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## **Editorial: Reflections on Dignity and Bioethics**

This issue of *EJAIB* includes a range of papers on topics in bioethics, with a focus on medical ethics. One of the common themes is related to dignity, with various interpretations of this, through questions of life. The paper by Tanida explores the growing number of conditions that are becoming "medical"

ones, with a number of ethical and economic implications for human well being and treatment at not only the end of life – but throughout it.

The next paper reviews global ethics, with a range of theories that are available as descriptions of the ways that peoples make ethical decisions. The question of universality of ethics is also addressed in the review by Kaelin of how the UN/EU report on organ trafficking could be applied practically in a country with organ trafficking, such as the Philippines. Similar issues are raised in many other countries as well. Yoshida discusses the anthropological and sociological issues of corpses, and Talukder discusses the concept of persons. There are many disciplines which can contribute to our understanding of dignity. The final paper in this issue also looks at whether the ethical responsibility of alleviation of poverty upon individuals or states.

The Eleventh Asian Bioethics Conference (ABC11) and Fifth UNESCO Asia-Pacific School of Ethics Roundtable was held in Singapore, on 1-2 August 2010 on the theme *Mundalization, Bioethics and Policy*. There were about 80 papers presented, and the abstracts appeared in the July 2010 issue of *EJAIB*. Some of the papers will be published in forthcoming issues of *EJAIB*. There were a range of sessions on education, environment, neuroethics, Asian bioethics, genetics, biobanks, for example. Related to these theme are two new volumes of Asian-Arab Philosophical Dialogues available from UNESCO Bangkok, and on the web. The content lists are printed in this issue. A number of the papers explore concepts of dignity through history, and how to apply this to issues of war and peace, globalization and democracy.

Gunn in this issue considers Buddhism and genetic engineering. This issue of the dignity of life and human choices is an important example of how different facets of dignity can lead to conflicting responses to ethical decision making.

Finally, we encourage all readers to renew their membership of Asian Bioethics Association, in time for the forthcoming elections of a new board, that will occur in November 2010. The 2011 conference will occur in Taiwan, dates to be decided soon.

-Darryl Macer

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## Medicalization; for a sense of peace or for a sake of profit with special reference to feeding through percutaneous endoscopic gastrostomy

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### Medicalization

Medicalization refers to the practice that certain human conditions are to be defined and included in part of medical issues. The term became fashionable by the book *Medical Nemesis* (Illich, 1982), which commonly denotes the spread of medical practices through life and death. Medical Nemesis, which has a subtitle "the expropriation of health," is also known as "Limits to Medicine." As the title itself speaks, Illich was critical to contemporary western medicine. It is true that medicine or medicalization frequently causes more harm than good. Yet, authentic medicine is continuing to grow, so the medicalization too. It is a natural consequence that a number of people who are suffered from medicalization are continuing to grow.

In a classical sense, the aim of medicine has been to ameliorate dis-eases and to cure disorders. Nowadays, seeking a healthier body and mind is added to the aim of medicine. Then, contemporary people never allow dis-eases or dis-orders, where they are seeking an eternal health. Thus, medicalization may include such conditions as symptoms associated with menopause, baldness and erectile dysfunction of men, mood changes (anxiety and depressiveness), behavioral changes of children and adults, enhancement of the body including short stature, breast implants, and so on so forth. In any case, medicalization has produced an infinite number of consumers for medicine.

On the other hand, once medicalized conditions such as hysteria, masturbation and homosexuality were demedicalized in modern medicine. Nutrition is another issue between medicalization and demedicalization. Particularly, the status of artificial nutrition is rather complicated; the to and fro has been observed in artificial nutrition between medicalization and demedicalization, presumably because a nutritional issue connotes so complicated social, ethical, legal, economical and religious aspects beside medical reasoning. Here, the attention is focused on medicalization and demedicalization of feeding via percutaneous endoscopic gastrostomy or PEG in dementia patients.

### Artificial nutrition and PEG tube feeding

Nutrition is essential for survival. Therefore, impairment in intake of nutrition is certainly a disorder. Naturally, maintaining nutrition became a target of medicine. Several methods are available for giving nutrition to patients, including parenteral and enteral routes. PEG tube feeding is the latest technique to give nutrition to patients. A PEG tube is located in the stomach through the abdominal skin using gastroscopy. Liquidized nutrition is infused through the PEG tube to patients. Once this technique was known to doctors, PEG has spread quickly replacing nasal gastric tube feeding. PEG tube feeding is now so prevalent among hospitals, particularly in long-term care facilities.

When nutrition is given through medical interventions such as a nasal gastric tube, PEG or injection, only healthcare professionals will be able to perform such procedures. Therefore, such a kind of nutritional support is medical by all means. On the other hand, when nutrition is given orally with a spoon by anybody even by healthcare professionals, it is not medical. In other words, nutritional support is mostly medicalized. In many acute cases, benefits of nutritional support seem obvious regardless of the dispute over medicalization. However, questions arise when benefits are not obvious particularly in chronic cases.

### To give or not to give

To make the discussion simple here, let us consider a case in which it is supposed that nutritional support is medically futile. Most cases with terminal dementia can be incorporated in this category, because there has been no proof that artificial nutrition or PEG tube feeding is beneficial (Cervo FA, et al, 2006). Then, to stop or to withhold nutrition in these patients is medically right decision. However, many people resist or hesitate to accept this idea, saying that nutrition is essential for survival; therefore, nutritional support is not medical. Thus, medicalized nutritional support is now forcibly demedicalized by those people who support artificial nutrition.

However, the fact remains that artificial nutrition or PEG tube feeding is only performed by medical professionals. Furthermore, these dementia patients must be kept in restraint with hand cuffs during artificial nutrition or PEG tube feeding, because these patients attempt to remove a tube and apparatuses for artificial feeding. It means that demedicalized technique is now medicalized again. Advocators of nutritional support keep saying that nutritional support is not medical, but they totally depend on medicine. There is only one way to overcome this confusion; that is solution from faith or religion, because it does not require rationality.

A typical example is the address made by Pope John Paul II to the participants in the International Congress: Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas on 20 March, 2004 (Vatican: the Holy See, 2004). He first commented on vegetative state that "there are well-documented cases of at least partial recovery even after many years," "A man, even if

seriously ill or disabled in the exercise of his highest functions, is and always will be a man, and he will never become a vegetable or an animal." Then, he taught that "the sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.)," "I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act." Also, he denied the idea of so-called death-in-dignity and quality of life as a basis of ethical judgment.

The Pope's words have a serious implication in the question as "to give or not to give." For example, after the Pope's words, many advance directives, which Catholics formerly signed in good faith, and which require the removal of food and water in cases of a persistent vegetative state, may have to be reconsidered. In any case, the Pope's words indicate re-medicalization of demedicalized medicalized nutritional support.

### **PEG tube feeding in dementia patients in Japan**

PEG tube feeding is used among hospitals and long-term care facilities for patients with dementia who do not eat. As a matter of fact, Japanese patients and families do not want PEG tube feeding according to the survey (Aita K et al, 2007). And doctors do not want PEG either, but PEG is practiced routinely. They raised several factors for unwanted routine use of PEG tube feeding.

Firstly, it is a legal barrier. Japanese police does not guarantee protection for withholding or withdrawing life-sustaining treatment, although there is no law which says stopping or withholding PEG feeding is illegal. Another legal barrier is related to the lack of a proxy decision-making system. The second factor is an emotional barrier. Nobody wants to the patient die by starvation. Also, doctors love to do things, and they feel difficulty in doing nothing for a patient. This attitude of doctors is not specific to Japan, but Japanese doctors are particularly prone to this attitude (Tanida, 2005). Thirdly, there is a cultural value. People attach importance on continuing the life of a patient for the family rather than for the patient himself/herself. Also, there is a hidden motivation of the family to want to prolong survival of dementia patients, which is to earn pension of the dementia patient. The fourth factor is a reimbursement-related factor. It is a common practice to begin PEG feeding for patients who cannot eat and have lost decision-making capacity before they are transferred to long-term care facilities. This is because long-term care facilities do not accept patients who are unable to be fed by mouth unless a PEG feeding tube is put in place. In addition, increasing reimbursement rates for PEG make the procedure more attractive for hospitals. These factors clearly illustrates that PEG feeding is to get satisfaction and profits of the family and doctor other than anything for the patient.

### **Medical indications of PEG tube feeding**

It has been claimed that PEG feeding will prevent malnutrition, maintain skin integrity, prevent aspiration pneumonia which often associated with nasal gastric tube feeding, improve quality of life, and eventually increase functional status and survival. However, according to the meta-analysis on the efficacy of PEG tube feeding in dementia patients (Cervo et al, 2006), there is no study which has shown improvement of nutritional markers; even some results showed that PEG tube feeding might increase weight loss. Despite the claim to maintain skin integrity, there is an increased risk for pressure ulcer formation. Prevention of aspiration pneumonia is always said as a benefit of PEG tube feeding compared with other methods. However, PEG tube feeding may reduce lower esophageal sphincter pressure; that means the increased risk of aspiration and aspiration pneumonia. PEG tube feeding does not stop oral secretion, therefore, there is no way to prevent aspiration pneumonia from oral secretion. PEG tube feeding may improve quality of life, but at the same time, it unexceptionally increases suffering and discomfort because of inevitable restraint with hand cuffs during nutritional infusion. Increase of functional status and survival is also claimed as benefits of PEG tube feeding, but the terminal diseases cannot be reversed by feeding tube placement. Indeed, observational studies on survival of dementia patients were disappointing.

At present, several organizations have produced a reasonable guideline for PEG tube feeding. For example, the ESPEN guideline (Loeser et al, 2005) says that "PEG is an elective invasive procedure with physical injury," therefore, "from a legal point of view, informed consent is essential." And indications of PEG feeding for patients include; a nutritional intake is inadequate for longer than 2-3 weeks, and PEG feeding is likely to improve or maintain the patient's QOL. Thus, indicated conditions may include oncological disorders, neurological disorders, other clinical conditions, and for drainage of gastrointestinal fluid in case of ileus. Regarding dementia patients, it specifically noted that "there was no evidence that PEG was effective, therefore an individualized but critical and restrictive approach is supported."

### **Summary of PEG tube feeding in dementia patients**

Despite the lack of evidence of efficacy in PEG tube feeding, only benefits are mentioned by pharmaceutical companies, endoscopic industries and doctors in practices. Medical associations are fully supported by these industries. Consequently, merits of PEG tube feeding are emphasized, whereas demerits of PEG are not explained to the patient and family to an enough extent. As a result, there are lawsuits about PEG feeding, because patients and families are hurt and disappointed by PEG.

Among the reasons for use of PEG tube feeding, profits from PEG tube feeding for doctors and

families are likely to be the driving force toward universal practice in dementia patients in Japan. Furthermore, people concerned will feel satisfaction and peace in the mind, because they think they do something for the patient. However, just satisfaction of these people is not likely to be compatible with ineffective harmful interventions such as PEG.

### Conclusion

Medicalization is the criticism on medicine on the one hand, but there is a bright side in medicalization on the other hand. Clinicians often encounter such patients who complain emotional symptoms and wander about doctors until they find a doctor who defines them "the patient" and gives them a "name of disease." Then, these patients are relieved and they will stop doctor-shopping. What will happen to these patients is solely a matter of that encountered doctor.

To illustrate the impact of medicalization, PEG tube feeding has been exemplified here. Although the nutritional issues exhibit complicated medical, social, ethical, legal, economical and religious aspects, the attention can be focused as to who will get benefits from medicalization of ineffective futile PEG tube feeding in dementia patients. The answer to this question is simple; they are industries and pharmaceutical companies in addition to families and doctors. In other words, globalization of world economy is the driving force to expand this area of medicalization.

As it is described above, nutritional support was first medicalized, then demedicalized and thereafter re-medicalized by people who insist to feed to dementia patients who do not want to be fed on. Although there is no medical reasoning to administer PEG feeding to dementia patients, people who insist to feed them firmly and mistakenly believe in the efficacy of PEG feeding in terminal dementia patients. Thus, medicalization is for a sense of peace in the mind of people who insist medical interventions.

At the same time, medicalization will produce profits for health industries and pharmaceutical companies. Such a situation is observed in other health situations which is medicalized in modern medicine. Because the target of medicalization is people who really do not require medical care, it is highly likely that "normal people" will be harmed by medicalization. In any case, unreasonable medicalization, demedicalization, and re-medicalization will be incompatible with the idea of respecting autonomy and self-determination of the patient in medical practices. Understanding what is medical is getting more and more important for patient's health and autonomy, otherwise human body and mind will be entirely in the hand of pharmaceutical companies. Farewell to the unrealistic expectations to medicine is badly needed for laypeople and doctors as well.

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## Global Ethics- A Malaysian-Singaporean Perspective

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The spires of the Twin Towers cut a majestic form upon the Kuala Lumpur skyline, a metropolis firmly anchored in its Asian roots, and like its host, the towers borrow the best that the West can offer, imbues it with local values and cultures and leaves her distinctively Malaysian. The same is true of the ethos of common law, the vision of the education systems, the precepts of medical practice and the concepts of biomedical ethics; western formulations made uniquely Malaysian. The idea that Western concepts have somehow been imposed upon local culture is as unlikely as the belief that shared ethical concepts, are impossible in an evolving world fast losing her cultural, religious and societal divides [1,2]. The ethical landscape of modern multicultural, multiracial, multi-faith Malaysia is evidence of the latter and may indeed have been what Ladikas envisaged when describing global ethics as 'the attempt to agree on fundamental conditions for human flourishing and to secure them for all' [3]. Here returning to the architectural analogy, we see that not only have Chinese, Indian and local Malay architectural styles blended well within the cityscape but they do so effortlessly with an increasing number of modernist and post modernist inspired structures to enrich Kuala Lumpur's panorama. However despite the undoubted success of cultural blending and the melding of Western and Eastern thinking and values within Malaysia and Singapore that have served both to inspire the global ethics movement and simultaneously dispel concerns of moral neo-colonialism, many doubters remain [4-9].

At the root of these doubts are the concerns that global ethics is simply a means of Western ethics and particular Anglo- American formulations to usurp local identity and culturally sensitive values under the

guise of professionalism and universality. This is fuelled in part by the belief that each bioethics formulation is 'a product of a specific strand of history and culture' that does not translate well to dissimilar strands. There are three points to consider here, firstly, in referring to western ethics many authors appear to be referring to Beauchamp and Childress's 4 principles, this paper however attempts to draw from the deeper well of western thinking and does not set out simply to defend Principlism given that there is inadequate justification for the bedrock of this formulation, that of 'common morality' that envisages the idea of a universal moral conviction upon which the 4 principles are based upon [10-12].

Secondly, a defence of Principlism is not required but rather the clarification that Beauchamp and Childress never intended Principlism to be an overarching ethical principle but simply a framework for the consideration of ethical issues [2,13-15]. It is the presumption of the former that has led to many a misconception. Reverting to the Twin Towers analogy of medical ethics in Malaysia, it is the scaffolding and to an extent its foundations that maybe represented by western ethics, leaving the rest of the structure purely Malaysian. This analogy is apt particularly since Asian ethics holds to and indeed requires wider ideals than Principlism in its unfettered form bereft of cultural and social contexts [13,14]. This then is part of the rationale for the need for a wider and deeper conception of western ethics than can be delivered by Principlism.

Thirdly, this paper in disagreeing with the charge of moral neo-colonialism, will justify this posture by focusing on the South East Asian situation given that it aptly highlights the 'world' situation and helps focus the mind to the more intricate concerns of such a process. As such this paper holds that it is only through the appropriate consideration of Asian ethnophilosophy can a global framework hope to be workable and relevant in Asia [1,9,16,17]. A task made easier by the fact that many ethical principles 'transcend cultural and geographical boundaries' envisaging a global compromise that builds upon these shared values whilst considering socially and culturally distinct values and norms [17-23]. History is replete with such successes, not least and maybe particularly because of the integration of communitarian influenced Mediterranean nations into the European Union and the subsequent successes of Spain's fusion of communitarianism and Anglo-American ideals in the field of consent for organ transplantation [24-28].

### The gap

It is only in appreciating the nuances of various cultures, religions and norms can the similarities be ascertained and built upon. Indeed despite stark differences perceived between Asian Communitarianism and Anglo-American Principlism, Tsai manages to demonstrate that all four of its tenets may be elucidated within 'Ancient Chinese Medical Ethics' [23]. The same may also be said to be so of Hindu, Buddhist and Islamic thinking [19,29-

38]. Tai commented that the principles of beneficence and non-maleficence have been a part of eastern values since the time of Confucius and Sakymuni and illustrated within the Mahabharata [19,32]. Indeed the ideas of justice have been promulgated within Hindu and Buddhist concepts of Dharma for over 2000 years [23,34,35]. Van Den Bossche's study reveals that Indian virtue theory shares much in common with stoicism, Epicurianism and Kantianism whilst Tai's analysis reveals strands of libertarian, egalitarian, utilitarian and rather surprisingly Marxist thinking as well [23,39]. Meanwhile Ayurveda's code of medical ethics has been found to have much in common with the tenets of the Hippocratic oath and may in fact surpass it in its definitions and standards [40]. The gap it would seem mayn't be as wide as first thought.

With regards to the issue of autonomy in Eastern ideals, many commentators like Fan have spared no critical ink in monotonously labouring the apparent incongruence of the two formulations. Yet when considered as a concept that is wider than the western individualistic view, this discordance begins to fade. Simply put, Confucianism views a person as a strand within a rich tapestry of communal interdependence that is so intimately entwined that it cannot be simply unpicked [13,14,17,20-23,41]. Appraised thus, the individualistic concept of autonomy ought to be replaced by the notion of 'holistic harmony', a theory that finds resonance amongst Asians, African and Southern European alike [42-44]. As Mbiti put it "I am because we are, and since we are therefore I am" [43].

Such a concept of 'holistic harmony' is not alien to Western thinking given that Palliative Care, places similar importance on an expanded idea of self-determination [45]. The narrow atomistic concept of autonomy that so vehemently protects the individual's rights elides the wider repercussions on the patient's family and the larger community. Unsurprisingly this socially insular concept of individuality is not deemed as important to patients as first perceived and neither as strictly nor as universally applied in the west as first thought [46,47]. In its place is a recognition of the concepts of a relational being, advocated by most eastern cultures, which countenances a holistic view of the individual, their social network and social circumstances and promotes a corporative and consensus based approach to decision-making [19,21,22,31,48-52]. Indeed such an approach is being applied in multidisciplinary approach within multiple fields in medicine [53-56].

Meanwhile Fan's overarching abnegation of the western sense of autonomy begins to crumble under admissions of a lack of homogeneity in the application and universality of communitarian practice within China and culturally related Taiwan, Singapore and Hong Kong [57,58]. Social change brought about by modernization along with the adaptation of cultures to local custom and norms and an ever-increasing porosity to intellectual, cultural and religious boundaries has led to an amalgam of

western and eastern ethics in Singapore, Hong Kong, Taiwan and Malaysia [52,59]. As a result of the adoption of more western ideals, the 'fiduciary self' approach has been neglected leaving reciprocity to guide the family role and as a result weakens the position of Confucianism [60-64]. Indeed Asians have heeded Kopelman idea that culture is an 'elastic notion' that ought not to dictate a course of action and are adapting their thinking thus [65]. It would seem the ever-changing nature of culture prevents staid immovable ideology from hindering 'progress' [66].

Similarly the rigors of time and social change have not left religious formulations impervious to change. Indeed globalisation has had the effect of modernizing societal and religious formulations with the proscription of the Indian caste system being testament to the effect of adopted cross-cultural values and thinking willing redress of religious and cultural injustices [1,29,34-38,67,68]. Yet despite these transformations, it would be folly to assume the abandonment of community-orientated life, religion and traditions when conceiving a global ethical framework within the Asian and African collectives [19,69].

Veritably progress toward a unifying framework of global ethics may flounder if it does not resist the tendency to stereotype Asian and African ideas of ethics [1,43]. Indeed within the Asian context there has been too much attention focused on China much to the detriment of other Asian nations. Indeed India's *Caraka Samhitas* and *Susruta Samhitas* already encapsulate the desired requirements and duties of a physician some 1000 years ago and share much with egalitarian and libertarian ethics [19,70]. Furthermore the ability of Indian ethics to evolve with time and thinking provides further encouragement that adaptation to a global ethics framework is possible, despite and maybe because of the present problems encountered by Indian ethics [36-38,40].

Malaysia provides ample evidence of such change and highlights the overstatement of fears of deep-seated nationalist and entrenched religious sentiment impeding progress of global ethics. The One Malaysia project puts aside the various cultural and societal differences to form a single identity across diverse cultures and in so doing accepts the need to modernise thinking and practice, leaving behind antiquated race and religious based differences as well as an inherent suspicion of all things western [31,66,73-75,106]. A similar tone appears to have been struck in Sri Lanka, Turkey, Japan and Iran where conservative cultures have accepted modern medical practices and ethics into their communities [29,30,76,77].

### **The Similarities**

With the growing trend towards medical tourism, Singapore, which actively promotes itself as a medical hub, faces increasing pressure to address the issue of global ethics as those with means turn to Singapore for second opinions, having exhausted treatment options in their own countries. These

patients harbour the idea that monetary considerations are the only obstacle to newer, more specialised treatment options [78]. They attempt to bypass ethical and clinical considerations, waive considerations both economic and health to pin their hopes on the slight chance that the experimental treatments, specialist surgical techniques or third or even fourth line treatment will provide respite for their conditions. Such desperation leaves them susceptible to unscrupulous physicians promising unrealistic results. The presence of such desperation and a willingness to exploit it has reinforced the need for a global governance of clinical practice. Here there is clearly a need for local ethics to come together with clinical practice and accepted western ethical precepts to set about a basic set of ethical tenets not simply between nations but between the public and private medical centres [19,23,79,80].

There is a rich vein of social justice running in all the major cultures in Asia and a global ethic based on such shared values could provide an opportune platform for the meeting of minds between these cultures and render adequate imperative for developing nations to disregard nationalistic rhetoric, fears of supranational interferences and act instead to protect the interests of their populous on a global stage and in doing so, address a significant obstacle to a global ethics framework [28,81]. The issue of subversion of cultural, national and racial identity has been a growing concern in many Asian nations and has led Sen to comment that it is 'the lives of Asians—their beliefs and traditions, their rules and regulations, their achievements and failures, and ultimately their lives and freedoms' that is being decided in the formulation of such a framework [4,17]. Such an understanding is imperative if this project is to progress and lends support for the inculcation of local values into a unifying global ethics framework [66].

After all Singapore's positioning as a medical hub and a destination for further medical training for South East Asian nations further highlights the need for the assimilation of universal ethical concepts into local moral thinking in order to realise 'holistic harmony' in biomedical ethics. Such a bridge will not only facilitate forays in biotechnology and life sciences research, collaborations between institutions, accommodation for cross border clinical meetings and training but provide a means of coping with the never ending onslaught of ethical concerns brought about by an ever evolving medical field. Indeed a common ethical formulation would provide an excellent platform for continuing scientific discussion further a field as ethics attempts to keep up with advances in medical science.

Thus far all conversation has focused on unilateral nature of changes, from the west to the east but what is required is a bilateral exchange of ideas. After all Western formulations are still being revised and may benefit from a fresh perspective. Hesselink argues that the Hindu based Thirukkural ethical concept maybe just such an angle [37]. Furthermore a reciprocal exchange of ideas and the west's willingness to adapt its thinking would be a show of good faith and may reduce concerns of Moral Neo-

colonialism. One example of such adaptation may lie with regards to euthanasia, which has been a source of great disquiet in the West, but in the East, medical philosophy from the time of Chung-tzu and Buddha has embraced a different idea of death and may provide a new avenue of contemplation on this issue [20,82].

Similarly Eastern medical constructs and their administration may serve to add to better medical management worldwide particularly as there exists remarkable agreement on ethical issues irrespective of situation and despite vast differences in health care systems [83]. The ethos of the Singapore health system, based on Confucian ethics has in varying degrees succeeded in arriving at a management structure that is congruent with a refinement of western macro ethical practice and the rigors of local demands and could serve as a blue print to better ethical considerations on a macro level in the advent of a global ethical ideal [84-87].

The presence of such shared beliefs, intuitions and codes of conduct can only serve to increase the chances of a formulation of a global ethic simply by showing that it is not imported ideals that are being sown but rather the tendering of old ideas.

### The benefits

Singapore's Centre for Biomedical Ethics is one such resource charged 'to do Asian bioethics rather than simply talking about it'. It attempts to address the practicalities of this subject, teaching and expanding its boundaries whilst stimulating research and debate within this field [88]. Such a service is of particular need given a growing divide between ethical constructs and clinical practice that has seen ethicists scampering to meet the demands of multicultural and multi-faith ethics in the midst of rapid socioeconomic and geopolitical changes within 'Tiger Economies' [89,90].

Such change has had a devastating effect on the Confucian based family units within China, Taiwan, Hong Kong and Singapore that have left the elderly especially vulnerable. This is particularly so given spiralling medical costs that place considerable strain on family finances and leave the interests of vulnerable people susceptible to the dubious intentions of those carrying out 'filial' duties [52]. Indeed the increase in elder suicides as a result of abuse and neglect has led the Governments of Singapore and Hong Kong to actively discourage familial intrusion in personal decision-making [52]. The idea of such an unencumbered atomistic view of self-determination has been adopted within Singapore's Human Organ Transplant Act with startling results [90-94]. Additionally the continued erosion of the patient-physician relationship within these regions due to the growing perception of the failings of the physician in protecting a patient's best interests and the growing trend of self empowerment of patients has also invoked a sense of urgency to redress present communitarian based practices [52].

Yet the unification of local ethics under the banner of global ethics may not simply be resolving

differences in culture and beliefs but addressing the differing access to care. It is hard to envisage attempting to fully affect change and ethical consideration in the east when access and indeed standards of care differ so significantly between and indeed within nations, frequently along social class divides [2,78,95]. Yet it maybe through striving towards an unencumbered vision of global ethics that issues of resource allocation, training, uniformity of access to health care, poverty, corruption and sustainable environmental resources will be addressed [2,36,96-100]. Sahai forcefully states that confrontation of issues of social justice and the common good through proper consideration economic factors is imperative if the idea of a global ethics is not to be simply a luxury that developing countries can ill afford [98,99,101].

### Conclusion

Indeed as we witness the progressive melding of cultures within a world fast losing its religious, cultural and social divides, a common understanding of ethical precepts has begun to feed a realisation of a 'critical culturally informed self reflexive' conception of global bioethics [102]. This gestalt entity will generate a more robust account of clinical practice grounding 'ethical universals' within the verity of wider social considerations and the reality of local geo-political, ecclesiastical and socio-economic confines [102,103].

Furthermore if sociological evidence is to be believed, the evolution of ideas, cultures and indeed the family unit as a result of advances in communication, travel, health and education will open even the most conservative of cultures to wider and possibly newer ideas. As a corollary to the apparent apostasy of some of the foremost proponents of Asian ideals and the obvious cracks in the armour of individualistic autonomy model in the west; the biggest obstacles to the realisation of this global ethics ideal may now be set for a meeting of minds heralding the way to a compromise framework [64]. Such an idea may find its anchor within the ideals of social justice, a moral precept that is observed by a significant majority of cultures

Yet we will need to be vigilant not to fall victim of attempting to homogenise diverse and distinct identities under a single banner and thus suppress their individuality in our haste to pursue a happy middle ground between Sakamoto's pseudo-utilitarian stance of communal harmony and Schroder-Back's rigid adherence to Principlism [17,66,104].

The cost would be unacceptable and the product unworkable as Hellsten so vividly describes. Only thus can a concept of global ethic be envisaged [105].

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## Genetic Engineering and Buddhism

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*So asking if genetic engineering is morally right or wrong is the wrong question to ask. Instead we should ask if genetic engineering is being conducted in a careful and responsible way so as not to harm the environment or us.* - Stamford 2007

Ancient religions such as Buddhism cannot be expected to provide any direct guidance on recent technology such as genetic engineering. However, the enduring strength of an ancient religion that continues to have hundreds of millions of adherents is that its principles can be interpreted without distortion to provide helpful guidance on issues that were undreamed of in the Buddha's day. Genetic engineering (hereafter GE) is one such issue. This paper defends the view that GE is not inherently inconsistent with Buddhism, but that Buddhists are rightly concerned about the risks of uncontrolled GE use. Indeed it may be that until we have learned a great deal more about these risks, we should adopt a moratorium on the release of GE organisms into the human body and the wider environment.

In this paper, GE is distinguished from genetic modification (GM) in general. GM is an umbrella term for techniques aimed at producing a new combination of genes in order to develop a plant or animal for a particular purpose. Of course, early breeders were not aware that they were selecting genotypes, since genes were not discovered until early in the 20<sup>th</sup> century. GM dates back around 10 000 years, to the earliest attempts at selective breeding of animals and plants by Neolithic farmers, typically by choosing the seed of plants with desirable characteristics and later by crossing plants with different desirable characteristics. No doubt, some of these developments resulted from random mutations. In any event, by early Buddhist times (c.

2500 BCE), people were breeding and raising rice, soy, dogs, pigs, water buffalo, horses and goats that often bore little resemblance to their wild ancestors but would be instantly recognizable today. It is unlikely that the Buddha would have been aware of the history of domestication and the origins of rice and soy from their wild ancestors, but no doubt he was aware of the practice of selective breeding and would have approved of it to the extent that it helped people to meet their needs without causing harm.

In contrast, GE is no more than a few decades old. The term GE is used in this article to refer to any procedure that changes the genetic sequence of an organism in ways that could not have happened, or at least were extremely unlikely to have happened, without human intervention, or more narrowly, without the techniques of sophisticated biotechnology. Typically, such processes involve direct transfer of genetic material in laboratories via gene splicing. Unlike traditional forms of GM, which mimic natural processes, GE bypasses them. This is most obvious in the case of transgenic organisms, where genetic material from one species is introduced into the DNA of an unrelated species. In the case of transfers between plants and animals, the organisms have been separated by well over a billion years of evolution.

Despite these differences, GE is not inherently different from GM, but is rather a type of GM procedure for achieving desired results. It has the advantage that, in principle at least, it is much more likely to achieve those results than are traditional methods. The disadvantage, which is stressed by its opponents, is that it is a new technology which may present major risks to health and the environment. As well-known Buddhist writer Ron Epstein (2001 p. 47) notes, "*What makes the situation with genetic engineering unique is the difference in the degree of damage it can do to life on the planet and the irreversibility of its effect on us and on the environment.*"

These issues are explored later. Meanwhile, I argue that there is no reason to believe that Buddhism is opposed to GE as such. First, Buddhism is open to new scientific discoveries and new technologies (Loy 2007) provided that they are carried out with good intentions (for instance, to save life or reduce suffering) and not with the goal of causing harm (for instance, to develop weapons of biological warfare) or for selfish reasons (for instance, purely to boost company profits).

Secondly, central to Buddhism is the idea that reality is in a constant state of flux: transience and change are the norm. Science should therefore study change, recognizing that what is seen as scientific knowledge is itself subject to change. In contrast, Western thought assumes that reality is unchanging, and that scientific knowledge is cumulative. A significant example is the idea of "fixity of species": that the number and properties of all species of plant and animal have remained the same over the whole of time. Aristotle taught that every entity has a permanent and unchanging essence, and that the essential properties of a thing are what define it. This idea was taken up by many Christian

theologians and linked to the doctrine of Creation: thus what was originally a purely secular idea became an item of religious dogma. This was the dominant Christian view in the mid nineteenth century and accounts for the hostile reception of the church to the idea of evolution.

In contrast, Buddhists generally accept that evolution is a natural process. A poll of Americans by the respected Pew Forum on Religion and Public Life (2009) found that 81% of Buddhists (and 80% of Hindus, whose view of the nature of reality is similar to that of Buddhism) agreed with the statement "Evolution is the best explanation for the origin of human life on earth", as opposed to 58% of Catholics, 51% of mainline Protestants, and 24% of evangelical Protestants. One author (Verhoeven 2001, p. 277) even claims that "...to a large extent Buddhism's flowering in the West during the last century came about to satisfy post-Darwinian needs to have religious beliefs grounded in new scientific truth".

It follows that there is nothing wrong with GE as such (subject to the above caveats). It is therefore questionable whether the Board of Directors of Real Buddhist Association (1996) is justified in stating: "[G]enetic engineering of food is not in accord with the teaching of Buddhism. Buddhism considers genetic engineering of foods to be unwarranted tampering with the natural patterns of our world at the most basic and dangerous levels."

But this presupposes that the world is characterized by "natural patterns" that (by implication) do not and should not change, which is specifically denied in Buddhism.

Epstein has expressed concern that, because of the interrelation between mind and body, "Genetic engineering has the potential for altering ... our bodies ... in ways that lessen their ability to support the process of personal transformation" (2001, p. 40), for instance our ability to meditate, to "resonate with the natural patterns of nature" (p. 45). Indeed, "how are transgenic animal body parts in our bodies going to affect the human quality of our everyday awareness?" (p. 44). No-one knows, of course, which seems to be a reason for proceeding with great caution. But once again the reference to "natural patterns" may be seen as unacceptably essentialist.

Advocates of GE, especially of GE crops, claim that the technology will produce benefits including higher yield, improved nutritional qualities, resistance to drought, salinity, diseases and pests. In a world in which over a billion people are malnourished, it would seem that Buddhists therefore ought to embrace GE, to the extent that it promises to reduce human misery. To date, however, there is little evidence of any such benefits to the poor and hungry, and the only beneficiaries seem to be large corporation. Losers include small farmers in countries such as India, who have faced financial ruin through commitment to GE seeds, and indigenous people who have had their traditional plant varieties stolen via "biopiracy" (Shiva 1997).

Most of the concerns about GE in the literature are concerns about its abuse, arising from *samsara*. As Epstein (2001) notes: "From a Buddhist perspective, the problems with genetic engineering are no different in principle from most other problems we face in our daily life. They are all the result of afflictions – desire, anger, ignorance, and so forth" (p. 47)

Because Buddhism condemns all forms of violence, it follows that the use of GE to promote or facilitate violence is wrong. because warfare is the ultimate form of violence against people it raises particular concerns. According to Epstein (2001 p. 46), in the late 1980s the Soviet Union had more than 60 000 people working on biowarfare, including a project to combine the smallpox and Ebola viruses. However, biological warfare predates GE by many centuries.

Scythian archers infected their arrows by dipping them in decomposing bodies or in blood mixed with manure as far back as 400 BC. Persian, Greek, and Roman literature from 300 BC quotes examples of dead animals used to contaminate wells and other sources of water. (Dire 2005, p. 1).

In the 20<sup>th</sup> century, many countries, including the US, Germany, Japan and the UK conducted extensive research on biological agents of warfare, mostly before the discovery of GE techniques.

In relation to the non-human world, Buddhism condemns "domineering and exploitation" (Harvey 2000, p. 150) and "has a gentle human-animal orientation" (P. de Silva 1998, p. 115). "[T]he natural environment should be treated with respect" (Keown 1995, p. 49) and "[M]an should be able to find happiness and fulfilment in life without harming the natural world in which he lives" (L. de Siva 2001, p. 260). To cause painful and life-threatening conditions in animals is forbidden by the principle of *ahimsa*, though the means (such as GE) is irrelevant. Again, in the case of the environment, the main concern regarding GE use is not that exploitation will occur, but that introduction of GE organisms risks serious and irreversible harm. Of particular concern is the risk to the integrity of species via horizontal gene transfer, thereby potentially threatening a whole ecosystem to which the species may be essential (Gunn and Walker 2008, p. 97).

The use of GE in medical research presents perhaps the most difficult challenge to Buddhists. It is true that most medical research achieves no benefits, and, equally importantly, that: "[I]n Buddhist perspective many of our diseases are self-producing ailments caused by our own unhealthy living, thinking and doing ... Many of our diseases would vanish if we led healthier and simpler lives." (Ratanakul 1993).

Moreover, "In Buddhist thought man will never succeed in conquering disease by torturing animals. The bad karma that is generated by this method of investigating and treating disease is itself one of the causes of man's increasing proneness to disease, and so a vicious circle is set up." (Ibid).

Many people, and not just Buddhists, would be appalled to know that vast sums are spent for the

sole purpose of creating animals (primarily mice) that are genetically prone to developing various strains of cancer, even though 95% of all experimental cancer treatments that enter the clinical trial stage never make it to market (Zielinska 2010, p. 34). Still, generalizations about what “we” could achieve by living healthier lives ignore the plight of innocent victims of other people’s selfishness and stupidity, such as children who suffer from the effects of passive smoking or their parents’ use of drugs such as alcohol. Chapple (1986) states that animal experimentation would be justified “*Only in an extreme case ... such as the testing of a vaccine desperately needed to stave off an epidemic*” (p. 231) and then only if pain was minimized, the animal was well treated, and researchers had good reason to believe that lives would in fact be saved and that there would be no adverse side effects. As he notes, these criteria would rule out the vast majority of animal experiments, whether or not they involved GE.

Epstein concludes: “*If there are some areas of genetic engineering that can safely benefit humanity while respecting other forms of life, then efforts need to be redoubled not only in the area of scientific risk assessment and use of the precautionary principle but also in developing broad ethical guidelines. Since the scientific establishment is acknowledging the need for public input, there is a window of opportunity for introducing the perspective of Buddhist ethics to current moral questions about proposed research in genetic engineering*” (p. 47).

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## Book Review: *Human Dignity and Bioethics*

Edited by Edmund D. Pellegrino, Adam Schulman and Thomas W. Merrill. Indiana: University of Notre Dame Press, 555pp, ISBN-13: 978-0-268-03892-2. Published 2009.

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As a member of a research ethics committee in the UK, I am acutely aware that our National Research Ethics Service, enjoins us to consider, in particular, the safety, health, welfare and dignity of the participants in the protocols we review. However I rather felt that I was not too clear about what the latter concept of ‘dignity’, in particular, meant, and whilst I understand that grown men may wear short-sleeved shirts in the southern hemisphere I believe it is still widely considered to be rather undignified for adult males to wear such a shirt in the UK. This book thus caught my eye in the bookstore as offering to put me right.

It is an edited book of invited essays and then commentaries which addresses the concept of human dignity from a number of angles, illuminating perspectives on the concept which I had previously failed to get a sense of. Dignity is an unclear and ambiguous concept. Many of the contributors to this work acknowledge this as fact, but this does not preclude them from going on to discuss the concept and eking out meaning from it. Each author focuses on their own definition or usage of the term, and there is plenty of disagreement. From the idea that any sensual pleasure must be beneath human dignity as maintained by the Stoics we understand that the same sensation would be regarded as an Epicurean goal; the notion is claimed to be a noble aspect of humanity deriving from religion and an aspect of the soul; it is also, in contrast, seen as a noble feature of humanity due to humanity’s unique capability for moral freedom, and whereas everything else on the planet may have a price associated with it, it is our dignity which precludes attaching a price to

human worth. Rather than deriving from God, dignity is said to come from our rational mind. Or it is simply a fact deriving from our being created in God's image. The latter notion would suggest humanity is special in a way incompatible with its artificial creation (such as *in vitro* fertilisation), and any 'enhancement' (genetic engineering and the like) would only serve to detract from it. It might mean no more than autonomy, or perhaps 'respect for persons,' and if this is so it must be rather an otiose concept. However, it may emphasise human self-worth in a way that neither of these alternatives can do.

Clearly this book does not offer any definitive answer to what human dignity is but suggests and discusses, compares and contrasts, various ideas about what it may be or involve. I was struck by several ideas, including one that points out that where a person is lying on their death-bed, any presumption about how to end that life, by conceiving of the person as being helpless can be to denigrate them, and to deny their dignity, whereas if one is to respect another person's human dignity one must recognise them as an agent and a moral equal and so needing to be involved in determining their fate, and in this case how they want to die. Yet this may not always be practical, for legal as much as moral reasons. We cannot presume to know what is best for the death of another. What we would want may not be what they would want. They still need a say to maintain their dignity – but then perhaps this is to see dignity as self-determination and it may not be thought to be the how matters are regarded universally. How is dignity to be assured in such circumstances? This seems to me to test any definition of the concept. Perhaps the book could have offered more about how dignity is perceived in different cultures and how the term has changed, or is changing, with time - but these are quibbles. I still do not know for certain what dignity is, but this is no failing of the book. The term has a number of facets and may be evinced in more than one way – I now know that it will certainly permit short-sleeved shirts (even with a tie), but never, I suspect, on me.

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## Darwinism & Cooperation

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Robert May (former President of the Royal Society, UK, and the present President of the British Science Association) in his first address before the Association, talked of Darwinism and the need of cooperation. The contents of his address have been summarized and reported by Williams (2009).

May, in his address, pointed out that in 1859, when Darwin's epoch making book, "*Origin of*

*Species*" was published, Darwin had before him three unsolved problems, viz.:

- (i) Whether age of the Earth was long enough to allow the evolutionary diversification of the organic world.
- (ii) Nature of inheritance, and
- (iii) How cooperation has evolved.

Palaeochemical studies in the following years have shown that the Earth has existed long enough to allow evolution of the existing biodiversity. The rediscovery of Mendel's work in early 20th century, and following it, the fast development of the science of genetics have well explained the mechanism of inheritance and its variability. But the problem of evolution of cooperation has still remained an enigma.

In group living cooperation and altruism are needed (Verma and Sharma, 2009). But a cooperating member of a group has to pay a cost for its behaviour. To bring home this point May has cited the case of prairie dogs, which live in groups or packs. On sighting an approaching predator, an individual in the group gives an alarm sound to alert others in the pack. After a while another member of the group gives a similar alarm, and the remaining members take their turn in doing this cooperative act. An individual, while sounding an alarm benefits the remaining group, but takes a small risk, as it may help the predator to locate it. In this cooperative behaviour an individual may act as a cheater, which does not take part in sounding an alarm signal, thus escaping the risk involved in it, but getting the benefit of the cooperative behaviour in the group. Hence the survival value of the cheater will be more, and selection may favour the variant. As a consequence proportion of cheaters will increase in the following generations, and cooperation will be eventually undone.

Obviously in this example selection has been taken as operating at the individual level. This situation is more explicitly stated by Coyne (2010), who says, "*Natural selection builds features that benefit individuals, not populations or species.*" But now it is known that selection operates at a group or population also (Wilson & Wilson, 2007). In a group or population there are some altruistic individuals, who care or act for good of the group and are cooperative, and there are some individualists, who care for their own convenience or gains, ignoring good of the group. Through several computer simulations it has been inferred that, if a population or a group is dominated by altruists, and individualists are only small in number, such a group is positively selected at the cost of another group, in which individualists outnumber altruists (Bowles, 2008). The latter group moves towards internal strifes or 'civil wars', and eventual disintegration (Verma & Sharma, 2009).

We are facing global problems of increasing proportions of greenhouse gases, climate change, increasing and unsustainable use of fossil fuels and of other natural resources, and water scarcity. Such global problems can be solved only through global

cooperative efforts. But we are politically divided into nation states. While in every nation cooperation may be promoted to ameliorate the situation, between and among states often there are rivalry and parochialism. Altruism, a necessary basis of cooperation, and parochialism are synergistically related (Bowles *loc. cit.*); the two may be seen maximally pronounced in state of war. But, as stated earlier, for tackling the global problems international cooperation is a prerequisite. Williams (2009) has pointed to the need of international cooperation for success of the Copenhagen meet in December, 2009, aiming at reducing emission of greenhouse gases. Perhaps lack of full understanding of the need of global altruism and cooperation led to the meet concluding with less than satisfactory results.

Now it has become imperative to work for trans-border altruism and cooperation, and for clear realization of this that all humans on the Earth are conspecific (i.e. belonging to the same species), and perhaps this can be achieved through a well planned bioethics education, aiming at imprinting the need of this attitude in young minds, and at removing trans-border prejudices and misgivings.

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## Organ Donation as a Question of Justice: The UN/EU Report on Organ Trafficking in the Context of the Philippines

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#### Abstract

A recent joint study by the Council of Europe and the United Nations focused on the criminality surrounding organ donations. Published in October 2009, it points out the various violations of the international prohibition on the trafficking of organs. This paper will first analyze this study and then contextualize it in the current discourse about organ

donation in the Philippines. Finally, the issue of organ donation will be put in the wider discourse of justice in organ transplantation.

Organ donation and trafficking are much debated issues in medical ethics. This paper will discuss this problematic in three specific dimensions. After an explanation of the general lines of the debate on organ transplantation (1), it will analyze the recently published joint report of the Council of Europe and the United Nation on the trafficking of organs (2). The discussion afterwards will be situated in the concrete cultural, ethical and legal framework of the Philippines as a test case for the validity and applicability of the reports recommendation (3). Lastly, it will conclude with some ethical considerations on the horizon of an elaborate concept of justice (4).

#### 1 The Debate on Organ Transplantation

A recurring topic of current debate in medical ethics deals with the issue of organ donation and organ trafficking. It is important to shed light on the parameters of this debate to situate the report of the Council of Europe and the United Nations (EU/UN) on the trafficking of organs. Given the chronic scarcity of available organs for transplantation, issues such as the right regulation for living donors, possible incentives for donation, the right allocation of the available organs are hotly debated. These ethical issues arise mainly out of a number of factors playing together. First of all, organ transplantation has become a standard medical intervention in many countries. In the case of kidney transplants, it brings about a considerable amelioration of life which otherwise could be sustained only by dialysis. With other organs like heart or liver, it might even be the only way of saving lives. Second, there is a worldwide shortage of available organs for transplantation. Many countries established their own waiting lists to secure fair distribution of the scarce resource. However, the waiting period may take a couple of years, which, for many patients, is too long. Frequent deaths on the waiting list are the consequences. These two aspects taken together bring about the ethical question of a fair allocation of the organs available for transplantation. The main ethical questions in this regard are the following: Which should be the criteria for the allocation of an available organ? Should the time spent on the waiting list be the only criterion? Should factors like the predicted life expectancy after the surgery, age and social background, patient compliance, and the survival chances be considered? The countries of *Eurotransplant* – a group of countries in middle Europe joint together for organ allocation – decided to have a mix of criteria to decide about who will get priority when an organ is available. The criteria are different depending on the organ. For kidney, bloodgroup, tissue characteristics, clinical urgency and waiting time are considered. For liver, heart and lungs, height and weight play an important role in addition.<sup>1</sup>

<sup>1</sup> <http://www.eurotransplant.nl/?id=methods> (accessed on November 29, 2009)

On the international level, the issue of organ transplantation gets an additional dimension due to global wealth disparities. Great financial prowess stands vis-à-vis dire need, poverty and despair. These different “worlds” are brought together by information technology that facilitates communication across the globe. This is how the issue of organ trafficking enters the picture. The willingness of both the wealthy patients to violate legal regulations and of the poor organ “donors” living in miserable conditions to sell their organs bring about an international organ market. This illegal organ market is the focus of the joint EU/UN report discussed below.

Discussions on the topic of organ transplantations stress the need for educating the public about the benefits of cadaver organ donations. An increased willingness of the overall population to serve as organ donors would ease the global organ shortage. In developing countries, an adequate infrastructure and organization would be further needed to implement an effective system of organ allocation. However, there is still unease about the criterion of brain-death as it occurs before organic death. The body of a brain-dead person is a body of a dead, but not a dead body (Kress 2009, 225). Thus, for many people it is difficult to accept that the brain-dead person is really dead. The criterion of brain death is socially constructed and might not be suitable to all cultures alike. This might be a hindrance for an increase in organ donations from deceased donors.

## **2 Organ Trafficking – The report of the Council of Europe and the United Nations**

It is with this background that the EU/UN report entitled “Trafficking in organs, tissues and cells and trafficking in human beings for the purpose of the removal of organs” is situated. The focus of the report therefore is the discussion of the established black market for organs. The report discusses, in a first step, organ donation from biological, statistical, ethical and legal perspectives and then turns, in a second step, to the issue of trafficking of organs, tissues and cells. The report distinguishes between the trafficking of organs on the one hand and the trafficking of human beings for organ removal. In my account, I will focus on the issues of organ donation and the trafficking of organs especially in terms of its prevalence and the ethical questions involved.

The report reiterates the basic parameters of the organ transplantation debate such as the success of organ transplantation, the problem of organ shortage and general bioethical issues. First, the report shows the increase in number and success rates of transplantation of solid organs over the past decades. Advances in immunosuppression and surgical techniques enhanced the survival of the graft and the graft receiver. Estimates of the number of world wide transplants indicate that almost 100.000 transplantations are performed annually. Two thirds of these transplants are kidney transplants. Of them, one third is from living donors (Joint 2009, 18). Second, organ shortage is presented as a universal

problem with a wide range of causes. The success of organ transplantation leads to an increase in the waiting lists of patients who are hoping for a cure of their fatal disease. Moreover, more patients with graver health conditions are admitted nowadays on the waiting lists than 20 years ago. An aging population, unhealthy diet and lifestyles are important factors for the prolongation of the waiting list. In the European Union alone, more than 4.000 patients die every year waiting for a kidney, liver, heart or lung (Joint 2009, 21ff.). Given the problem of organ shortage, the improvement of organizational structures to avoid organ loss is needed. Organ transplantation requires a high degree of supra-hospital organization to deal in a fast and efficient way with deceased organ donation (Joint 2009, 25). Not surprisingly though, deceased donation stands in proportion to development; only in developed countries one finds systematic deceased donation (Joint 2009, 19).

In the discussion of the bioethical framework, emphasis is given on the general demand of treating the dead body with dignity as it stands at the centre of our moral self-understanding. The individual's self-determination reaches beyond his death. This right of self-determination operationalized in the medical practice of informed consent is generally accepted. The core of the ethical debate then is about different ways to increase organ supply. A minority position demands for a liberalization of living organ donations by allowing people to sell and buy organs in a market which might be free or run by the government. Such a market could provide a sufficient amount of kidneys from living donors to make the waiting list redundant. The Iranian example shows where such a government organized market exists, that such a model succeeds in providing the kidneys needed. Iran is worldwide the only country without a waiting list (Joint 2009, 31). On the ethical level, questions arise about the fairness of such a market as it raises the issue of exploitation of the poor. It is questionable whether one can still speak of an autonomous decision in a situation of distress which prompts the selling of organs. The discussion of organ donation in the Philippines will enlighten this problematic (see 3 below).

Another way of increasing organ supply is by substituting informed consent with presumed consent. Instead of the explicit consent of the deceased person or his relatives, only the absence of his or their objection is deemed necessary for organ donation. Such default model could loosen up availability and access to organ donation. This model is practiced in a range of European countries like Austria, Belgium, Italy, and Spain as well as Singapore (Joint 2009, 32). It has proven to increase organ supply of deceased donors but poses the inherent risk of presuming consent when in reality the deceased patient failed to manifest his dissent. In any case, the fair and just distribution of available organs according to a transparent procedure is not only ethically required but also necessary to

strengthen the acceptance of organ donation in the wider population.

Against the background of this bioethical debate about organ transplantation, the issue of organ trafficking takes shape. The scarcity of organs and the disparity of wealth bring about the phenomenon euphemistically described as "transplant tourism". In this practice prosperous patients from dominantly rich Western countries buy an organ from a person from a poor donor country. From the point of medical and social scientist research, it is difficult to gather comprehensive data about the extent of organ trafficking. In general, it is believed that 5 to 10% of all kidney transplants worldwide result from organ trafficking. In absolute numbers, this results to 3.400 to 6.800 transplants a year (Joint 2009, 58). This global flow of organs runs from Africa, Asia, Eastern Europe and South America to Western Europe, North America and rich Asian countries (Joint 2009, 58). The great majority of the trafficked organs are from living unrelated donors and only a majority from deceased donors. It has been argued that the great majority of the transplanted organs in China have been retrieved from executed prisoners (Kennedy 2004, Watts 2007).

While it leaves no doubts about the heinous practice of organ trafficking, the report however disentangles facts from fiction in the realm of the trafficking of humans for the purpose of organ removal. Mainly, two persistent storylines are debunked as myths: the recurring stories of abducted tourists in South American countries for organ removal as well as the killing of poor street children for the same purpose. There is no evidence showing that any of the alleged crimes happened. On the contrary, there are technical reasons that can explain why these stories cannot be true: organs from children would not be suitable for adult patients and children are rarely in need of donated organ. Furthermore, organ transplantation requires well trained professionals, a sophisticated technology and good organizational structures. Given this infrastructural setting, it should be simple to trace these criminal activities and bring the culprit to justice (Joint 2009, 60f.). These stories thus are nothing more than myths. The grain of truth of these stories, and this gives them initial plausibility, is that many street children worldwide are victims of violent acts, disappear or are sold by their parents. Stories indicating them to be used as organ donors however have failed to produce any evidence.

On the ethical level, a "mere" organ market has to be distinguished from organ trafficking. Arguments against the organ market either point out from a deontological perspective that our body parts should not be traded or they emphasize in a utilitarian vein the negative consequences of a free market for organs in terms of an expected decline of altruistic donation motivation. Beyond these arguments, trafficking of organs includes two distinguishing features which make it particularly dreadful acts: coercion and exploitation. In academic debate, the issue is often posed as one of paternalism versus autonomy. It is argued that it would be a violation of the people's autonomy to prohibit them from selling

their organs. According to Savulescu, general prohibitions of organ selling add a second injustice to poor people who already suffer from disadvantages due to poverty. The poor person cannot have what others have and he is hindered to achieve his desired goal by selling his kidney (Savulescu 2003, 139). However, conceptualizing the debate this way misses the point. Autonomy presupposes the freedom to *choose* among a range of options. Such a choice is hardly present in the case of organ sellers. As the report points out: When individuals are "coerced by threats of violence [...] they are not making choices. Nor are those for whom the sale of their bodies is the only possible option they have to maintain their very existence." (Joint 2009, 62)

### **3 Paid Organ Donation in the Philippines**

Turning to the Philippines as an illustration for the problematic of organ trafficking, one finds the critical view of the report empirically confirmed. Organ vendors are recruited among the urban and rural poor. Quite often, kidney selling remains apparently their only choice. The decision is taken often under considerable pressure and without sufficient information. Not surprisingly, though, most kidney vendors in the Philippines experience dissatisfaction and regret afterwards. A recent study on 135 kidney vendors in Quezon province showed that almost all would not recommend kidney selling to others. Three out of four would not do it again given a second chance (Padilla 2009). In general, organ selling provide no long term financial benefits and organ vendors remain poor (Dizon 2008). The Philippine data mirror the international experience on kidney selling. Organ sellers overestimate the expected gains but underestimate the physical, psychological and social costs (Turner 2009).

Organ selling is a lasting problem in the Philippines. Sandvand reported more than ten years ago about the Bagong Lupa slum area where more than 150 men sold their kidney (Sandvand 1999). The stories of these slum dwellers illustrate how poverty and despair motivated them to sell their kidney. Quite often, selling the kidney was seen as the only possibility to send children to school or to finance the vital surgery for a daughter etc. This practice was made public by Jessica Soho's documentary "Kidney for Sale", which caused a public uproar and brought the topic into the political agenda (Ona 2000). The documentary illustrated the lack of any amelioration of the living conditions of the vendors, the insufficient to non-existent information about the surgery as well as their deteriorating health condition.

Studies have shown that altruistic donations have better results for donor and receiver alike. A long term study conducted with altruistic donors on average 12 years after donation with a median age of 61 found that donors have good long term medical conditions (Fehrman-Ekholm 2001). The health conditions reported among organ vendors in the Philippines were comparably poor. This might have different reasons. The pre-transplantation screening procedure might have not showed a substandard kidney functioning and/or their bad health is caused

by their socio-economic status and their deprived living conditions. Furthermore, compliance with medical follow-up was poor. Padilla reports that 4 out of 5 donors did not have a single medical check-up after the transplantation (Padilla 2009). This poor medical compliance might be caused by the lack of informed and enlightened consent in the first place or by psychological trauma or social stigma resulting from the surgery.

This rampant kidney selling was brought to public attention by above mentioned documentary and caused much academic and political debate. In the field of the academe, some argued that the best way of dealing with the problem of exploitation is making it legal under strict state supervision. Ona suggested paid organ "donation" to be acceptable, if an informed and enlightened consent is ensured, no coercion is involved, the donor is adequately cared for, and just and fair compensation is paid (Ona 2000). De Castro takes a similar stand. He argues that a regulated model of compensated donation is better suited to minimize commodification and exploitation than a restrictive prohibition (De Castro 2003). Two aspects are worth pointing out in both authors and among proponents of a liberalization of organ donation. Euphemistically, the word "donation" rather than selling is used. The concept of "compensated donation" is apparently incoherent. Donations are supposed to be free and what is paid or compensated for is consequently no donation. But there seems to be an inherent inhibition to call it according to its true meaning. Interestingly too, Ona as well as De Castro are both concerned about a free market of organs not so much in terms of price decline but of an "indecent" price rise. The suggestion then is to impose a price ceiling to allow an equal chance to avail an organ (Ona 2000, De Castro 2003). That this equal chance is limited to a small portion of the overall population is not discussed.

At the political level, attempts have been made to introduce a state-organized model of compensated organ donations. Through the Department of Health, a National Transplant Ethics Committee (NTEC) has been created. One of its main functions was to set guidelines for the so-called living unrelated donors (LURDs). Sale of organs was prohibited but gifts in form of health and life insurance, compensation for lost income, covering of education fees and job offers were accepted (Manauis et al. 2008). Between 2002 and 2006, almost 700 potential donors were registered but only about 10% kidney donation actually took place. More than half of the potential donor withdrew their consent; others were deemed medically unfit or were declined because of their attempt of sale. About 53% of the organ donors in this program complied with post-surgery medical check-ups, which leaves room for improvement in terms of donor education to increase medical compliance (Manauis et al. 2008). However, this program was not successful to control organ trafficking as the comparably small number of compensated organ donation over the five-year

period shows. A news report speaks of 3000 people in one slum area of Manila who have sold a kidney (Jalbuena 2007). Furthermore, questions have been raised about the extent of the gifts of gratitude as the overall sum "exceeded the national average income for the whole family for an entire year" (Padilla 2009, 121). This brings the government program of compensated donation close to a state-run organ selling and distribution program.

Also at the political level, the government regulated the transplantation to foreigners by introducing a 10% cap. Only one out of ten transplants should be given to a foreign organ receiver. However, the government was unable to enforce this law due to a lack of capacities (Padilla 2009). As a consequence, this quota was largely ignored (Uy 2008, Jalbuena 2007). In this situation the government decided in 2008 to prohibit organ donations to foreigners completely (Torres 2008).

#### 4 Organ Donation as a Question of Justice

Having presented the joint study of the Council of Europe and the United Nations as well as the experience of the Philippines in the last decade, I will turn to the specifically ethical part of this paper. Medical ethics as a scientific discipline has to be careful of two traps. First, it needs to be mindful of the medical practice and the empirical data on the one hand and the philosophical theory on the other hand without falling into either of the two extremes. Applying the Categorical Imperative of Immanuel Kant or the Greatest Happiness Principle of John Stuart Mill to organ trafficking will not do justice to a complex biomedical issue such as organ transplantation. However, ethical norms can neither be found with a focus only on empirical reality and medical practice. Therefore, an approach which recognizes empirical practice while dwelling upon an ethical framework is required. Second, this empirical practice has to be understood in its social, economical and cultural context. The ethical deliberations will have to acknowledge the cultural differences underlying diverse practices. A "one size fits all" type of ethics is neither suitable for all moral questions in a differentiated and increasingly complex field of medical ethics nor is it able to do justice in a plural world with a range of different cultural and social practices.

The focus of this ethical evaluation of the situation in the Philippines in the light of the cited EU/UN report is the issue of justice. The topic of justice has a long tradition in social and political philosophy. In the 20<sup>th</sup> century, the liberal theory of John Rawls (1999) and its communitarian counterpart of Michael Walzer (1984) have shaped the discussion on justice most prominently. Rawls asks about the necessary requirements for a fair and just society. Health belongs among the primary goods needed by the citizens to play an active role in society and make use of the civil liberties crucial to a just society. If people were ill, they will not be able to enjoy their basic liberty and thus the basis of mutual cooperation for the benefit of all is shattered. It is therefore

imperative that basic health care is provided. In the area of organ transplantation, we face the problem of allocation of scarce resources. From the perspective of the people requiring an organ, their ill-health excludes them from participation in society. However, it would be an inadequate interference with the individual liberty to require a healthy person to donate an organ. Organ donation is no moral duty, but a voluntary act. The question to ask then would be whether people should be allowed to sell an organ for financial compensation. International legal documents and treaties unanimously prohibit selling body parts such as organs. On the basis of Rawls theory, such a decision can only be deemed morally acceptable if it were undertaken with free and informed consent. Consent is questionable if it were given in a position where participation in society is not guaranteed. Where there is no choice, where living conditions are too poor for allowing for an active role in society, informed consent becomes a fiction.

Following the German philosopher Theodor W. Adorno, one might say that "there can be no good life within the bad one" (Adorno 2001, 1). On the basis of inequality, one can not find a just decision. Either option – legalization of paid organ donation or its prohibition – brings about moral problems. Wealth disparities and a privatized health care system betray equal access to health services. As a consequence, some people are deprived of the health care they need. Given this inequality, the question is raised about the right way of dealing with the practice of paid organ "donation". The minimal requirement that can be formulated with John Rawls is the assurance of an enlightened and informed consent along with the guarantee of preserving the health of the organ donor.

In theory, this requirement might be fulfilled and paid organ donation might be deemed ethical. However, the concrete practice is different. In the discussion of compensated organ donation in the Philippines, several problems have been pointed out: the health of the vendors has quite often deteriorated; the financial benefits have hardly been permanent, and often, no adequate information has been provided. Certainly, the government program for living unrelated donors could be seen as an improvement for donors as it provided them with certain securities not found in illegal organ selling. It guaranteed that minimal standards of information and consent were respected. Through medical insurance and job placement, efforts were made to guarantee a lasting improvement of the socio-economic situation of donors. However, this system was also accompanied by "a boost to transplant tourism" (Padilla 2009, 122). The government-organized organ donation (and compensation) must be seen in this wider context of transplant tourism. It remains to be seen whether the ban on transplantation to foreigners will effectively reduce organ selling. The minimal requirement from a liberal theory of justice will certainly be that informed and enlightened consent is given, no coercion was in play, and that the donor's health is not seriously put at risk. However, health risks are much higher in

polluted and hazardous social environments, thus organ donation might put the donors health under serious risk (Turner 2009). It is at least doubtful whether health risks can be kept low, and it is also dubious whether one can speak of informed and enlightened consent given the desperate situation of organ donors.

From the communitarian perspective of Michael Walzer, the moral argument would run differently. Developing his main idea of different "spheres of justice" further, Walzer argues that there are two moral standards: a "thick" moral binding together communities, and a "thin" moral, which applies universally. This thin moral is justified by the convergences of the thick moral and can best be understood by a set of negative injunctions – against murder, slavery etc (Walzer 1994, 10). Such a theory only allows for minimal judgement beyond one's moral community, and therefore there are tight limits for universal claims about specific moral questions. An ethical evaluation of paid organ donations needs to take into consideration the specific moral framework of the Philippines. Although influenced by Western norms of interaction, there are genuine Filipino values which structure society. Rather than radical independence, the security is sought after in a web of interdependence (Lynch 1984, 41). The basic social institution is the family; all social activities – economic, political, and religious – are based on the family: "The importance of the family in understanding contemporary behavior cannot be overemphasized" (Jocano 1998, 62). The right action is not so much what corresponds to the inner desires and wishes of the person but rather what is good for the family. The question of paid organ donation needs to reflect this particular social fabric. The decision for an organ donation is mainly done for the sake of the family. To put it bluntly, the main organism that needs to be maintained is the family rather than the individual. Nevertheless, bioethics literature in the Philippines emphasize the need for individual, autonomous consent (UST 2001, 34). Generally speaking, acting against exploitation and coercion is a command of the "thin" moral which applies universally. The communitarian perspective would emphasize the development perspective as well as the social ethical question underlying the whole issue of organ transplantation. Initiatives that provide everyone a fair access to the health care system would need to have priority in a communitarian perspective (as well as in a liberal perspective focused on development). Communitarians would find fault at the intensification of social inequality by means of a social practice which reinforces social stratification.

## **5 Conclusion**

This paper has presented the recently published EU/UN report on the trafficking of organs and put it into the context of the Philippine experience of the past decades. This experience has showed that an official government program, which endorses paid compensation, cannot contain the problem of rampant organ trafficking; and such a program might even lead to transplant tourism. Although recent legal

changes try to contain the trafficking of organs, government efforts are needed to enforce the existing law. On the ethical level, the injustice is basically found in a health care system which excludes large portions of the population. Liberal and communitarian theories of justice point out the importance of health care for social participation. In the present circumstances, any regulation of paid organ donation is under the suspicion of exploiting disadvantaged organ donors. Informed and enlightened consent can hardly be guaranteed in such situations. On the level of health care, the focus must be on prevention of renal diseases, building better organizational structures for deceased organ donations, and especially to increase coverage of the overall health care system to the least advantaged.

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## Corpses as a Part of Society: A Sociological and Anthropological Perspective

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### The Corpse and Sociology

Sociology literally refers to "the wisdom or knowledge (*logos*) of friendship (*socius*)" (Turner 1984, 11). If Turner's understanding is accepted that "[t]he task of sociology is to analyse the processes which bind and unbind social groups, and to comprehend the location of the individual to the social world" (*ibid.*), the location of a corpse would not be a minor one. Such an understanding implies that, by taking advantage of ritual practices (e.g., funerals and burial), religion (e.g., Christianity and Buddhism) has been in a deep and long time association with humans and society in terms of norms and regulations. As far as a corpse has a particular locus in the mode of social life, it functions as being normative in light of its appearance, characteristics and images.

Death thwarts the living's association with society. In that regard a corpse is a completion of frustration.

Since a dead body (excluding a brain dead body) is physically an inactive chunk of meat it cannot function in such a way as human activities. However, a corpse is a continuum of a living body. When an individual faces a corpse as well as he/she faces others, the corpse can be a reality to the individual. It is a completion of human activities and at the same time is externalised. The externalised corpse which was given its meanings by the living transfers from a biological objective structure to a subjective one of consciousness. In other words, even after that completion a corpse generates a new association with society by signifying its locus. The relation between the corpse and society has been unveiled by the surviving ritual practices and other new relations made by medical practices of organ transplants.

Historical reviews suggest that there have been *private* meanings or values and *public* meanings or values in a corpse. Death of a family member is an eternal deprivation and a severe frustration to his/her survivors. It follows that his/her dead body in front of the relatives is a symbol of deprivation and frustration and a harsh reality to them. The relatives find *private* meanings and values in the corpse. Simultaneously the corpse is open to *public* evaluations. The body does not only receive an evaluation by members of the community but also can be a social phenomenon or communal event by collective rites held in the community. Namely, this means that through the association with the community, society loses an individual as a part of society rather than the individual loses society. When inner organs or parts of a body are related to society, such dual meanings and values can be taken into account.

In this way a dead body sociologically illustrates an association between itself and society through *private* and *public* meanings and values and how the social characteristics of the body represented in the society. An extreme figure that we can show as the dead's social characteristics is a body who died from anorexia. The essence of the social characteristics of an anorexia sufferer is the bodily state of affairs generated by refraining from eating. For example, extreme slimming is associated in puberty with a rejection of sexuality through the suppression of menstruation. An extremely slimming figure *per se* is a seemingly extraordinary object for observation and its observers are likely to fix their images of anorexia. It would be possible sociologically to understand that anorexia, a women's assumptive disease, is "*part of symbolic struggle against forms of authority*" (Turner 1984, 202). Turner also states that anorexia is "*an attempt to resolve the contradictions of the female self, fractured by the dichotomies of reason and desire, public and private, body and self*" (ibid.)

### Part of Society

A phrase from G. Lukács suggests that the paradoxes of anorexia reproduce the antinomies of bourgeois thought (Turner 1984, 185). Anorexia can be understood as "*a search for individual freedom and individualism from the "golden cage" of the middleclass, over-protective family and a quest through rigours of secular asceticism for personal*

*perfectability*" (ibid.). Of course, the paradoxes are resonant with the culture of consumerism, sexual symbolism of body and "the patristic norms of slender feminine" (ibid.). At last anorexia results in a rebellion that often ends in death. The miserable figure of a dead person that suffered from anorexia illustrates that the whole person is so confused and dialectically divided. Thus the social characteristics of the body are recognised as a consequence united by a social cultural exercise and a natural one such as "*the loss of weight, deformities of bone structure, loss of menstruation, hyperactivity, malnutrition, hypersthenia and anaemia*" (ibid.). From here a rights-based claim for a remedy will be made because the dead person failed to exert control over his/her own body and character. The starved to death anorexia figure has a more normative power than an ordinary dead body has.

If it is acceptable to understand that, as far as one has a body, one is a part of nature, and, as far as one has a mind, one is a part of society, then a dead body as a continuous entity of the living body is a part of nature and, at the sametime, of society. Yet in that case, since there is found no consciousness and perception in a corpse, a corpse is not conscious of society but related with society through the living's conscious. The sociology of a corpse has role in analysing the relation between corpses and society so that we will focus on that point in the below section.

### Corpses and Anthropology

In most cultures and civilisations a corpse has symbolic meanings and values. If it were not for the symbolism imbued in a corpse, then the corpse would be drastically treated as a mere thing. Although there were times when dead bodies had been badly treated, this was a difference in the degree of treatment. In light of a continuum from a living body to its dead body, we would say that there are no cases where we are not conscious of the corpse as a symbol.

Here symbolism refers to a state of affairs where a power in a material is embedded by the character of the previous owner or a power that symbolises the embodiment of the character. It includes what is stemmed from the sacred characteristics of the corpses, the sacredness which can be constructed in the context of religious practices. A corpse as a symbol affects people's consciousness and continues to sustain a power of expression. The Amazonian aborigine Apinayé have a belief that spirit is embedded in blood or that blood is the equivalent of spirit (Matta 1982). Even in contemporary society there is a religious belief that blood is taken as a symbol and the symbol plays a vital role in being a norm for human behaviour. One's corpse is a strongly influential symbol to one's relatives, so that the relatives have a belief that they cannot alienate the body as a commodity.

The belief in a symbolised body is inseparably associated with the interpretation that a dead body is relevant to the character of the ante-mortem owner. This belief is that a body is a symbol which evokes, even after death, the diverse attributes,

characteristics and features of an individual. In his *Golden Bough* (1936) Sir James George Frazer explained what he called "Contagious Magic". Contagious Magic is based on "the notion that things which have once been conjoined must remain ever afterwards, even when quite dissevered from each other, in such a sympathetic relation that whatever is done to the one must similarly affect the other" (ibid., 174). The most familiar example Frazer took is "the magical sympathy which is supposed to exist between a man and any severed portion of his person, as his hair or nails" (ibid.). This magic is not regarded as a punishable offence both in England and Japan, but in specific times and areas the people believed in its effect. Even if a part is severed from an individual body, it is believed that the characteristics of the individual are embedded in the part.

Even in contemporary society people acknowledge that a corpse still retains the character of the ante-mortem person and that the strongly symbolised entity is not transferable (Yoshida 2009). On the other hand, we know a social reality that despite such strong symbolism, organs of a corpse are as a gift distributed from donors to recipients. Why do organs become transferable? This question may be answered by the comparison of gifting and bargaining. In general bargaining the personal details of buyers/sellers and groups related by business and their relationships with each other are not taken into consideration. The relations of buyers/sellers are allowed to be anonymous and temporary. On the other hand gifting generally takes past relations and interactions into account. A commodity as a gift functions for maintaining, modifying and advancing the relation. A mere thing is, through a gifting action, incorporated into the intimate relation and comes to be a symbol of the relation. When a gift shows a power of the maintenance and modification of the relation, it can be regarded as a transferable symbol.

This can be understood by the relation between donors and recipients of organ transplantation: how a body and its parts which have an untransferable symbol become transferable. For his/her relatives the corpse of the donor holds strong power as a symbol. The donor's irreplaceable relation with his/her relatives is embedded in the body so that it can evoke the relatives' memory of the deceased. Although the organs cannot be transferred if they still have strongly symbolic meanings and values, it would be possible to be transferred in the mode of "a gift of life". For organs re incorporated in the relation between organ donors and their recipients and they are symbols of the relation. When people expect the communal bond and the maintenance of social relations to be strengthened by organ transplantation, organs can be transferred from donors to recipients. In this way the symbolism located between donors and their relatives moves to a new relation that donors and their recipients created through transplantation procedures. The relation symbolises organs and changes the

untransferability of organs to being transferability. Thus the transferability of organs can be justified.

The brief anthropological review would suggest that we cannot take a simple paradigm that, because an organ is considered as a commodity, organ donation is not acceptable but, because an organ is considered as a symbol, organ donation is not acceptable. The relatives respect for the donor's will and intention to donate and their own wish the donor's to be alive in the recipient's body even after the donor's death. Such things may persuade organ donation. In this case, despite the anonymity of organs, they can be regarded as a symbol by both a donor and recipient.

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## The concept of "person" and its implication in bioethics

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### Abstract

Recent bioethical debates on abortion, euthanasia, brain death, prenatal screening, and animal experimentation, have gripped the concept of "person". Because of the revolutionary developments in the biomedical technologies a growing concern regarding this topic is not surprising. A human being, even though in PVS state, is rarely distinguished from a person in the religious sense. This view is also advocated by some bioethicists. However, others do not share the same concept of personhood. The paper discusses some major views on the concept of "person" and their implication in various bioethical problems. It argues that the capability of using complex brain function could be a significant criterion to be considered as a person.

## Introduction

Since the last decade, the concept of "person" is one of the central issues in bioethical discussions. The philosophical resolution of many controversies, such as abortion, euthanasia, brain death, prenatal screening, animal experimentation, and so forth, is closely related to the concept of person. But who is a person? What are the criteria of personhood? When is a being a person? These are the fundamental questions of personhood. Ethicists who support the Conservative view hold that any human being is a person from the moment of conception. That is, *only* human beings at any stage of their biological developments are persons. There is no distinction between a person and a human being according to this view.

Contrary to them, supporters of the liberal view believe that personhood deserves some special criteria, for instance, self-awareness, self-motivation, rationality, and consciousness. So, some human beings are *not* persons. However, certain animals, for example, dolphins, whales, and primates, according to them, are clearly persons. If we accept the latter view then several bioethical discussions, such as rights to animals, animal experimentation, responsibility toward PVS patients, become extremely complex. I begin by discussing different views on "person", and then I will explore a brief implication of these views on recent bioethical issues. At the end, my own position of personhood will be presented.

I divide the views on the concept of person into two sides, the conservative and the liberal.

**1. The conservative view:** This view is mainly based on religious ideas. Almost all religions have a similar concept of personhood. The Roman Catholic Church's position is a prominent example of the conservative view. According to this view, the human being is a person from the moment of conception. He or she should be respected and treated as a person from conception. He or she has full moral rights as a person does. Don Marquis' view is close to Catholic position (cf. Warren 2001, p.127).

**2. The liberal views:** Early in the last century, the terms 'human' and 'person' were used in the same sense. In general discussion, these appear interchangeably. However, many philosophers in the latter half of that century drew a sharp distinction between humans and persons. It is specially found in the writings of Michael Tooley, Peter Singer, and Mary Anne Warren. They have discussed the meaning of personhood, its rights, when does personhood begin, what are the characteristics of a person, and so forth. There are significant differences in their opinion on the criteria of a person.

However, Tooley identifies 17 properties which are common among contemporary bioethicists. This is a long list of criteria though it is possible to include more. So, it might be better to identify the significant characteristics of a person. According to some ethicists (e.g. Tooley), the significant criteria of personhood include self-consciousness, rational thought, being a moral agent, non-momentary interests, simple consciousness, and so forth (Tooley 2001, p.120).

I will discuss Tooley, Warren and Singer's liberal view of personhood.

**Tooley's view:** Tooley distinguishes the concept of person into two different meanings: biological and mental. Biologically, all human beings are *Homo sapiens* and persons. In the latter meaning, some entities that are not human beings (e.g. gods, angels, whales, dolphins and primates) are also persons. Tooley clarifies the concept of persons by considering the wrongness of killing. He tries to answer whether personhood is a necessary condition or sufficient condition for moral status. There are some entities which are non-persons but have the same moral status as a person. For example, the potential person is not the same entity as a person but possesses all the qualities to become a person in the course of time. But how can the moral status of some entities (e.g. anencephalic human babies), which are neither persons nor potential persons, be measured? Tooley finds the boundaries of personhood are controversial. He identifies other issues regarding personhood, for example, All-or-Nothing issues. Do all persons, potential persons, qua persons possess the same moral status? Or, does the degree of their qualities matter? The dominant view is that personhood does not depend on degrees. Tooley holds that without a systematic moral theory, resolving the personhood issue is difficult. Therefore, Tooley's position is that capacity for thought could be plausibly the most significant criteria for personhood (Ibid, pp. 120-121).

**Warren's view:** Warren distinguishes two senses of the term 'human', human in a genetic sense and human in a moral sense. In a genetic sense, any member of our species is a human being and no member could be human being from another species. By contrast, moral sense makes a distinction among human beings. Some human beings are not persons in this sense. Her concept of personhood involves: consciousness capacity (particularly the capacity to feel pain), capacity of reasoning, self-motivated activity, communicating capacity, self-concepts, self-awareness activity, and so forth. Like Tooley, Warren criticizes the potential person argument (Warren 2001, p.130). In my view, to some extent, Tooley's arguments are more acceptable. I agree that there are a lot of uncertainties from conception to birth in the mother's womb. Anything may happen before the human fetus touches the criteria of personhood. But as soon as it becomes viable, fetus achieves some important qualities, such as brain function, psychological, mental and social relationships with the mother, and so forth. In fact, at this stage, the relationship between fetus and mother is almost the same as an adult child. So, human fetus receives its mother's love, feeling, and emotion due to its characteristics at the time of viability. These unique qualities of the fetus could be sufficient for personhood.

**Singer's view:** Peter Singer generally defines persons as rational and self-aware beings. He criticizes strongly speciesism. Tooley also says that species membership is not itself morally significant (cf. Tooley 2001, pp. 123-124). However, in my view, speciesism is not contradictory to get a moral status

as presented by some philosophers including Singer. Rather, one's species is important for identification. If a human being and a rat are transgenically bred, then we do not know the species of that new entity, let alone its moral status. So, one's species is important for claiming moral status. It is also possible to establish this thesis from contemporary animal ethics. Philosophers like Singer, Cavalieri and Orlans, argue that at least great apes (humans, chimpanzees, and gorillas) possess moral status. According to them, great apes are persons as they have psychological, social, and rational similarities to human beings (cf. Orlans 2001, p.409). It is hardly acceptable that they are arguing for moral status of a special species (apes), not for protozoa or other lower species though they are against speciesism. I find it is a double standard. On the one hand, they are criticizing speciesism, on the other hand, they are claiming moral status for a certain species (apes). So, the argument against speciesism is circular.

### **Implications of the concept of person for various bioethical issues**

The concept of person has various implications for bioethical issues. Moral considerations of many bioethical issues depend on how "person" is defined. The concept of person is a crucial concern for the debate on abortion, euthanasia, brain death, responsibility to anencephalic children, and the moral rights to animal. I will focus on these issues.

#### **Abortion**

The traditional argument regarding abortion is - it is wrong to kill a person; a human fetus is a person; therefore, it is wrong to kill a human fetus. The moral permissibility of abortion relies on the second premise. Some ethicists make a sharp distinction between human and person. They offer some necessary criteria for personhood. On the basis of these criteria they argue that the fetus, even a newborn child, does not qualify as a person and therefore abortion specifically late abortions are morally acceptable. Some ethicists argue that a fetus at the viability or pain reaction stage has consciousness, the ability to feel pain, which are sufficient to consider them as a person. So, a viable fetus has full moral status as a person. Abortion is morally wrong at this stage. The conservative ethicists argue that the human fetus has potentiality from the moment of conception. Therefore, there is no difference between a fully developed human being and a zygote. Abortion is wrong at any stage from conception to birth. Hence, three positions could be identified regarding the moral status of human embryo and fetus. These are: Radical Gradualism, Moderate Gradualism and Absolutism. These three positions basically demarcate three different conception of personhood. Thus, the concept of personhood could settle moral as well as legal status of abortion.

#### **Euthanasia**

The term 'euthanasia' is related to allowing die. Euthanasia could be understood in two different ways. If a physician administers 'a lethal injection' to a terminally ill patient, from the point of view that the patient is better off to die, then this act is euthanasia. Another form of euthanasia is withdrawing treatment, withholding treatment, deep sedation and withholding treatment, and so forth. Voluntary euthanasia is performed after an informed request by a competent patient. But there may arise several situations for nonvoluntary euthanasia. For example, an individual might be in a persistent vegetative state (PVS), Alzheimer dementia, an irreversibly deep coma, and as a result incapable of having consciousness, thought, feeling, and recall memory. The moral decision for non-voluntary euthanasia involves personal identity.

#### **Brain death**

The traditional criterion for death is the stopping of the heart and lungs functions. When the breathing of a person stops, within a few minutes the cognitive brain function ceases. However, the development of life sustaining technology and modern medicine can continue a person's heart and lungs functions artificially. For this reason a wide range of ethical question emerge to redefine death. Death is now defined based on the function of the brain. There are two views on the brain death issue, both of which relate the concept of person. First, the whole brain death, meaning when the brain ceases integrating and coordinating functions including psychological functions like consciousness, thought, feeling. Second, higher brain death means full damage of cerebrum, but respiration and heartbeat function will continue. Is such a patient a person? Bioethicists have different views in answering this question (cf. McMahan 2001, pp.250-254).

#### **Personhood and Brain function**

The concept of person is one of the classic problems that has been discussed in many fields. Today it is not limited to philosophical discussions, journals or newspapers rather it is about the ethics of killing and letting die. Immanuel Kant gives emphasis to rationality. It is the sole criterion of personhood. However, John Locke considered a person to be a thinking intellectual being with the capabilities of consciousness, reason, and reflection. This conception of personhood is wide enough and includes any species (e.g. animal) that has these capabilities.

After Locke and Kant, a lot of criteria of personhood have been proposed. My primary focus is on complex brain functions. The human brain function is more complex than animals. In addition, the distinction among humans at different stages of their development is the capability of using complex brain functions. A fully developed human being is more able to use its brain function. By contrast, a viable fetus is less capable to use its brain function. Self-awareness, thoughts, ability to feel pain, and so forth, all proposed criteria are within brain function.

But the capability of using brain function is not the same for all creatures. Therefore, capability to use brain function is my sole criterion for personhood. Now, I examine the three basic arguments (fetuses are not person, marginal peoples e.g. infant are not person, and some non-human animals are person) using this criterion.

The embryos and fetuses develop gradually. There is a significant point in this gradual process and that is viability (week 24). At this point the fetus brain function develops fully with the ability to feel pain as well as the ability to survive outside the womb. The only limitation is that fetus could not use these complex brain functions fully. It is able to use partially. The capability of using complex brain function is gradual for the fetus and also for fully developed human beings. So, both possess active, unique, complex brain function and in this sense the viable fetus is a person.

In my opinion, marginal peoples (infants, newborn) are person also. However, the anencephalic and PVS patients are not persons because they do not have a minimum capability of using complex brain function. But they are semi-persons by which I mean they have not full right as a person rather have a right to care. We may have personal and social relations with them. So, they have right to get care from us. In the case of animals, we may not compare the capability of human fetus to animals and deduce that some non-human animals are persons because such type of analogy is a categorical mistake. Animals have consciousness, but they do not have consciousness about rights and duties. They have feelings, but are unable to provide justification for those feelings. Moreover, I think they lack the capability of using complex brain functions like human beings. So, animals are not persons but they are also semi-persons.

### Conclusion

The issue of the criteria of personhood is still unsolved. It is very difficult to identify all the criteria for personhood, and say the final word on the concept of person. We may characterize a person as a being with higher mental capabilities.

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## Health Professionals Ethical and Legal Liability on Patient's Inadequate Clarification in Order to Obtain Free and Informed Consent

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### Abstract

It is required that patients are provided information about therapeutic possibilities, showing the risks, benefits, prognosis and costs of each possible and indicated alternative. This is an ethical and legal resolution. However, health professionals possess the clinical/technical/scientific knowledge and determine what information will be (or not) provided. The patient in question decides to undergo a treatment, providing his/her free and informed consent on the basis of the data presented. Unfortunately, some professionals may not provide all the information necessary for making an informed decision or, after obtaining the consent of the patient, may provide him information that causes the patient to give up on the treatment initially accepted. Such information, if relevant, and not a supervening fact, should have been provided initially. However, the information may not be entirely true, and bring the patient, for instance, to decide based on inadequately presented risks. The craniofacial rehabilitation of the temporomandibular joint (TMJ) by means of TMJ prosthesis, is indicated in many situations. Often, patients in need of such prostheses have aesthetic and functional problems and the rehabilitation expectations run high. This work presents a case and discusses ethical and legal issues, including the liability of partial and inadequate information to a patient.

### Introduction

Until the 1960s, health care services characteristically held the benevolent Hippocratic paternalism. Health professionals treated their patients the best way they knew, with the intention of caring for them and restoring their health. However, patients usually had no participation in the decision-making on the possible treatment alternatives, and

were rarely informed about the aspects of their treatment. The prevailing view until that time - often tacit - was caring for their patients the best possible manner, and their obligation was to follow the guidelines.

But in the 1960s, patients began to demand their rights - the right to information about their health, the possible treatment alternatives and the right to decide about their bodies, their health and their lives. This caused a significant change of paradigms.

With the emergence of bioethics at the beginning of the 1970s, and the four pillars of bioethics at the end of that decade - autonomy, beneficence, non-maleficence and justice - the appropriate information to patients about their health condition and alternative treatment, the right to choose the best alternative, in accordance with their personal values, became a consequence of following the bioethics principle of autonomy.

At the same time, ethical (deontological) and legal standards emerged, hence determining the respect for patient's autonomy - keeping in mind that this also has limitations. Thus, in Brazil, the Consumer Defense Code (3), Code of Medical Ethics (6), and Code of Dental Ethics (5), are examples of the professional standards that require patient clarification from health professionals.

The Consumer Code (3), applicable to the health professional/patient relationship, establishes:

Article 31. The offering and presentation of products or services must provide accurate, clear, specific, and overt information in Portuguese about their characteristics, qualities, quantity, composition, price, warranty, expiration dates and origin, among additional data, as well as the health risks they present and consumer safety.

The Code of Medical Ethics (6) in effect, in Chapter IV - Human Rights, Article 46, states:

The doctor is forbidden to:

Article 22 - Perform any medical procedure without the patient's, or legal guardian's, prior information and consent, unless under imminent risk of death.

The Code of Dental Ethics (5), in Chapter V - Relationship, Section I - With the patient, provides:

Art. 7 -Violates ethics:

IV . Fail to adequately explain the purposes, risks, costs and treatment alternatives;

XII - start any dental procedure or treatment without previous consent by the patient, or his legal guardian, except in cases of urgency or emergency.

The Universal Declaration on Bioethics and Human Rights (16), at international level, approved at the General Conference by the 192 member countries of UNESCO on October 19, 2005, specifies in Article 5 and 6, the need for Free and Informed Consent:

Article 5 - Autonomy and individual responsibility

The autonomy of individuals with regard to decision-making, as long as it takes on the responsibility and respects the autonomy of others, should be regarded. For persons unable to exercise

their autonomy, special measures must be taken to protect their rights and interests.

Article 6 - Consent

1. Any medical intervention that is preventive, diagnostic or therapeutic should be performed with prior, free and clear consent by the person concerned, based on adequate information. Where appropriate, the consent must be expressed and the person concerned can withdraw it at any time and for any reason, without this ensuing any disadvantage or detriment.

It is noteworthy that the clarification should be provided both in cases of health care and in research involving humans. Thus, after being properly informed, the patient/research subject consents (or not) to submit to a particular treatment or experiment, by means of his/her Free and Informed Consent (FIC). The formalization of FIC is made by a document called Statement of Free and Informed Consent [4, 7, 13].

As previously mentioned, health professionals have a bioethical, ethical and legal duty to explain adequately to their patient before starting any treatment. The alternatives, risks, pros, cons, costs, must be presented, and in plain language, accessible to the patient's level of understanding. If this is not done, health professionals may respond ethically and legally for information omission. The need to obtain consent after the explanation is a unison voice among the authors of the area [1, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15].

### **Inadequate Clarification to Obtaining Free and Informed Consent**

Health professionals hold the clinical/technical/scientific knowledge to be transmitted to patients. In practice, they decide what to inform - and are responsible for the information provided.

There are professionals who strive at appropriately informing their patients. However, unfortunately, there are professionals who deliberately and consciously do not provide all necessary information to clarify their patients, these are professionals who manipulate the information to their own indulgence, with the intention of inducing the patient to take (or not) a decision in agreement with their own partisanship, according to their own interests. In this situation, the patient ends up forsaken - he/she places his/her trust on a professional who provides inaccurate information, or maybe even false, and based on this, takes a decision. Sometimes, wrong or incomplete information is provided at the beginning of the treatment. Other times, it is provided after obtaining the Free and Informed Consent, resulting in the withdrawal of a previously accepted treatment/procedure. Obviously there may be supervening events that must be informed as soon as they occur. However, if this is not the case, such information, if applicable, must be provided at the beginning of the treatment.

The temporomandibular joint (TMJ) craniofacial rehabilitation by means of TMJ prosthesis is

indicated in many situations. Often, patients in need of such prostheses have aesthetic and functional problems and the rehabilitation expectations run high. All information, both related to the TMJ prosthesis, as well as the surgical procedure and the risks should be provided before the patient's consent to receive such prosthesis.

A last-minute information that presents an infection risk, for instance, can cause withdrawing from the treatment, and with this, the patient's frustration, hence upsetting his/her expectations, besides removing the opportunity for an appropriate, necessary and indicated rehabilitation treatment. If such risk - which caused the patient abandoning the treatment - has not been well dimensioned, it will cause harm to the patient, as it will determine his/her giving up. The patient is able to exercise his/her autonomy if adequately informed. If the information received is inadequate, the patient, in practice, will be making a choice based on irrelevant information, which leads to the loss of autonomy.

Those professionals behaving this way - providing inadequate information to their patients - should be held accountable both legally and ethically. With inadequate or false information, patients are induced to making a wrong decision, to their detriment.

The legal responsibility is segmented in civil and criminal liability. The former involves damage, injury, embezzlement, imbalance or decompensation of an individual's assets (15).

The Brazilian Civil Code (2) stipulates the duty to indemnify, stating;

Article 186. The individual that, by voluntary or negligent omission, or by recklessness, violates one's right and harms others, even if only moral, commits an unlawful act.

Art. 927 – Article 927 - Whoever, in tort, harms others, is obliged to repair it.

The Consumer Defense Code<sup>3</sup> provides, explicitly, the compensation for moral damage.

Article 6 - Basic consumer rights:

VI - the effective prevention and repair of property and moral damage, individual, collective and diffuse;

The professional that does not adequately explain to the patient, affronts the deontologic ethical devices of their professional area.

Exemplifying with medical and dental professionals, if they disobey the Codes of Medical and Dental Ethics, they are subject to sanctions by their professional Councils.

Taking away the patient's right to an indicated and necessary treatment, not providing adequate and relevant information, or even providing irrelevant information, to the detriment of a patient's decision, is a posture that may require the professional to indemnify the patient, because this attitude, caused the patient moral damage, liable to compensation payment.

shall only be obtained after the patient has been properly informed, because only then will he/she be able to choose and decide. If the health professional provides inaccurate, unsubstantiated, or false information, the patient is left without the right to exercise his/her autonomy, as well as unable to choose the best option for his treatment and health. Thus, with such a posture, the professional causes serious damage to the patient, and must respond ethically, by his/her professional Council, as well as legally, indemnifying the patient for the damage inflicted.

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## Final Considerations

The duty to only initiate a treatment or a procedure with the consent of the patient is based on deontological and legal norms. However, this duty

## **Does the responsibility of helping the global poor lie with nation states or individual persons?**

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Does the responsibility of helping the global poor lie with nation states or individual persons? In the following paper I shall argue that nation states are causally connected to the creation and sustenance of global poverty, which makes wealthy nations, and not individual persons, morally obligated to help the global poor. I will start by explaining the nature of the distinction between the role of an individual's obligations versus those of a nation in the context of global poverty. I will follow this by drawing a difference between negative and positive duties to argue that the obligation to help the global poor stems from a negative duty rather than a positive one. I will present Pogge's argument for a Global Resource Dividend to show why a violation of negative duties by wealthy nations makes global poverty their responsibility. Following this, I will attend to a possible criticism of my position and address the problem of coercion to show why it cannot be held as an argument against my thesis. After assessing Pogge's argument, I will present Singer's Principle of Sacrifice. I shall make two key arguments against it being a reason as to why individuals, instead of nations, should be responsible for helping the poor. First, I will argue that Singer's argument that a positive duty holds as much weight as a negative one is wrong. In order to show this, my paper will argue that one's "ability" to do something does not imply that one has a "duty" to do it. Even if individual persons are capable of solving the problem of global poverty, it does not mean they have a moral obligation to do it. Second, I will show that individuals are simply not capable of suitably solving the problem of global poverty. This premise will demonstrate how Singer's Principle of Sacrifice does not apply to individuals in the context of global poverty, and will therefore lead to the conclusion that the responsibility of helping the global poor does not lie with individuals.

In order to differentiate a nation's responsibilities from those of individual citizens, two points need to be made. First, we need to realize that even though citizens elect their governments, and responsibilities of a nation are ultimately shouldered by its citizens, a distinction between national and individual responsibilities can still be made. National leaders make decisions at a legislative level which are implemented on various economic, political and social levels. Individual decisions on the other hand only influence smaller groups of people, such as

close social circles, communities or families. Even though individuals decide who leads their nation, for the purpose of this paper legislative decisions made by nation states will not be reduced to "individual" obligations. This is because any such discussion will result into a circular argument, thus making the purpose of this paper futile.

Second, decisions made by governments not only influence a single nation's policies but also affect policies at an international level. Political leaders are in a position to discuss reforms that shape a global economy. To say the obligation of global poverty lies with nation states implies that leaders of different countries need to resolve this issue by addressing it at international summits such as G8 or G20 summits, United Nations sessions and meetings with other international trading partners. The same cannot be said about individual responsibilities which represent personal choices and do not have the impact legislative decisions do.

Wealthy states have violated a negative duty of not causing harm to poor nations and are therefore causally connected to the misery of the global poor. This imposes an ethical obligation on them to reduce global poverty. Pogge addresses the problem of global poverty by referring to it as a state of "Radical Inequality" that has been a cumulative product of decades of an economic system shaped by more affluent societies who have used their "advantages in capital and knowledge to expand these advantages further".<sup>2</sup> Global poverty exists because there is an institutional order that is constantly shaped by a status quo between the rich and the poor. Wealthier nations with their superior military and economic growth influence the economies of poorer nations. Several examples from history point to such a system. The end of British rule over the Indian Subcontinent created a demarcation of borders for India and Pakistan that still has them fighting over sovereignty of their territory and rivers. The frequency of civil strife and disputes between poor nations is directly related to international arms trade. If affluent nations have had a role to play in causing a state of radical inequality, it seems ethically necessary that they ought to play a role solving the problem.

It can be argued here that individuals in wealthy nations too have violated a negative duty by making commercial choices that shape economies in poorer nations. However, this argument assumes that private citizens have had a bigger role to play in shaping international trade laws than governments of developed nations. If individuals do buy goods that have negatively influenced the economy of a developing nation, they are only doing so because their government's trade policies have made that good available in the local market. Nations, not individuals, have had a bigger influence in shaping this dynamic and nations, not individuals, have violated a negative duty here.

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<sup>2</sup> Thomas W. Pogge, "Eradicating Systemic Poverty: brief for a global resources dividend," *Journal of Human Development*, 2 no. 1 (2000), 66.

Not only have wealthy nations contributed to the problem of global poverty, they are also in the best position to solve this problem. It is true that "efficiency" here does not entail a moral "responsibility", but it gives us further reasons to state why it is *better* for nations to address this issue. Since wealthy nations have already violated a negative duty, it is incumbent upon them to fulfill a positive duty of aiding the global poor, especially because they are in a position to do it.

Pogge's Global Resource Dividend proposal is based on the idea that the global poor have an inalienable share in the world's natural resources. Therefore, wealthy nations are obliged to give to poorer nations a dividend of resources their share or use.<sup>3</sup> If such a scheme is implemented, a GRD would be on all natural resources, including those depleted, eroded or occupied. These would include oil, coal, sites for dumping pollutants, and land used for farming or infrastructure.

Pogge further argues that a GRD would solve the problem of global poverty without putting an extraordinary burden on the economies of wealthy nations. He goes to show that a mere 1% GRD from affluent nations would currently raise "about \$300 billion annually." This would mean "\$250 per year for each person below the international poverty line, over three times their average annual income."<sup>4</sup> A mere 1% contribution of GRD would not be financially draining on the economies of affluent nations but would make a phenomenal impact on the global poor in just one year. Similarly, a \$2 per barrel GRD on crude oil extraction would raise 18% of the annual revenue target, but affect oil prices by just a nickel per gallon.<sup>5</sup> The financial feasibility of a GRD is promising and presents an effective way to quickly and adequately take measures to address the problem of global poverty.

Some may argue that if nations start following Pogge's GRD scheme, the problem of coercion can arise. Citizens who are part of that nation and do not wish to contribute to global poverty may feel 'coerced' if their governments started allocating money from their funds for the global poor. There are two reasons why this argument cannot be made against my thesis. First, the GDP of a nation does not include taxes the citizens are paying. Therefore, since individuals will not be contributing anything from their taxes, nor be required to pay additional taxes, the problem of coercion will not arise. Secondly, all citizens of a democratic nation already consensually participate in a system of election in order to elect a government. They do so after willfully assessing mandates of various political parties, and consciously making a decision to vote. Whatever decisions the elected government makes now cannot count as coercion because *individual citizens* elected that government. If the conservatives in Canada get elected, liberal Canadians cannot complain that they are being coerced into following conservative policies

because they autonomously participated in a system of election which they had consented to.

While Pogge holds nation states responsible for aiding the global poor, Singer defends a Principle of Sacrifice which places this responsibility on individual persons. Singer uses an example to illustrate his argument. He asks us to imagine a situation in which we are walking by a pond in which a child is drowning. The pond is shallow enough for someone to wade in it and rescue the child, but at the minor cost of spoiling his very expensive clothes. Common sense morality would say that one has an obligation in this case to rescue the child even if it means dirtying one's clothes to do so. Using this example, Singer states his Principle of Sacrifice which says that, "if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought morally to do it."<sup>6</sup> He then states that because "suffering and death from lack of food, shelter, and medical care are bad", we as individuals have a moral duty to prevent them from happening. Singer argues that at the individual level, people in affluent nations have an obligation to respond to the problem of global poverty. This implies that individuals need to cut down on personal purchases in order to contribute generously to relief funds.

The Principle of Sacrifice may seem intuitively appealing to our everyday moral convictions, but it does not lead us to the conclusion that the obligation to help the global poor is incumbent on individuals. There are two reasons why this is so. First, Singer assumes that the positive duty to help the global poor is strong enough for it to be morally incumbent on individuals. This is not the case, because the "ability" to do something does not entail a "duty" to do it. Singer assumes that if money is simply given away from the rich to the poor till a point of marginal utility is met, the problem of global poverty will be solved.<sup>7</sup> What he fails to appreciate is that the possibility of individuals giving to the point of marginal utility is an unrealistic one to begin with. It is hard to imagine why a person should feel *he* has a direct moral obligation to help the global poor when global poverty is actually a result of the structure of social institutions shaped by nations over time. If I have the ability of cleaning the mess in my house, it does not mean that it is *my duty* to clean the house even when my sister dirties it. I might choose to do it as an act that philosophers term "supererogatory", but it would be wrong to insist that I have an obligation to clean the house even when my sister is responsible for the mess.

Certainly, the harm caused by having a messy house is in no way comparable to the death of people caused by abject poverty. What this example does, however, is identify that agents who might be capable of solving a certain problem, are not necessarily those obligated to do it. Though it is certainly charitable to do so, individual persons are not *obligated* to solve the problem of global poverty,

<sup>3</sup> Pogge, 66.

<sup>4</sup> Pogge, 67.

<sup>5</sup> Pogge, 67.

<sup>6</sup> Peter Singer, *Philosophy and Public Affairs*, "Famine, Affluence and Morality," 231.

<sup>7</sup> Singer, 234.

because it is nation states that have shaped policies that have caused global poverty.

The Principle of Sacrifice may be very valid in stating that a person has a responsibility to save a child drowning in a pond, but it fails as a philosophical argument to apply to individuals in the context of global poverty. This is my second arguments against Singer's position. The Principle of Sacrifice says that "if it is in our power" to prevent something bad from happening, we morally ought to do it. The question that needs to be raised here is whether it is really in the power of individuals to prevent global poverty. Earlier in this paper I presented the argument for a Global Resource Dividend which illustrated how global poverty is a result of manipulation of the global market by a few affluent nations due to their superior military and economic growth. Global poverty will not be solved by the act of individuals alone due to the inherent nature of the problem which makes global poverty more of a political problem than simply a monetary one. Therefore, since it "is *not* in our power" to prevent global poverty, the Principle of Sacrifice does not apply to individuals. Singer's example of a child in the drowning pond cannot be extended to the role of individuals in the context of global poverty.

In this paper I have used Pogge's arguments for a Global Resource Dividend to show why the problem of global poverty should be one addressed by nation states. I have relied on the distinction between negative and positive duties to argue why a negative duty is stronger and entails a moral obligation while a positive duty does not. I have also presented two major counter arguments against my position and have addressed the problem of coercion and the criticisms raised by Singer's Principle of Sacrifice. Since nations are causally responsible for contributing to the problem of global poverty and since nations are the best resource to combat this problem, I conclude that the obligation to help the global poor is incumbent on nation states and not individual persons.

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## Conferences

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[http://www.unescobkk.org/index.php?id=current\\_and\\_future\\_events](http://www.unescobkk.org/index.php?id=current_and_future_events)

*Dialogues on Universalism, Human Rights, War and Peace, and Climate Change*, 30 August 2010. Venue: Fifth Floor Conference Room, UNESCO Bangkok, 920 Sukhumvit Road, Prakanong, Bangkok, Thailand

*UNESCO-UKM Conference on History, Politics, Strategic Studies and Climate Change*, 29-30 November 2010, Palm Garden, Putrajaya, Malaysia. Organized by Universiti Kebangsaan Malaysia (UKM) and the Regional Unit for Social and Human Sciences in Asia and the Pacific (RUSHSAP), UNESCO Bangkok. For further details, please contact [apc.ukm@gmail.com](mailto:apc.ukm@gmail.com)

*International Conference on Ethics and Professionalism (ICEP 2010): Sustainable Science, Technology and Society*, 1-2 December 2010, Equatorial Hotel, Bangi-Putrajaya, Malaysia. Co-organized by: Centre for General Studies, Universiti Kebangsaan Malaysia (UKM) and the Regional Unit for Social and Human Sciences in Asia and the Pacific (RUSHSAP), UNESCO Bangkok. Papers accepted on:

1. Ethics and Professionalism in science, technology and engineering
2. Ethics and Professionalism in medical, nursing and public health
3. Ethics and Professionalism at the workplace
4. Ethics and Professionalism in governance, business and social responsibility
5. Ethics and Professionalism in education

There will also be a Bioethics Education Intensive Workshop on 3 December.

*Fourth UNESCO-Kumamoto University Bioethics Roundtable: Bioethics and the Concept of Happiness*, 11-

12 December, 2010, Kumamoto, Japan. Inquiries to [rushsap.bgk@unesco.org](mailto:rushsap.bgk@unesco.org)

## News in Bioethics & Biotechnology

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

## International Bioethics Education Project News

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

## UNESCO Asia-Pacific School of Ethics

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

## Asian Bioethics Association (ABA)

<[www.eubios.info/ABA.htm](http://www.eubios.info/ABA.htm)>

Membership fees are usually payable at the time of renewal to *EJAIB*, the official journal of ABA. A **three tier system exists for annual fees:**

a) Regular price (US\$50 Euro 50 Yen 5000).

This includes the *EJAIB* journal subscription and free associate membership of Eubios Ethics Institute.

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This includes the *EJAIB* journal subscription.

c) No fee, because the person is not in a position to pay the fee.

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**Shaping Genes: Ethics, Law and Science of Using Genetic Technology in Medicine and Agriculture**

by Darryl Macer, Oct. 1990, 421pp.

Cost: US\$20 UK£10 NZ\$30 A\$25 C\$22 ¥2500 Others or credit card **NZ\$30**

**Equitable Patent Protection in the Developing World**

by William Lesser, May 1991, 150pp.

Cost: US\$15 UK£8 NZ\$20 A\$20 C\$17 ¥1500

**NZ\$25**

**Attitudes to Genetic Engineering: Japanese and International Comparisons (Bilingual)**

by Darryl Macer, May 1992 330pp.

Cost: US\$30 UK£15 NZ\$35 A\$30 C\$30 ¥3000

**NZ\$40**

**Human Genome Research & Society**

Eds: Norio Fujiki & Darryl R.J. Macer July 1992 ISBN 0-908897-03-0 (English),

230pp. ISBN 0-908897-04-9 (Japanese), 240pp. Cost: US\$20 UK£10 NZ\$30 A\$25 C\$22 ¥2000

**NZ\$30**

**Intractable Neurological Disorders, Human Genome Research and Society** Eds: N. Fujiki & D. Macer

Feb. 1994 ISBN 0-908897-06-5 (English), 320pp. ISBN 0-908897-07-3 (Japanese), 340pp.

Cost: US\$25 UK£12 NZ\$30 A\$30 C\$27 ¥3000

**NZ\$40**

**Bioethics for the People by the People**

by Darryl Macer,... May 1994 ISBN 0-908897-05-7, 460pp. Cost: US\$30 UK£15 NZ\$35 A\$35 C\$32 ¥3000

**NZ\$50**

**Bioethics in High Schools in Australia, Japan and New Zealand,**

by D. Macer, Y. Asada, M. Tsuzuki, S. Akiyama, & N.Y. Macer

March 1996, ISBN 0-908897-08-1, 200pp.(A4)

Cost: US\$25 UK£15 NZ\$30 A\$30 C\$30 ¥2000

**NZ\$40**

**Protection of the Human Genome and Scientific Responsibility (Bilingual)**

Editors: Michio Okamoto, Norio Fujiki & D.R.J. Macer,

April 1996, ISBN 0-908897-09-X, 210pp.

Cost: US\$25 UK£15 NZ\$30 A\$30 C\$30 ¥2500

**NZ\$35**

**Bioethics in India** (includes 115 papers from Jan.1997 conference)

Eds: Jayapaul Azariah, Hilda Azariah & Darryl R.J. Macer June 1998 ISBN 0-908897-10-3, 403 pp.

(Printed in India)

Cost: US\$30 UK£18 NZ\$34 A\$36 C\$36 ¥3000

**NZ\$45**

**Bioethics is Love of Life: An alternative textbook**

by Darryl Macer, July 1998 ISBN 0-908897-13-8, 152pp. Cost: US\$26 UK£14 NZ\$34 A\$34 C\$32 ¥3000

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**Bioethics in Asia** (includes 118 papers from Nov.1997 conferences, ABC'97 Kobe and Fukui Satellite)

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**Ethical Challenges as we approach the end of the Human Genome Project**

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**Bioethics Education in Japanese High Schools (in Japanese only)**

Editor: Darryl Macer April 2000 ISBN 0-908897-16-2, 112pp. Cost: US\$20 UK£12 NZ\$30 A\$30 C\$30 ¥1000

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**Bioethics and the Impact of Human Genome Research in the 21<sup>st</sup> Century**

Eds: Norio Fujiki, Masakatsu Sudo, & Darryl R.J. Macer March 2001 (English and Japanese bilingual, 350pp).

Cost: US\$30 UK£20 NZ\$40 A\$38 C\$40 ¥3000

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**Bioethics in Asia in the 21<sup>st</sup> Century**

Eds: Song Sang-yong, Koo Young-Mo & Darryl R.J. Macer

August 2003 ISBN 0-908897-19-7, 450pp. Cost: US\$35 Euro35 UK£20 NZ\$40 A\$38 C\$40 ¥3000

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**Challenges for Bioethics from Asia**

Ed: Darryl R.J. Macer

November 2004 ISBN 0-908897-22-7 656 pp. Cost: US\$35 Euro35 UK£20 NZ\$40 A\$38 C\$40 ¥3000

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