable, because it may miss the individualistic perception of morality and ethics innate to every professional, which is a blend of one's own unique cultural, socioeconomic and geographical background. In order to formulate ethical curriculum pertinent to every region, the first step may be to determine current basic knowledge and attitudes of the healthcare practitioners in the region.

In Pakistan literature review shows that knowledge of medical ethics and application is extremely poor. Even though Pakistan Medical and Dental council code of ethics specifies that medical ethics be taught in medical colleges in Pakistan, unfortunately bioethics has still not found its way into formal medical curricula.

With this background the present study is an attempt to elucidate the knowledge, attitude and practice of the physicians and medical students in relation to health care ethics laws in Pakistan.

Methods

A six item self-administered structured questionnaire was distributed to elicit the Physician and medical students' knowledge, beliefs and attitudes towards commonly encountered clinical ethical scenarios, who attended a one day Medical Ethics workshop held at Shifa College of Medicine.

The initial part of the questionnaire consisted of demographics such as age, gender, level of education, duration of work experience. The second part of the questionnaire comprised questions regarding six commonly identified ethical situations; resource allocation, abortion, deciding the care of severely malformed or dying infants, end of life issues like withdrawal or withholding treatment, disclosure of errors done during procedures to patients and attitude of doctors to

pharmaceutical company sponsored gifts. The respondents were asked to answer in 'YES' or 'NO' regarding all options given against the different ethical scenarios.

The survey was distributed at one point in time to all attendees of a lecture on clinical ethics. The data were entered in Microsoft Excel. The results are reported in frequencies and percentages.

Results

A total of 110 medical personnel completed the survey. There were 34 physicians with postgraduate diploma, 28 medical students, and 48 physicians who were either trainees or without any postgraduate qualifications. There were 56 males and 57 females. The mean age of respondents was 32±12 years.

The responses of medical students and physicians regarding the identified, everyday ethical issues were variable (Table 1).

Table 1: Responses to the survey questions (% , (N))

Questions in the survey	Yes	No
1- Allocation of Resources in Elderly patient, in regards to restriction of access to expensive treatment like "Transplant	25.4% (27)	74.5% (79)
2a Abortion when strong chance of serious defect	66% (70)	34% (36)
2b mothers health is seriously threatened	91% (96)	9% (9)
2c abortion in case of a rape victim	62% (65)	38% (40)
3a infant had normal brain but severe physical deformities	26 % (28)	74% (78)
3b infant with normal brain and physical deformities which are likely to cause death in next twenty years	9% (10)	91% (96)
3c newborn with a normal life expectancy but severe disfigurement	10% (11)	90% (95)
3d infant with severe brain damage but able body only able to learn simple tasks	12% (13)	88% (93)
3e able body but such a severe brain damage that he was never to wake up	43% (46)	57% (60)
4a who might wake up from coma but had terminal illness likely to cause death in next few months	21% (22)	79% (83)
4b who might wake up from coma but left paraplegic for life again	21% (22)	79% (83)
4c may wake from coma but will learn only simple tasks like feeding	23% (24)	77% (81)
4d case who will be persistent vegetative	28% (30)	72% (76)
4e person in deep coma unlikely to get awake	55% (58)	45% (47)
5 disclosure of errors done during procedures to patients	95% (101)	5% (5)

Discussion

The findings of the present study clearly show the difference in the knowledge and attitudes between physicians regarding the medical ethics and law. The respondents were representative of different levels of physicians, consisting of junior physicians inclusive of post-graduates, consultant physicians, and medical students. Responses from both medical practitioners and students to questions pertaining to practical ethics suggest that the majority of them were aware of the common ethical issues.

On the question regarding restriction of allocation of expensive treatment to elderly patient majority responded in "NO", underlying concept governing this was probably

Beneficence to patient and influence of local religious values with a tend towards preserving sanctity of human life. Every decision is to be taken, keeping in view patients values and preferences, and according to rule of justice treatment cannot be restricted to any individual. The fact that many senior level staff did not feel that the patient's wishes should be asked and adhered to at all times, also reflects that decision making is influenced by cultural and socioeconomic conditions prevailing in the area. In developing country like ours physicians tend to adopt somewhat paternalistic attitude, as most of the population is uneducated and poor. The patients give doctors the status equivalent to their parents or elders and say that you are the best person to decide whatever is in our best of interest, the physicians have started exploiting this fact and take final decision without discussing with patient.

In case of the possibility of obtaining legal abortion for a pregnant female, responses were again variable, 91% allowed doing abortion if the women's own health was seriously endangered. In case of serious defect in baby and pregnant rape victim, there were mixed responses again showing the impact of local cultural and religious traditions, the respondents believe that every baby is also representative of human life, do not allow legal abortion unless there are reasons justifying it.

In case of question pertaining to decision to forego life sustaining treatment by the parents in consultation with pediatrician in case of different types of severely deformed babies, most of the respondents were in favor of continuing treatment irrespective of the given clinical scenario. The controversies involving treatment at the beginning of life have been long debated. Recent controversies surrounding the proper care of imperiled newborns have emerged from the advances of medical technologies (6). Yet the ability to save lives places parents and physicians in a morally precarious position, they must determine when the costs of expensive interventions outweigh the benefits. Physicians must anticipate the vulnerability of parents, collaborate with them, and gently guide them through their decision. In our country it also shows the strong influence of religion which states that life and death is in hand of creator so in counseling the parents we have to realize the importance of religious values and let parents make ultimate decision seeking religious guidance in particular case.

On the question related to the decision to forego life sustaining treatments in an elderly comatose patient by the relatives, majority opted to answer in "No". In such situations patients own wishes are also to be taken in account before deciding for the patient. It again shows the influence of local traditions in our country where it's the family or khandan, tribe or biradari which is also closely involved in decision making, the individuals 'Autonomy' is never the only principle governing decision making.

This also happens because of high poverty prevalence in country, health is not funded at most levels by state so the family is paying and they have to keep their meager resources in view.

In response to disclosure of errors done during procedures, almost all were in favor of it. Failing to disclose errors to patients undermines public trust in medicine because it potentially involves deception and suggests preservation of narrow professional interests over the well being of patients. Disclosure of error, by contrast, is consistent with recent ethical advances in medicine toward more openness with patients and the involvement of patients in their care (7).

In a developing country like ours doctors usually think that disclosing such errors to uneducated, poor patients is not required as they will be unable to understand completely, and will stop trusting and coming to them in future.

In response to accepting gifts or trip from pharmaceutical companies half of them were in favor of it while others were against it. Campbell et al. (8), present disturbing evidence that many physicians accept inappropriate gifts from industry. Physicians should not accept such gifts, because the reciprocity

they engender is known to affect prescribing decisions, which may harm patients and increase the cost of care.

This survey shows that both the knowledge and attitudes regarding medical ethics are variable and may be strongly influenced by local religious, cultural and socioeconomic factors.

Physicians deal routinely with ethical issues

Over the past few years bioethics has become an integral part of medical education worldwide. In Pakistan at present bioethics is not a part of curricula, both at undergraduate and postgraduate levels except in few institutes. Pakistan as a Muslim country with specific socioeconomic and cultural environment has its own requirements of medical ethics encompassing the daily problems faced by medical professionals that must be addressed (9).

The current situation requires a multi-pronged approach addressing ethical teaching at all three levels of medical education under-graduate, post-graduate and as part of Continuous Medical Education.

It is well documented that students start facing ethical challenges right from the first year of medical education. It is therefore imperative that bioethics education should be introduced from the very start. In order to be effective, ethics education has to be seamlessly integrated into the existing medical curriculum with clinical relevance so that it does not assume the role of just another series of lectures that have to be endured. Ideally this integration should not only be horizontal but also vertical throughout the five years of medical schooling. Ethics training that not only sensitizes the students with common ethical issues but also help's to develop practical judgment may be especially worthwhile for physicians (10).

Conclusions

Overall, this survey reflects the current situation of knowledge, attitudes and practice of ethics by clinicians in Pakistan where ethics is not taught as a formal subject at the undergraduate or postgraduate level (10).

This survey was done as an initial step to assess the level of understanding of physicians about ethical issues being faced by them. It was followed by series of workshops held at the institute for capacity building of faculty in addressing and solving these issues.

Also this needs assessment led to planning and implementation of undergraduate ethics curriculum at Shifa College in form of foundation module at start of new academic year followed by addressing relevant issues in system based modules successfully in last two years.

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Altruism: An Ethical Resource for Dealing with HIV and AIDS

- Helen Kunbi Labeodan, PhD

Department of Religious Studies, University of Ibadan, Nigeria

Email: kunbial@yahoo.com

As we enter the third decade of the HIV and AIDS epidemic, effective and creative strategies to combat the disease and deal with the challenges posed by it are more critical than ever. The issue of HIV and AIDS invites us to reflect on human relations at communal and global levels. Globalization increases this problem by promoting a consumer mentality whereby sexuality is reduced to a commodity.

According to Sam Kobia (WCC Study Document, 2001: vii) in promoting prevention measures it is imperative to have the wider picture – to restore to sexuality its integrity. If sexuality is treated as a commodity, the technical advice that would be given to stop the spread of Sexually Transmitted Diseases (STDS) is to increase the use of condoms. It should be noted that the moral admonition to remain faithful has its limitations because its emphasis is more on the individual than on the community. A sufficient and effective control of HIV and AIDS will depend more on the quality of human relations and of our institutions.

Benezet Bujo, (2001: vii) argued: "Although the problem of AIDS is too often linked to sexuality alone, it must be put forward explicitly that our materialistic desires also let many people fall victims of this disease".

To a very large extent public health action is a function of political considerations, which take place in the context of contested meanings and unequal power (2001: vix). When it comes to resource allocation the rural areas usually get a raw deal. The urban elite who dominates political power considered HIV and AIDS as an "urban disease" and for a long time health budgetary allocations were tilted in favour of the urban areas. The health work was also concentrated in the urban centres. It was a long time before the key players recognized AIDS as a development issue (2001: ix).

The newly formed Ecumenical Advocacy Alliance (EAA) acknowledges the HIV and AIDS pandemic to be "one of the greatest health challenges facing the world at the moment. It is also, arguably, the gravest challenge to prospects of social and economic development and global security". The question now is: "How do we stop the spread of this deadly disease?" Before we can answer this question, let us briefly examine practices that put people at risk.

Practices that put People at Risk

Communities continue to embrace cultural practices that put people at risk of contracting the HIV and AIDS. Since cultural practices do not give room for open discussion of sexuality, people might never be educated on issues related to their sexuality. It is therefore importance for there to be sex education, which will help in dealing with HIV and AIDS. The sex education is for both sexes: without involving both parties the problem will not get solved. According to UNIFEM, the culture of silence that surrounds female sexuality in many societies prevents women and girls from accessing information and services for protection or treatment.

There are, however, other cultural practices that aid the

spread of HIV and AIDS. A few of these factors include:

Female Circumcision

The instruments used for circumcision are most times not sterilized. This leads to multiple infections the reason being that, the same instruments are used for many people.

Widowhood Inheritance

In a situation where a widow is inherited by one of her husband's relatives, the widow, who may already have the virus, is likely to transmit it to the unsuspecting partner who will then transfer it to his own wife. And it may be vice-versa.

Polygamy

The practice of marrying several wives is also a major problem. If either the husband or one of the wives should get infected, there is a high risk of others in this marriage to become infected as well.

Prostitution

There are numerous reasons why women go into prostitution but most times the reason given is poverty. As a result of this, they are not in a position to demand safe and responsible sexual practices, which include the use of condoms.

Violence

According to UNIFEM reports, gender-based violence, both inside and outside the household, increases women's vulnerability to HIV and AIDS. This vulnerability increases because of a mistaken belief that sex with a virgin can cure AIDS.

AIDS is transmitted in several ways including: sexual intercourse; transfusion of unsterilized blood; the use of unsterilized syringes, needles, blades, knives, shaving sticks and other sharp objects; or any other act that allows the transmission from one person to another like drinking another person's blood, direct contact with another person's blood or body fluid. It can also be transmitted by trans placental infection (vertical transmission of HIV). An HIV infected pregnant woman can pass the virus to the foetus in her womb.

There are some variables affecting the mode of transmission and the rate of progression of the HIV, and multiple sexual partners is a great risk factor in the spread of HIV and AIDS. This habit leads to the formation of a sexual network, which is the real environment for the rapid spread of the disease in many places.

Challenges Faced by People Living with HIV and AIDS

People living with HIV and AIDS usually face discrimination, stigmatization and denial. It has become important for PLWHA to risk stigmatization, discrimination and denial by breaking the silence around HIV and AIDS.

In many places, people are still reluctant to acknowledge the relevance of HIV and AIDS to their own lives because of the shame and fear that surround this fatal disease and the discrimination and stigmatization directed at those affected. People having or suspected of having HIV infection may be turned away by health care providers, denied jobs and housing, refused insurance and entry to foreign countries. Their spouses or families may throw them out. They may even be murdered. Surprisingly, they are also thrown out of their churches, a place where they expect to find solace and comfort.

It is for these reasons that individuals who suspect or know that they are infected do not wish to disclose their status publicly. Some infected persons even shy away from telling their spouses or partners. This attitude of keeping silence hinders both prevention and care and these people will lose precious opportunities for warding off or treating illnesses brought on by the infection.

The stigma surrounding AIDS can extend into the next generation, placing a further emotional burden on the shoulders of orphans and other survivors (Daini, 2002: 49). When children

whose parents had died of AIDS in the hard-hit rural community of Rusinga Island, Kenya, were asked about the cause of their parents' death most of them said that their parents died of a curse. None mentioned AIDS (Daini, 2002: 49). We have similar stories in other counties of Africa, for instance Nigeria. The reason why stories of this type are told is the fear of being stigmatized as children of AIDS victims, for this may cost them a lot within their society or community. They may be isolated out of a fear that they, too, may be carriers. Most importantly when these children are of marriageable age, no one will want to marry children of AIDS victims. It is for this reason that we have stories of witchcraft attack and curses.

HIV and AIDS is a severely stigmatizing illness. It is not a "glamorous" disease nor is it one that excites public sympathy like cancer and hepatitis. News of HIV and AIDS is usually received in lay circles with fear and avoidance. AIDS still carries a stigma like that experienced by lepers in most African societies today (Daini, 2002: 78). This has, however, changed over the year through love and sympathy for those affected.

Today, a diagnosis of HIV and AIDS is like issuing a death certificate to a person. Society sees the person as an outcast, a dirty, morally inferior, and most times as being promiscuous, and besides having a relationship with a person living with HIV and AIDS is a 'death trap'. Society withdraws from PLWHA and PLWHA themselves withdraw from the society. Some employers terminate the employment of such persons and landlords sometimes evict them from their houses. There is also social isolation of PLWHA by friends, associates, lovers and sometimes relations.

Many people living with HIV and AIDS deny and reject the veracity of the diagnosis of AIDS by qualified medical authorities saying: "I don't have it..." They seek sympathy in order to avoid the presumption of involvement in promiscuity saying: "I have a terminal cancer", or "I have tuberculosis". Sometimes they decide to be superstitious, attributing their conditions to supernatural forces. All these are just attempts by the positive person to avoid the social scorn and rejection that is commonly associated with the disease. Unfortunately, people who deny the veracity of their HIV positive condition and the cause of it sometimes continue in various activities that may encourage the spread of the disease. The issue now is how we can put an end to these challenges faced by PLWHA before it gets out of hand. This paper has put forward **altruism**, a philosophical concept that is also ethical in nature.

The Concept of Altruism

Auguste Comte used the term altruism in 1851 from the Italian adjective *altrui*. He employed the term to denote the benevolent propensities as contrasted with the selfish propensities (Kelvin Knights, 2002: 1). It is used in a psychological sense to designate emotion of a reflective kind, the immediate consequences of which are beneficial to others. Its significance is ethical. As such it defines a theory of conduct having for their object the happiness of others.

Comte's system is both ethical and religious. Not only is happiness to be found in living for others as the supreme end of conduct, but also a devotion to humanity as a whole is the highest form of religious service.

Altruism denotes pure concern for others. It is an action designated to benefit others rather than the doer. It is a highly revered human activity that is eulogized by religious apologists, social reformers and revolutionist movements. Christian discipleship involves self-sacrifice and attention to the interest of others: "Do unto others as you would have them to do unto you" (Aina, 2001: 21).

It is better to be an altruist than to be an egoist. Egoism means a regard for one's private good at the expense of other's interests. It depicts the solitary state of existence. It is also a principle that supports the view that what suits me always justifies my conduct, since no one else is sufficiently like me.

An egoist does what he thinks will give him the greatest balance of good over evil. Human beings are naturally egoist,

for according to Thomas Hobbes, all voluntary acts of men tend to the benefit of themselves and all voluntary acts, the object is to every man his own good (Barcalow, 1992: 84).

It has, however, become imperative for human beings to be altruistic in their attitudes toward life for the sake of others. As human beings we have to be benevolent. According to A.C. Ewing, benevolence is just as natural as self-love. Self-love is not the only self-instinct. It is wrong to hurt ourselves, as it is wrong to hurt others. Hence the need for altruism which is the pure concern for others.

Applying Altruism to HIV and AIDS

Going by the definition and explanation given on altruism above, it is not only people around those living with HIV and AIDS who have to be altruistic in their attitude; those living with HIV and AIDS too must be altruistic in their attitudes toward others. How is this to be done? Persons living with HIV and AIDS must be ready and willing to let people know their status. We are aware of the fact that in letting people know of their status, they are open to all forms of discrimination and stigmatization by those around and even by those from whom they think they will find support. But then, this is a chance they must be willing to take and a price they have to pay for being infected, even though it may not be their fault.

Since altruism means showing concern for others, PLWHA must let those around them know their status so that existing relationships can be redefined. For instance, in a situation where a man tests positive, he must let his wife know and encourage her to go for a test and in a situation where she is not infected, he must be willing to use condom when they want to have sex so as not to get her infected.

One of the questions that readily come to the mind of PLWHA is, "Will I be welcomed in my family, among my friends and in my local church?" This is, indeed, a question that will test the integrity and credibility of all people who bear Christ's name. The question also challenges the church to live in loving acceptance of all persons whose lives have been touched by AIDS.

Those around PLWHA must also be altruistic in their attitudes to those living with HIV and AIDS. They must let their faith reflect in their attitude towards them. They must ask themselves, "What would Jesus Christ have done in this situation? Would He send them away, discriminate against them and stigmatize them and deny them the much needed love and support?" Jesus Christ would not have done these. Rather, He would have shown them great love and compassion.

Since, as Christians, we are followers of Jesus Christ, we must be ready to do as He did. Jesus Christ was altruistic in His attitude towards human beings. He was not thinking of Himself when He gave Himself up on the cross of Calvary for the salvation of mankind. What was on His mind was what could be done so that humanity could be delivered from Satan. He knew that the only way Satan could be defeated was by giving Himself up. Likewise, in the face of the HIV and AIDS pandemic now plaguing the whole world, the only way by which we can defeat this deadly disease is by being altruistic in our attitude.

It has therefore become necessary that those around PLWHA must ask for God's guidance that they may respond in ways that bear witness always to Jesus' own compassionate ministry of healing and reconciliation, and that to this end we may love one another and care for one another with the same unmeasured and unconditional love that Jesus embodied (The United Methodist Church's Resolution on "AIDS and the Healing Ministry of the Church" The Book of Resolution, 1992).

People around PLWHA can be altruistic in their attitudes by destigmatizing the disease through education and care and support programmes. They can also demystify the scourge through healthy and social interaction with PLWHA. They should help PLWHA accept their condition and encourage them that it is possible to continue to live a normal life.

PLWHA should come together to form a formidable force, relate well with one another and try as much as possible to help the society in preventing the spread of the disease. They should get education on the disease, how they can continue to live a healthy and normal life and they should also educate those around them – like their lovers, their spouses, their children, their families and their friends.

We all know that people are not angels and that they tend to look after themselves and their own first. Yet we know that cooperation does occur and that our civilization is based upon it (Axelrod, 1994: 88). A cooperative attitude brings about altruistic attitudes. You look out for others and other people do the same for you.

It is important to point out here that if the highest level of understanding and cooperation is not used to solve the problem, no member of the society can claim total freedom from risk of infection, considering its modes of transmission and its ubiquity (Daini, 2002: 80).

The Church and Altruism

From the beginning of the pandemic some churches have been altruistic in their attitudes to those living with HIV and AIDS. These churches and church-related institutions have been active in education and prevention programmes and in caring for people living with HIV and AIDS. However, the responses of the churches have been inadequate and have, in some cases, even made the problem worse (WCC Study Document, p. 5). As the WCC executive committee noted in 1987, "through their silence many churches share responsibility for the fear that has swept our world more quickly than the virus itself".

Altruistic Attitude of the Churches

Christian love is another word for altruism. Showing love means you are concerned about others. In the face of HIV and AIDS, some churches have shown true Christian love by caring for, supporting and praying for those living with HIV and AIDS.

Here is the story of Peter Braswell, a caregiver.

Peter Braswell loved one Tim who was living with HIV and AIDS. After a while they both needed the kind of support only a church could give. Peter knew that he had to tell his Pastor about Tim. Peter said,

"My faith in the church and my ministers had never been put through a test before, and certainly not with anything as frightening and controversial as AIDS. How were they going to respond? I wanted my pastor to respond with love and compassion and even I had an angry response ready just in case he did not respond, as I want. My fears and anger were quickly dispelled by his warmth and compassion, along with his promise to do everything in his power to help Tim. Later, I found not that he was not only there for Tim, but he was there for me as well".

What has happened here is the true meaning of Christian love. Not only was Peter's faith nurtured; his friend Tim got the support of his church and his pastors (Braswell, 1989).

Peter's experience reminds us that there are people living with AIDS and their loved ones are reaching out and waiting for the church and the community of faith to respond being altruistic and adhering to Jesus' injunction to love our neighbour as our self.

The experience of the Corys was, however, different from that of Tim. Catherine Cory received a massive transfusion of blood after experiencing post-operative bleeding after giving birth to their son, Alex. This was in February 1986. In the spring of 1987, she tested positive for HIV and subsequent testing of the rest of the family showed that Alex was positive and Richard (father and husband) was not.

Catherine had got infected through the fault of the hospital, which did not screen the blood before transfusing, and Alex got infected through breast-feeding. The Cory family met with lack

of love and support from everyone around them, even from their church.

HIV and AIDS is a pressing issue that needs an immediate solution. People must be encouraged to make altruism a reality in the society by showing concern for those around them. Being altruistic is a mindset that must be adopted by every member of the society. People living with HIV and AIDS are human and they have a need to be needed. Treating those with HIV and AIDS with kindness and dignity is by far the greatest gift that can be given. The "golden rule" applies: "Do unto others as you would have them do unto you".

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Evolution of altruism

- K. K. Verma, Ph.D.,
Retd. Professor of Zoology, HIG 1/327,
Housing Board Colony, Borsi, Durg – 491001, India.
Email: kk.sheel@gmail.com

- Suresh C. Sharma, M.A. (Eng.), M.A. (Psychology),
Retd. Professor of English, 'Jagdish-Satya'
55, Mohan Nagar, Durg – 491001, India.
Email: 108@rediffmail.com

It has been shown through several examples from among insects and mammals that altruism has evolved as a corollary to group living, and that it is maximally developed in eusocial species, specially among humans due to their compact and intricate social pattern of life (Saxena and Verma, 2007). It has also been inferred that humans have genetic proclivity both for altruism as well as for violence (Verma, 2008). Evolution of both the proclivities has been deduced from group behaviour among chimpanzees and from comparable phenomenon among primitive human tribes. Verma and Saxena (2000) have pointed out, "Human nationalism and patriotism have their origin in the territorial instinct", which is so common among animals.

In this context a small but a very significant paper by Bowles (2008) has been published, and it is of special interest. The author has developed the thesis that altruism and parochialism act synergistically mutually. Altruism is subjugation of self for good of others. As per Bowles (*loc. cit.*) "parochialism is favouring ethnic, racial or other insiders over outsiders".

Genetic proclivity for violence and parochialism find their maximally pronounced expression in wars. As Bowles has pointed out, wars have been taking place since prehistoric times, as has been inferred from examination of a large number of prehistoric burials of men and women with broken skulls and forearms and pointed stone pieces embedded in the bone.

War-like group conflicts are known among chimps and fire ants, but among humans such conflicts are often on much larger scales. A group of humans, suffering from scanty natural and reproductive resources, may attack a neighbouring group to augment its resources, and a war-like situation results. Under these circumstances both altruism and parochialism show an upward trend in either group; this is what is referred to as

mutual synergistic effect between altruism and parochialism. In a war altruistic attitude is maximally developed among 'insiders', and also parochialism takes an exaggerated form of hatred and animosity towards 'outsiders'.

But among tribals there are also instances of sympathetic and friendly relations among neighbouring tribes. Tribes in vicinity may exchange gifts, and may offer help to neighbours in adverse conditions.

Development of projectile weapons, killing enemy from a distance, has reduced the immediate personal cost of aggression, and has made lethal conflicts more lethal and destructive (Bowles *loc. cit.*). Continued development of such weapons has led to long shooting range guns, missiles and even nuclear warheads. The enormous destructions, caused by such advanced weapons has led to peaceful coordination among states, as evidenced by formation of United Nations and the European Union as an aftermath of the Second World War.

Natural calamities have also promoted interstate altruism. There are numerous instances of developed countries extending help to less developed nations in the event of famine or calamities like earthquakes and floods.

Bowles points out that the synergistic relations between altruism and parochialism could be repeatedly verified by several workers through computer simulations. In such simulations groups were made with both altruists and parochial-altruists (i.e. with both attributes of altruism for 'insiders' and parochialism for 'outsiders') in different proportions. On creating war-like situations between two such groups, the group with higher proportion of parochial-altruists was found to be the winner in such conflicts. When populations, resulting from thousands of generations of selection, were examined, some populations had become tolerant and selfish, with little warring tendency, while others were parochial and altruistic with frequent and lethal encounters with other groups. Some transitional groups between the two types were also obtained. What is important to note is, "neither altruism nor parochialism ever proliferate singly; they share common fate, with war the elixir of their success" (Bowles *loc. cit.*).

'Ingroup' altruism is enhanced not only by increase in 'outgroup' parochialism but also by the fine distribution of labour in a human society. As a result of such a distribution individuals in one trade have to depend for the 'fruits' of another trade on the specialists of the latter trade. Through their mathematical models Fletcher and Doebeli (2009) have come to a similar inference, that 'give-and-take' promotes mutual dependence and altruism. These authors say, "an altruistic genotype requires that carriers of the genotype are overcompensated for their altruistic sacrifice by benefits received from others".

Fletcher and Doebeli (*loc. cit.*) point out that 'population viscosity', i.e. limited dispersal, also promotes altruism. Wilson and Wilson (2007) have formulated a hypothesis about evolution among humans. They say that evolutionary changes in humans are multilayered. Such changes occur both at the individual level as well as at the group level. The hypothesis further says that in a group or a society there are some individualist members and some altruistic ones. An individualist considers only his individual gains and not the social needs. He may take even to tortuous ways for personal benefit and ignore the social ethics. He may well provide his family and afford costly education for his children, who will inherit the traits from their parents, and theirs will be a prosperous family. Thus this family will be positively selected at the family level, but will contribute little to or even harm the social structure. An altruist will concentrate on social needs, will keep in view the laws of the land and the religious ethics, but may do not much for his family. In this family there will be, in comparative terms, a negative selection at the family level, but at the group or social level evolution theirs will be a positive contribution and selection. Thus both individualists and altruists have to face a "trade off". If in a society altruists dominate, this society will do better and will be more progressive than another society, in which individualists have dominance. A society with the latter

constitution may suffer from internal conflicts and eventual breakup.

In the preceding paragraph, inheritance by children in the family has been mentioned. It may be kept in view that among humans inheritance is not only genetic but also cultural, because of a long post-natal association with parents and the rest of the family, and an extra long period of psychological immaturity.

The hypothesis by Wilson and Wilson (loc. cit.) has been well supported by several computer generated models considering all the relevant factors.

One of the inferences, reached from the recent studies, discussed above, is that increasing altruism within a group is associated with increasing parochialism against another group. But for growth of civilization the highly destructive and lethal wars have to be avoided, while interstate and intergroup altruism is desired. Can we counter the natural tendency of altruism and parochialism increasing hand-in-hand through cultural processes, like education and religion? It is an important question awaiting an answer. If an answer, suggesting a feasible plan of action, could be found, it will help practicing a basic precept of Hinduism, "vasudhev kutumbakam", i.e. all the world one family.

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The rare plants' lamentation

- Bing H. Tang, M P H, M D
Research Consultant, New York College of
Traditional Chinese Medicine
Address: Research and Ethics, 182 - 01 Union Tpke, Fresh
Meadow, N Y, 11366, USA
Email: prof.bing@gmail.com

We are Rare plants;
you may want
To tell us that since we know
We are rare, we likely have no
Value in your market.

Well, we
Also know that we
Have'n created by the Creator
Just like you have'n - no more than you,
No less than you either

Of course,
You can find us as
Carnivorous Plants of
Australia; also, learn us
In the U S as imperiled plants.

Rare plants
From the watershed;
The rarity is decided

On the humans' listing for us:
How do they view about us.

For examples, Just to name a few:

The plant such as curly grass fern,
Is the one circuitous.
There are, too, others.

Swamp pink,
Bog asphodel,
Slender nutrush, sedge livid,
Pine barren smoke grass, sand myrtle
And bladderwort purple.

Neither,
We're complaining all;
Never have we claimed about
All of the human's vigilance
Nevertheless, as to

We live
Up to the human;
Some of their turmoil
Helps: recreation carriage,
And digging ponds and dykes.

Besides,
Many sand roads,
The widespread sand residue,
Furthermore, power-line clearance
And the huge borrow pit.

Humans' all
Other turbulences
Yet are detrimental:
Such as excessive landscaping,
Residential and industrial
development corrupting.

We are
Now sobbing and trying
To survive between our
Continued subsistence and their
Own excessive desire.
Is there no way for them to weigh?

For humans, they must appraise;
The human should bring all to light.

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Arts Bioethics Network (ABN)

Yatho hasta thatho dristi
 Yatho Drishti thatho manaha
 Yatho manaha thatho baavou
 Yatho bhavou thatho rasaha

Where the hand goes, the eyes follow,
 And where the eyes are, is the mind,
 And where the mind focuses, it is reflected in the expressions
 (facial and otherwise)
 And when the mind focuses, the dancer and the audience
 engage.

- Natyashastra (A classical Indian text on dance)

With such a structured approach to dance, *Bharathanatyam* is capable of capturing complex and difficult ideas and engaging the audience at an intellectual and emotional level. *Savithri*, a solo *Bharathanatyam* dance composition on death and life extension, inspired by Sri Aurobindo's epic work of the same name was presented at the 9th World Congress of Bioethics at Croatia, in an attempt to encapsulate Hindu ideas on death and the nature of life and the ethics of the quest for life extension. As art is often the keeper of knowledge and ethics in many communities the pursuit for inclusiveness in international bioethics debate would be well served by taking account of artistic explorations. By showcasing *Savithri* and other works the Arts Bioethics Network endeavours to bring diversity to the international discussion of bioethics.

The aim of the **Arts Bioethics Network (ABN)** is to bring artists and non-artists together and to introduce arts as a component in interdisciplinary research and knowledge building. In order to facilitate creative approaches to bioethics, ABN organised two major events – an arts exhibition and a performance session at the 9th World Congress of Bioethics. Other papers at the Congress which incorporated arts into bioethics and education explored eastern ethics via yoga, explored the use of pelvic dance movements to increase health awareness about low back pain, the use of speculative social narrative and design proposals to generate an alternative way of debating about social, cultural and ethical issues surrounding life sciences, and the use of DVD for teaching philosophy, ethics, law and linguistic analyses. The highlight of the evening sessions at the congress was the screening of the movie *Romulus, My Father*. This was followed by an active discussion that arose from topics covered in the movie.

The arts exhibition entitled *The Art of Bioethics* was well received. In his opening remarks for the exhibition, Professor Raimond Gaita, a philosopher and bioethicist from Australia, commented that the exhibits prompted the viewer to meditatively reflect on bioethical issues, rather than deliberate on bioethical issues. He was of the view that bioethicists should not just engage in analysis of what the principles of conduct should be and how to rationally justify them, but to reflect on moral thought in the context of the human condition. Among the exhibits were *The Lake* which raised the question of whether humans should manipulate other life just because it is possible for them to do so, *Closed Reality Embryo* - an interactive exhibit allowed two participants to jointly create an embryo, while allowing them to choose genetic characteristics of the baby. *Balance of Power, Drugs for Healthy People and Promotional Mugs* alluded to the power relationships existing between

doctors, patients and pharmaceutical companies. *The Smile of a Stem Cell* was a collection of photographs produced by scientists based on their laboratory work on stem cells. Finally *Quantum Gene* was an amalgamation of ideas from quantum physics and the genome sequence.

The performance session, chaired by Dr. Paul Ulhas MacNeill along with Dr. Chamu Kuppaswamy saw the participation of both in performances. Dr. MacNeill played a role in *The Carousel Ride* – a drama on organ transplantation and the moral issues surrounding payment for organs. Dr. Kuppaswamy presented the *Bharathanatyam* dance performance. Two documentaries on care of the elderly and women's reproductive choices highlighted the power of the medium of documentary well. *The Icarus Project* was a tale combining modern and mythical narrative to educate and inform teenagers about stem cell research. Poetry also featured in the session and was presented in French preceded by a short commentary on its poetic features and content.

The co-ordinators intend, through their efforts to expand the work of ABN, to deepen and extend the role of the arts in bioethics by fostering joint thinking amongst scholars from different disciplines. One such effort is taking shape as a project proposal to promote health awareness amongst women in Taiwan through use of pelvic dance movements developed from ancient cave paintings in Dunhuang.

Artistic collaborations have great potential in involving the public, the academics and policy makers in a joint engagement on bioethics. At the very least ABN events added an additional dimension to ethical debate at the congress. Perhaps, and more ambitiously, it has inspired participants and viewers to push the boundaries of interdisciplinary knowledge production into unprecedented territories.

ABN Contributors: Bailey Barash (203 Days), Gus Clutterbuck (Balance of Power, Drugs for Healthy People and Promotional Mugs), Katherine Koller, Angela Thachuk, Florencia Luna, Paul Ulhas MacNeill, Bailey Barash (The Carousel Ride), Chamu Kuppaswamy (Quantum Gene, Savithri), Andreja Kulunčić (Closed Embryo Reality), Peter Rumney and Nettie Scriven (The Icarus Project) Julie Freeman (The Lake), Sebastien Duprat (Smile of a Stem Cell, La vie, Ma vie : c'est quoi ? c'est quand ?), Debora Diniz (Severina's Story), Serene Chi, Elio Caccavale, Paul Ulhas MacNeill (arts papers)

For more information contact the coordinators of the network:

Dr Chamu Kuppaswamy (c.kuppaswamy@shf.ac.uk) and

Dr. Paul Ulhas MacNeill (pmacneill@med.usyd.edu.au)

Human Cloning: Prospects and Challenges in the Asia-Pacific Region

- Shamima Parvin Lasker
Professor of Anatomy
City Dental College
Dhaka, Bangladesh.
Email: splasker04@yahoo.com

Abstract

Cloning research has been said to be one of the world's ten great technologies achieved in 2000. A number of Asian countries are pioneers in human cloning research. The source of the material for cloning research has raised ethical questions. Although most of the countries in Asia and the Pacific have passed laws prohibiting the implantation of cloned human embryos for reproductive purposes, embryonic stem (ES) cell research has drawn special attention for undertaking revolutionary treatment of disease, in China, Japan, Singapore, Thailand and Malaysia. Regulations concerning stem cell research differ from nation to nation in Asia-Pacific region. Guidelines regarding the reproductive and therapeutic cloning are discussed. Freedom of research and discovery for the benefit of humankind must be respected but unethical scientific adventurism also needs to be checked. Biotechnological advancement in 21st century in this line may challenge us to rethink and redraw the moral boundaries of the United Nations Declaration on Human Cloning.

Introduction

Cloning research is one of the world's ten greatest technologies achieved in 2000. By modern biomedical technology, it is possible to produce every tissue from embryo stem (ES) cells to repair and replace the pathological or decrepit tissue and organ of human. Thus scientists hope to treat cancer, diabetes, nervous tissue disease, heart disease, immunity disease and genetic disease as well. Although immunological rejection is still not resolved, cloning human embryos and stem cells for auto transplantation could eliminate immunological rejection. Therefore scientists are pursuing experiments to reduce the human suffering and expand the life of human. But the source of the material and purpose of research has raised scientific, medical, moral, ethical and legal questions.

Definition of Cloning

A group of organisms with an identical genetic make-up are derived from a single individual as a result of non-sexual reproduction is called cloning. It should not be forgotten that this sort of cloning exists in nature, particularly in certain plant species, several invertebrates and lower organisms. Genetically identical monogygotic twins in humans are the result of a natural form of cloning.

Embryonic Stem (ES) cells are early original cells with high multiplication as well as unilateral and multilateral polarization potential. There are totipotent, pluripotent and monopotent stem cells. Totipotent stem cells could polarize into 200 types of human cell constituting every tissue, organ and finally grow into a whole body. Pluripotent cells are derived from totipotent cells and have potential to form many sort of cells. Monopotent stem cells are formed from pluripotent cells and can only give rise one or two closely interrelated type of cells such as stem cells for epithelial or muscle cells.

Source of stem cells:

1. Embryonic tissue from abortions

2. In vitro fertilization (IVF) to make embryos from donated gametes
3. Use of surplus embryos from IVF
4. Cloning embryos by somatic cell nuclear transplantation technology via asexual reproduction.

Human Cloning in Asia-Pacific

A number of Asian countries are pioneers in human cloning research. Lee Boyon, Professor of an Infertility clinic at Kyonghee University succeeded in cloning a human embryo using nuclear transfer technology in 1988. This is the 1st reported case of cloning of a human embryo.

In the beginning of the 21st century, Chen Xigu, professor of experimental animal centre of Sun Yat-sen University, transferred a skin cell nucleus from a 7 year old boy into a rabbits denucleated egg and created a embryo aiming to use cloning to cure diabetes and Parkinson's disease. Next year, in 2002, Li Lingsong, at Peking University announced that he has cloned a glandular structure that secretes chemicals helpful in treating diabetes and Parkinson's disease. He is trying to put human cells into animal embryos to produce human organs for use in organ transplantation. One research group acquired embryonic brain tissue from 6 to 8 months gestation aborted fetuses/miscarriages. The Medical Science Institution of Shijiazhuang city of China and Henna Medical University did intracranial transplant with human embryo stem cell and reported good curative effect in brain agenesis.

A Japanese scientist put tretinoin into thousands of frog stem cells and produced frog eyes and ears. Another Japanese university scientist transplanted the experimental rat heart into ventral aorta and cultivated a new rat's heart. In 2000, Hwang Woo-Suk, Veterinary Medicine at Seoul National University succeeded in cloning a cow named Yongrongi for mad cow disease research. Singapore is a leading manufacturer of embryonic stem cells world wide.

Laws on Cloning and Stem Cell Research in Some Asian Countries

Regulations regarding reproductive and therapeutic cloning differed from nation to nation in Asia-Pacific region. All types of cloning are illegal in some countries like Hong Kong, Philippines and Bangladesh. But most countries, except Iran in the Asia and the Pacific, have passed laws that prohibit the implantation of cloned human embryos for reproductive purpose only allowing ES cell research.

In China any research for human reproductive cloning shall be prohibited. Experiments in vitro cannot be done more than 14 days after fertilization or after nuclear transfer. ES cells used for research should derive only from:

- a) Spare gamete or blastula after IVF
- b) Fetal cells after natural or voluntary selective abortion.
- c) Blastula or monosexual split blastula by somatic cell nucleus transfer technique
- d) Germ cell voluntarily donated.

In India research on cloning through nuclear transplantation or embryo splitting with the intent to produce an identical human being is prohibited. In Republic of Korea, reproductive cloning is strictly prohibited. Under any circumstance this will be considered as criminal act. But ES cells research is accepted with regulation. Like Korea, Japan also prohibits reproductive human cloning firmly and it imposes criminal sanction. Putting of embryos into a human or animal uterus is also strictly prohibited. However, it allows the application of these technique and other similar ones for research purpose as long as it is not allowed transplantation inhuman or animal. Reproduction cloning is banned in Malaysia as well. But the therapeutic cloning of human embryo is acceptable as long as it reached before 120 days of age.

Singapore has a complete ban on reproductive cloning but permits therapeutic cloning under strict regulation. Embryos created by IVF or SCNT for research purposes must have

strong scientific merit, potential medical benefit where no acceptable alternative exists. Withdraw of stem cells from adult tissue, aborted fetuses and surplus embryo from fertility treatment are allowed, as long as the embryo is less than 14 days old.

Both the reproductive and non-reproductive cloning are acceptable only in Iran. For reproductive cloning it imposed some regulations such as:

1. Identity of male or female donor should be known.
2. No junction of somatic and sex cell. Cell should not be adulterated.
3. Person deal with clone should be specialist and aware of secret of the operation.
4. Should not harm a future child in to human society.

Causes of Rejecting Human Cloning:

Human cloning is rejected by most countries because:

1. Impairment of sanctity of life: Exercise discreet manipulation over the process of reproduction, which is reserved or omniscience and an almighty creator.
2. Risk of informed consent: experiment performed on human being, the subject must know the risks beforehand and give consent. In case of human cloning, the embryo being produced can not give such informed consent.
3. Risk and inevitability of mistake: The techniques are still in rudimentary stages. So it could lead to many unsuccessful attempts. Before Wilmut succeeded in achieving the birth of Dolly he was confronted with many experimental pregnancies resulting in anomalies that are horrible.
4. Loss of dignity: Many believe that life should have mystery and a child comes about as the mysterious outcome of the loving union of husband and wife.
5. Little is known about potential side effects. Manifestation of ill effects may emerge only after birth or when a cloned person reaches adulthood.
6. What would be the age of clone person? Does it count from their birth or the date of birth of the donor?
7. Biological diversity of the species will be jeopardized.

Conclusion

There is a need for further reflection in Asia and the Pacific about human cloning, because of the varied aims. Some researchers hope to relieve the anguish of infertile couples by cloning technology. Some scientists set out cloning research from curiosity or thirst for exploring truth; they want to discover the mystery of the growth and development of human life through this research. Freedom of research and discovery must be respected but the scientific adventurism needs to be checked.

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