Eubios Journal of Asian and International Bioethics

Contents   page

Editorial: Volunteerism and Social Inclusion

Many people have been volunteers for some activity. Eubios Ethics Institute has two active programs of youth volunteerism with RUSHSAP at UNESCO Bangkok: Youth Peace Ambassadors International and Youth Forums Looking Beyond Disaster. There are over 200 youth led action plans underway in different countries linked to these programmes, involving over 500 trainees. In the first paper of this issue Youth Volunteerism in Asia-Pacific—YPA and LBD Trainees' Voice of Volunteerism, one of the LBD and YPA trainees, Min Zhang, has conducted a survey of volunteerism among the trainees. There is some correlation to other published studies, and some interesting views presented. Evaluation of the action plans has also been conducted, some have been fully implemented, and soon there will also be templates on the Eubios Ethics Institute website for exchange of volunteers and tourism. There will be further training events held in 2013, and some of those who have implemented their action plans will come to present the issues they faced, along with the experiences of persons from around the world. Please conduct the editor if you are interested in joining future trainings.

The ethics and legality of euthanasia in general, and then a particular analysis of the Indian Context is presented by V Prabhu and Tanuja Kalita. They discuss a Supreme Court decision.

A Framework for Advancing Health Equity in Pakistan is presented by Nida Khan, with a number of ethical principles that can promote social inclusion in other countries as well. Sarah Kroske and Ann Boyd present an Individual Case that reveals dilemmas in Just Healthcare. Tyler Hislop and Ann Boyd write about valuing individuals within a Social Justice Framework. The principles of solidarity are seen to some degree in every society, and culture, but how can we also promote individual choices. K. K. Verma and Rashmi Saxena look at the biological evolution of cooperation, and how this can be applied not only among siblings but also among non-siblings.

Miyagi Akiko presents a paper on Learner's Attitudes to be Cultivated through Clinical Ethics Case Studies: with Reference to the Method of Psychotherapy Diagnostic Interviews. In this teaching method a clinical ethics case is taken as a literary story that should be interpreted by making full use of literary imagination. She refers to the method of psychotherapeutic interview at the first contact, which places importance on individuality and creating a hypothetical interpretation of the aspects of the patient. Using the style of a psychotherapeutic interview and perusing cases in clinical ethics case study encourages imagination, such as focusing on the life history of characters in the case and detecting what they do not understood yet in the given case, without eliminating their own subjective impressions. This encourages imagination, that most teachers have encouraged in early learners, yet something we do not always encourage in high school or university. We should.

There will be at least an entire day at the 14th Asian Bioethics Conference on bioethics education,19-23 November 2013 in Chennai, India. Please renew your Asian Bioethics Association subscriptions for 2013, and send your abstracts to the secretariat!

– Darryl Macer

Youth Volunteerism in Asia-Pacific—YPA and LBD Trainees' Voice of Volunteerism

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Volunteerism

Volunteerism is about people's need to engage to help their communities or societies, and can help people obtain a greater sense of belonging and inclusion. The concepts of volunteerism may vary from culture to culture, yet the driving force is universal: "a desire to contribute to the common good, out of free will and in a spirit of solidarity, without expectation of material reward".[1]

Shure (1991) broadly defined volunteering as persons offering themselves for a service without obligation to do so, willingly, and without pay. Wilson (2000) stated that volunteerism is any activity in which time is given freely to benefit another person, group or cause. A more narrow definition was given by Ellis and Noyes (1990): "To volunteer is to choose to act in recognition of a need, with an attitude of social responsibility and without concern for monetary profit, going beyond one's basic obligations". Anheier and Salamon (1999) also mentioned social responsibility, saying that, "volunteering is much more than simply the giving of time for some particular purpose. In fact, as a cultural and economic phenomenon, volunteering is part of the way societies are organized, how they allocate social responsibilities, and how much engagement and participation they expect from citizens". In Jenner's (1982) "pure" definition, she limited a volunteer to, "a person who, out of free will and without wages, works for a not-for-profit organization which is formally organized and has as its purpose service to someone or something other than its membership". Finally, in the paper "*Defining who is a volunteer: Conceptual and empirical considerations*", Cnaan et al. (1996) reviewed 11 widely used definitions of volunteer and then defined four key dimensions from those definitions. They analyzed the importance of these four dimensions in determining how people define who is a volunteer. They also raised the concept of the net cost as a basis for public perceptions of what makes a volunteer.

Some international organizations also give their own understandings of volunteerism. The Red Cross considers voluntary service as one of its seven fundamental organizational principles, defining volunteers as, "individuals who reach out beyond the confines of paid employment and normal responsibilities to contribute in different ways without expectation of profit or reward in the belief that their activities are beneficial to the community as well as satisfying to themselves".

The United Nations offers a broader definition of volunteering as contributions that individuals make as nonprofit, non-wage, and non-career action for the well-being of their neighbours, and society at large. The United Nations sees volunteering primarily in its service function: "Voluntary service is called for more than ever before to tackle areas of priority concern in the social, economic, cultural, humanitarian and peacekeeping fields."

This paper looks at volunteerism from a broad perspective, and presents results of a survey of youth volunteers from different countries. Because volunteerism manifests itself in various ways: helping your neighbours, taking care of homeless dogs and cats, visiting orphan schools, organizing activities for environmental protection, holding charity donations in your community, etc.. We can also see that volunteerism is closely related to people's daily life in many countries, and everyone can be called a volunteer at some time in his/her life.

Volunteerism and MDGs

In 2000, the United Nations Millennium Development Goals (MDGs) were set after the Millennium Summit. The eight goals express the most basic, yet urgent aspects of application of the Universal Declaration of Human Rights. Achieving the MDGs requires not only actions from governments of all member states, but more importantly, the joint efforts of all people around the globe through volunteering work. In fact, volunteerism is closely related to each of the eight goals. In the former UN Secretary-General, Kofi Annan's report on the follow-up to the implementation of the International Year of Volunteers (IYV), he claimed that volunteerism, when properly channeled, is a powerful force for the achievement of the MDGs.

MDG 1: Eradicate extreme poverty and hunger.

Individual volunteers and volunteer organizations are helping people living in poor conditions. Around the world, they provide technical and financial supports to people in need; provide information to local farmers, fishermen and herdsmen on production methods, natural resources and natural disaster control; promote experience exchanges among different groups of people; and etc.

MDG 2: Achieve universal primary education.

Volunteers help to train teachers; some organizations even send volunteer teachers to rural areas every year. They also help develop creative curricula, provide literacy courses and skills training, and promote girls' education.

MDG 3: Promote gender equality and empower women.

Volunteer activists form the backbone of international women's movement, advocating for compulsory education for girls, protecting the rights of teenage girls, supporting single mothers, raising women's voices on policies and etc.

MDG 4: Reduce child mortality.

Local and international volunteers are working together to address child mortality, especially in Africa where one in six children won't see their fifth birthday due to poverty, poor health care and HIV/AIDS.

MDG 5: Improve maternal health.

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[1] *State of the World's Volunteerism Report*. (2011). Forward. Retrieved 23 November 2012 from http://unv.org/en/swvr2011.html

Around the world, volunteers serve as health workers to help train local women in public health, nutrition and communicable diseases prevention. They are also working as birth attendants to help pregnant women for the birth delivery.

MDG 6: Combat HIV/AIDS, malaria and other diseases.

Among the thousands of NGOs who provide voluntary service, a large number of them focus on prevention of epidemics such as HIV/AIDS, tuberculosis and malaria. They provide basic prevention information, support health campaigns, and give assistance to people living with HIV/AIDS and other diseases.

MDG 7: Ensure environmental sustainability.

Local volunteers and volunteer organizations hold campaigns to raise people's awareness of environmental protection, promote the sustainable use of natural resources, and provide training programs in natural resources management and support experiences exchanges between local communities in handling environmental issues.

MDG 8: Develop a global partnership for development.

Volunteers and volunteer organizations have established a widespread network worldwide to promote partnership for development. Volunteer organizations build partnerships with the private sector by helping build corporate social responsibility (CSR) of private companies, and encouraging dialogues between private companies, local governments and NGOs.

The United Nations proclaimed 2001 the International Year of Volunteers (IYV), and 5 December the International Volunteers Day, so as to raise the recognition of volunteerism and encourage more people involved in volunteering activities to work together for a better future. Among millions of volunteers all over the world, youth form the backbone of many volunteering activities.

Youth and Volunteerism in Asia-Pacific

According to the UN's regional overview in 2011,[2] the Asia and Pacific region is home to over 45% of the world's youth, amounting to around 700 million young people. The region's enormous social and economic dynamism in recent years has created tremendous opportunities for its young people. For example, the East Asia sub-region maintains the world's lowest level of youth unemployment (about 8 per cent).

However, due to some traditional cultural barriers, young people across the region often remain at the margins with regard to participation in the decision-making process. Some senior government officials and the local media often regard young people who are enthusiastic about social changes as troublemakers.

Nevertheless, Asia and Pacific youth are still trying to make their voices heard; one of the channels they turn to is volunteering activities. Young people in this region are getting actively involved in volunteerism to address common concerns, to promote peace and development in their communities and to get involved in policy-making. For example, the Student Army in Christchurch, New Zealand has made a great contribution to the recovery and reconstruction process after the 2011 Christchurch earthquake. Also, with the help of several international

organizations, forums and workshops are being organized to provide a platform for Asia-Pacific youth to exchange experiences and ideas to enhance their participation in the process of social and economic advancement. The Youth Peace Ambassador Training Workshops and Youth Looking Beyond Disaster Forums are among the active and successful ones.

Youth Peace Ambassadors (YPA) and Youth Looking Beyond Disaster (LBD) Programme

Eubios Ethics Institute incorporates youth engagement in all activities, mainstreaming youth in a wide range of social concerns, including promotion of the culture of peace, poverty eradication, human rights and the fight against discrimination, the ethics of science and technology, bioethics, environmental ethics and ethics of climate change, philosophy, gender, human security, social development, dissemination of information, research and training. The Youth Peace Ambassador (YPA) Training Workshops and Youth Forum Looking Beyond Disaster (LBD)[3] are two training programs organized by Eubios Ethics Institute. Young people all over the world who are motivated to work for peace, or disaster prevention and recovery, are welcome to participate in the workshops. Participants review cross cultural aspects of peace education, human security, post-conflict reconstruction; ethics of science and technology; disaster prevention and recovery; and development of action plans. After the workshop and forum, participants then complete their own action plans as follow-up activity (as individuals or groups), and will receive certificates from UNESCO when they complete their action plans. The participants are expected to engage in activities in their own institutions and communities after the workshop or forum to promote peace or build youth resilience and disaster response through action, research and policy changes.

Up until now, five Youth Peace Ambassador International (YPA) Training Workshops and two Youth Forums Looking Beyond Disaster (LBD) have been held. Participants have formulated and implemented action plans varying from environmental protection, peace education, women's rights, poverty eradication, disaster recovery, HIV/AIDS, to human rights and refugees. Through making and implementing the various action plans, participants have had deeper understanding of social problems, have been more involved in decision-making, and are becoming young leaders of their societies.

Volunteer Interviews

This research examines youth volunteerism in Asia-Pacific through collecting and analyzing feedback on volunteerism questions from a select group of youth. At the time of writing there were 76 responses from 412 youth who were emailed. All the youth have once been a participant of Youth Peace Ambassador (YPA) Training Workshops or Youth Forums Looking Beyond Disaster (LBD). They were asked to reply on 30 November 2012, and reminded on 7 December 2012 and 18 January 2013.

The ten interview questions (sent by email) were:

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[2] UN, 2010. Regional Overview: The State of Youth in Asia and the Pacific. http://social.un.org/youthyear/docs/ESCAPFinal5.pdf

[3] Eubios Ethics Institute, Youth Peace Ambassadors and Youth Looking Beyond Disaster, http: ww.eubios.info

1. Please write your name, country, gender and age.
2. Do you consider yourself to be a volunteer?
3. How do you define the term "volunteerism"?
4. Have you done any volunteering work in the previous six months? If yes, how many hours on average did you spend on it each month?
5. What types of volunteering activities did you do in your life?
6. Were the volunteering activities performed through an organization or with a group of friends informally, or individually?
7. In your culture, how is volunteerism related to traditional values and community practices?
8. What's your motivation to become a volunteer? And what do you expect to acquire from volunteering actions? (Friendship, happiness, self-fulfillment, and etc.)
9. Would you like to get a paid job to continue your volunteer activities? Would you feel as much satisfaction in doing the activities?
10. Do you have any other comments?

Demographics

Question one asked participants' personal information like name, gender, age and nationality. Among the 76 respondents, 38 are female, accounting for 50% and 38 are male, making up the other 50%. Generally speaking, female are rated as more empathic and altruistic than males (Greeno and Maccoby 1993, cited in Wilson, J. and Musick, M. 1997: 697), related to their given role of maintaining the "public household". Taking this cultural role allocation into consideration, many researchers considered gender as a variable in volunteering. Some studies found that women are more likely to provide help than men (Hodgkinson and Weitzman 1992, cited in Wilson, J. and Musick, M. 1997: 697); others showed the opposite result (Hayghe 1991, cited in Wilson, J. and Musick, M. 1997: 698). Gallagher (1994) presented an interesting finding that men belong to more voluntary organizations but that they devote no more time to volunteering than do women. In this research, we received more male's responses than female's responses, yet this study's target group is youth, with no special attention on gender difference.

As for respondents' age, 50% are from 21 to 25 years of age, 29% from 16 to 20, 14% from 26 to 30, and 6% are older than 30 years old (Figure 1). The UN defines youth as those between the ages of 15 to 24. Therefore, about 80% of the participants are within the UN definition of youth and the rest except two (older than 40) were under 35 years old.

Figure 1: Respondents' age distribution
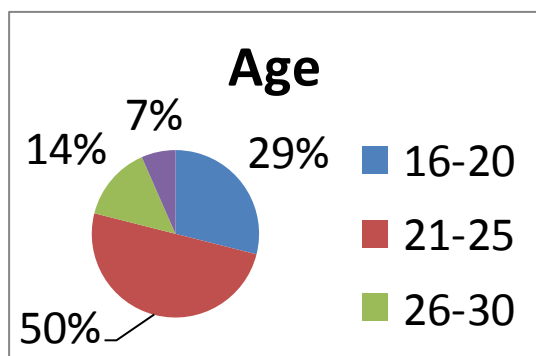
The 76 respondents come from 22 countries, including Australia(1), Brunei(1), Bangladesh(1), Cambodia(6), China(1), Indonesia(23), Iran(1), Japan(2), Lithuania(1), Micronesia(2), Mongolia(1), Myanmar(3), Nepal(2), New Zealand(6), Nigeria(1), Niue Island (1), Oman(1), Pakistan(4), Philippines(10), Thailand(4), Tonga(1), and Vietnam(3). All of them except Lithuania and Nigeria are Asia-Pacific countries.

Definitions of Volunteerism

Question two "Do you consider yourself to be a volunteer?" asked whether the participants considered themselves to be volunteers or not.

Table 1: Number of respondents who considered themselves to be a volunteer

Type	Number of respondents	% of total
Yes	70	92
Sometimes	4	5
No	2	3

As can be seen from Table 1, 92% of respondents wrote answers stating that they consider themselves to be volunteers. Four respondents thought that sometimes they are volunteers, and two did not consider themselves to be volunteers. Yet, for the two who didn't think they were volunteers, they still helped people, for example, one respondent's answer to this question was: "Nope, I don't. If someone needs my help, then I'll just help them."

Among the four who thought sometimes they were volunteers, two original answers were: *"At some stage where I can utilize my experience besides the work normally employed me.", "I only consider myself to be a volunteer when I spend my time helping others or areas in the community, such as running campaigns, fundraising for a cause etc. I attend youth forums out of interest and wanting to learn more about our world, so I do not consider myself to be a volunteer at youth forums."*

Since this paper looks at volunteerism from a broad perspective, believing that volunteerism refers to any unpaid work and time spent to offer a service to other people or groups, we could actually consider all of the respondents to be volunteers based on their answers and the broad definition of volunteerism.

Question three asked "How do you define the term 'volunteerism'?", and was an open response question.

Table 2: Definitions of the term "volunteerism"

Key phrases/ideas	Number of comments	% of total
1. Altruism, selfless	4	5
2. No expectation of return	40	53
3. Help society/people	44	58
4. Gain experience	6	8
5. Free will	10	13
6. Vague concept of help	11	14
7. Skills sharing	8	11
8. Social movement/ social responsibility	8	11
9. Save earth	1	1
10. Teamwork	5	7

11. Help without prejudice	1	1
12. Promote love/peace	4	5

Although different respondents have different definitions of volunteerism, the core values are more or less the same. "Help society/people", "No expectation of return", "Help", "Free will", "Skills sharing", "Social movement/social responsibility" and "Gain experience" are the most frequently appeared key words in their answers.

58% of the 76 respondents mentioned the key word "help society/people", such as,

"*Volunteerism is the practice of willingly using one's time and service (without payment) for the good of people/community who require it.*" (+No expectation of return)

"*What I feel about volunteerism is in 3 facts: You motivate to do some activities for your society…you don't expect any profit in doing this, but great experience and good chances are coming to you...*" (+No expectation of return; Gain experience)

"*I define volunteerism as a powerful means of engaging people in tackling solidarity, reciprocity for peace and development to give sustainability positive changes in society.*" (+Promote love/peace)

53% mentioned "help with no expectation of return" in their understanding of volunteerism, for example,

"*Volunteerism is giving your time for someone who needs help without expecting any benefits.*" (+ Help society/people)

"*Volunteerism is the act of being altruistic by helping others directly or indirectly, without wanting or expecting anything in return*".

"*Volunteerism is the willingness of people to work on behalf of others without the expectation of pay or other tangible gain.*"

14% of the respondents gave a vague concept of help for volunteerism, like,

"*…volunteering time to help in any capacity.*"

"*Voluntarism is simply doing something (an action) for the sake of improving something (an institution, a society, or a country, etc.) without being forced or even paid for the work.*" (+No expectation of return; Free will)

13% raised the idea of "free will", for instance,

"*I define the term of volunteerism as a feel free job but we can get the team spirit…*" (+Teamwork)

"*…the term volunteerism includes all those preparations, organizing and works which are done by a person without any kind of pressure that he must do the work…*"

Eight people believed they have the "social responsibility' to volunteer, such as *It is a social responsibility and without concern for monetary profit, do something from heart.*" (+No expectation of return)

Another eight would like to "share skills" through voluntary work, for example,

"*In my opinion volunteerism is a social movement that allows people to help others through the way of share and exchange their knowledge or experience with others.*" (+Social movement)

Six people mentioned "gaining experience", for example, "*Volunteerism is one of social work to gain our experience. It will train our ability to work in a team.*" (+Teamwork)

There were five people regarding volunteerism "will train our ability to work in a team". Four thought volunteers did activities to "promote love and peace and decrease pain and suffering in the world". One person mentioned "saving earth" and another mentioned "help without prejudice".

In the *2011 States of the World's Volunteerism Report*, the United Nations Volunteers (UNV) Programme has given three criteria of free will, non-pecuniary motivation, and benefit to others to assess whether an action is volunteerism or not. First, the action should be performed out of one's free will. The person shall not receive any kind of pressure, feeling that it's a must or an obligation. Second, the action should not be carried out for the purpose of monetary gain. And third, the action should directly or indirectly benefit others (usually people outside the family). It is clear to see that the key words most respondents listed are quite similar to the three criteria that UNV has given.

Figure 2: Time spent on volunteering work in the previous six months.
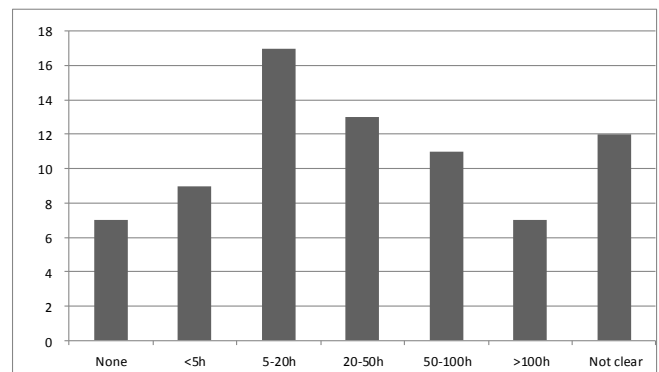
Frequency of Volunteering

Question four asked "Have you done any volunteering work in the previous six months? If yes, how many hours on average did you spend on it each month?" asked about the frequency of volunteering. Except for seven respondents, others more or less have done some volunteering work during the past six months (Figure 2). More than half of the 76 respondents volunteered 10 to 100 hours per month, among them, 17 spent 5 to 20 hours per month, 13 spent 20 to 50 hours, and 11 spent more than 50 hours. Seven respondents said they could volunteer more than 100 hours per month because they were working for NGOs. As for the "not clear" column (12 people), it's because the nine respondents didn't calculate their volunteering service hour.

Types of Volunteerism

Question five asked What types of volunteering activities did you do in your life?

Table 3: Types of volunteering work done by respondents

Types	Number of respondents	% of total
1. Education	32	42
2. Arts & culture	4	5
3. Environment protection	22	29
4. Animal protection	2	3
5. Fund-raising, donation and charity work	16	21
6. Disaster recovery and rehabilitation	20	26

7. Community service and social work	23	30
8. Advocacy work and campaigns	4	5
9. Children and youth development	20	26
10. Events/conferences organizing, training	17	22
11. Health program	10	13
12. Research	4	5
13. Helping vulnerable groups	14	18
14. Farm and agriculture work	2	3
15. Translation and interpreting	3	4
16. Media	2	3
17. General work/others	2	3

Respondents from different countries have done different volunteering activities according to the needs of their own communities and societies. Among those activities, there are several popular themes: Education (42%), Community service and social work (30%), Environmental protection (29%), Disaster recovery and rehabilitation (26%), Children and youth development (26%), Events/conferences organizing and training (22%), Fund-raising, donation and charity (21%), and Helping vulnerable groups (18%).

One of the respondents has been chosen to be part of the British Council's Global Changemakers, a global network of young people who have a significant track record as social entrepreneurs, community activists, and volunteers. At present, he is spearheading the "When I Was 20" campaign, a global action project implemented in several Asia Pacific countries supported by the British Council's Global Changemakers and YPA. This initiative aims to inspire and challenge young people around the world to be change makers in their own communities through social media and various grassroots activities.

Other volunteering activities like health program, research, organizing arts & culture events, advocacy work and campaigns, translation and interpreting, farm and agriculture work, media and animal protection were also performed by respondents. And one person mentioned that he did "any type within his capability".

Question six asked Were the volunteering activities performed through an organization or with a group of friends informally, or individually? Many respondents performed volunteering activities through all the three channels (Table 4); yet the way through organization (92%) is still the most common one. For instance, ten respondents mentioned they did volunteering work under university or school name, two mentioned Boy Scouting, one mentioned network like Global Changemakers network and several others performed volunteering activities through NGOs /NPOs such as Myanmar Egress organization, and CamYPA.

Table 4: Different ways to perform volunteering activities

Types	Number of respondents	% of total
1. Individually	52	68
2. With friends	52	68
3. Through organization	70	92

Values, Beliefs and Motivations

Question seven asked In your culture, how is volunteerism related to traditional values and community practices? The results are in Table 5.

Table 5: Relations between volunteerism and culture

Relations	Number of comments	% of total
1. Religion (general)	15	20
2. Specific terms/principles	17	22
3. Indigenous thought/traditional value (general)	15	20
4. Community practice (general)	24	32
5. New concept/not common	5	7
6. Collective activities organized by government	1	1
7. Others	5	7
8. Not stated/don't know	2	3

Asia-pacific cultures are deeply influenced by religions and collectivistic traditions. In all the main religions in the Asia-pacific area, Buddhism, Christianity, Hinduism and Islamism, and their religious doctrines and classics, the benefits of giving are highly appreciated. Sages from the religions are serving their people without any monetary reward. For example, the Buddha volunteered to teach the Dharma of liberation and spiritual enhancement for fifty years after he became enlightened. He said: "With wisdom and compassion as my plow, I grow the Bodhi seeds in the field of merits."[4] In Islamism, the dearest to Allah are those who are the most beneficial to people. Therefore, Muslims are strongly encouraged to make volunteerism an integral part of their lives, and to carry out their assigned duties in the best possible manner and with utmost integrity.[5] In China, although not a religious country, volunteerism has a strong cultural base on Confucian benevolence, Mohist universal fraternity, Daoist philanthropy and Buddhist leniency,

For religions, community work is a feature of their congregations. Usually, churches, gudjawaras, temples or mosques play an important role in supporting volunteerism, which, like religion, is deeply value-based. The religions in this region help make more people engaged in volunteer-based programs and provide participants with a strong sense of community belonging.

Modern western society is heavily individualistic whereas Asian cultures are largely collectivistic. In the past, people in the Asia-pacific region lived and worked together in small villages. In order to fight against natural disasters and survive, they usually applied their energy, skills, knowledge and resources in collective endeavors such as planting and harvesting, building flood defenses, or collecting firewood for mutual aid and benefit. For example, in Indonesia, there is a local word called "Gotong Royong", which means mutual aid that people work together to alleviate social problems. Another example is a Filipino concept called "Bayanihan", which means a spirit of communal unity or effort to achieve a

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[4] Volunteerism and Buddhism: http://www.blpusa.com/download/bies28.pdf
[5] Volunteerism In Islam: http://www.muslimahcompass.org/index.php?option=com_content&view=category&id=23&Itemid=32

particular objective. Therefore, even though "volunteerism" is a new-born word and may sounds new in some Asia-pacific countries (5 people mentioned), volunteering action in this region has been hundreds of years old. Just as UNV's description of volunteerism:

"Volunteerism is one of the most basic of expressions of human behavior and arises out of long-established ancient traditions of sharing and reciprocal exchanges. At its core are relationships and their potential to enhance the well-being of individuals and communities."

Question eight asked What's your motivation to become a volunteer? And what do you expect to acquire from volunteering actions? Among the various motivations to become a volunteer, there are four most common ones: Help society/people (46%), Moral obligation and social responsibility (22%), Learn more and gather experience (20%), and Self-fulfillment and own happiness (20%) (Table 6). Other motivations include religious reason, passion and interest, experience gaining, and belief in volunteerism. One respondent also mentioned that his family was disaster-affected, the damage gave him inspiration to do something and he chose volunteerism as the best weapon to tackle it.

With regard to expectations, most respondents expect to get friendship (41%), self-fulfillment (33%), happiness (29%), and self-improvement (26%) from volunteering actions. Two respondents also wanted to acquire inner-peace, and eight people didn't state what they expected (Table 6).

Question nine asked Would you like to get a paid job to continue your volunteer activities? Would you feel as much satisfaction in doing the activities? 48 out of 76 respondents replied that they would like to get a paid job to continue their volunteer activities, because they thought that would make them be able to do volunteering activities more efficiently without being less concerned on budget problems, and they felt delighted to be paid to do what they love (Table 7). Yet, they also agreed that financial gain is secondary when it comes to volunteer activities. There are also 25 respondents who said no to a paid job since they believe that by taking money those activities wouldn't be called voluntarism.

Table 6: Motivation and Expectation to do volunteering work

Motivations	Number of respondents	% of total
1. Multiply the act of volunteerism	2	3
2. Help society/people	35	46
3. Learn more and gain experience	15	20
4. Passion, interest	3	4
5. Moral obligation and social responsibility	17	22
6. Believing in the value of volunteerism	4	5
7. Self-fulfillment, own happiness	15	20
8. Religious reason	2	3
9. Was a victim	1	1
Expectations	Number of respondents	% of total
1. Complacency, self-fulfillment	25	33
2. Friendship	31	41
3. Self-improvement	20	26
4. Happiness	22	29
5. Inner peace	2	3
6 Not stated	8	11

Table 7: Percentage of respondents who want a paid job for volunteering work

Types	Number of respondents	% of total
Yes	48	63
No	25	33
Not clear	3	4

Discussion

This study examined 76 Asian-Pacific youth's opinions on volunteerism, asking about their definitions of volunteerism, the frequency of volunteering, types of voluntary work they did and their values, beliefs and motives related to volunteerism. The respondents to this research were basically Asian-Pacific youth, and the sample was of gender balanced (50% female and 50% male). The sample comprised replies from 20 Asian-Pacific countries; and represented more of the South-East Asia (66%). There were only two responses from China and none from India. The sample also couldn't well represent the situation in the Middle East and the Central Asia. That was probably because there were not many YPA and LBD trainees coming from those sub-regions.

According to our broad definition of volunteerism, we considered all the respondents to be volunteers. The respondents' definitions of volunteerism could be generally summarized into several key phrases: "No expectation of return", "Help society/people", "Free will", "Skills sharing", and "Gain experience" (Table 2).

Among the various definitions of volunteering around the world, there are three or four common elements: non-obligatory; for the benefit of others; unpaid; and, somewhat less common, performed through an organization, which are similar to the key words seen in the responses given by the 76 respondents. Yet even the most common criteria are sometimes controversial. First, the element of being non-obligatory is often being questioned. There are situations requiring voluntary work that an individual can hardly refuse, such as community service as an alternative for imprisonment, voluntary work through which students can get credits for their study or gain experiences for their future job-hunting. For example, the IB (International Baccalaureate) requires their students to do 150 hours of activities related to creativity and community service in the diploma program (16-19 years of age). [6]

In the former socialist countries of Central and Eastern Europe, there existed "obligatory voluntary work", a state and party requirement to contribute time and efforts freely for some common social, cultural, or political cause (Anheier & Sakamin, 1999). The same was true in the past elementary and middle schools in China.

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[6]Retrieved from IB official website: http://www.ibo.org/

Voluntary work is not totally for the benefit of others, it can also be performed out of self-interest, such as to make new friends, to gain experience, or to enjoy the satisfaction of seeing the results of their work. Moreover, the parameter of being unpaid is also not entirely straightforward. From reimbursements of expenses to in-kind compensation, volunteers more or less get paid. Finally, in recent years, unorganized, informal volunteering activities have developed rapidly and are gaining acknowledgment. These controversial arguments drove this study to go further and explore deeper on volunteerism.

Question four was about the frequency of volunteering, asking about the time spent on voluntary work by respondents in the previous six months. As readers have realized the time spent in volunteering hour varies widely (Figure 2), and may wonder why there is so much variation. That could because many respondents actually didn't have the awareness of measuring their volunteering work, and could only provide an approximate time spent. However, it is interesting to find a measure of volunteerism, for both individual volunteers and volunteer-based organizations.

For individual volunteers, documenting the time and efforts helps to gain recognition and to encourage more engagement. Besides, others may be motivated to participate when they see the contribution of volunteer action and appreciate that volunteering is a normal part of civic engagement. For volunteer organizations, measurement helps facilitate their programs, increase accountability and enhance their management by providing first hand data and figures. For example, some penal systems require community service as punishment, and this should be a fair system.

Moreover, on a national level, reliable data helps to make governments realize the social and economic value that volunteerism creates, and may facilitate governments to factor volunteerism into decision-making.

Types of volunteerism were examined in question five and six. The collected data showed that respondents did different volunteering work varying from education, community service, children and youth development, environmental protection, disaster recovery and rehabilitation to translation and interpreting, according to the needs of their communities and societies. These voluntary activities were performed through both formal organized voluntary work and informal volunteering help as individuals or with friends.

Some scholars argued that connecting to formal organizations should also be regarded as a parameter of volunteerism. As a matter of fact, a large number of empirical studies are concerned with volunteering activities performed through formal organizations. Gaskin and Smith (1997, cited in Anheier, H. K., and Salamon, L. M. 1999: 53) found a strong relationship between membership and volunteering: Sixty percent of all volunteers were members of the organizations in which volunteering take place. In Wilson and Musick's (1997) study, they believed that to a varying degree, volunteer work involved collective action. They also distinguished formal volunteering and informal volunteering, explaining that "formal volunteering was typically carried out in the context of organizations; informal volunteering (helping friends, neighbours, and kin living outside the house-hold) was more private and none-organized. Obligation

exerted a more powerful influence on informal helping than it did on formal volunteer work". Putnam (1995) mentioned social ties, which included friendship network and organizational memberships, and could supply information, foster trust, make contacts, provide support, set guidelines, and create obligations. They made volunteer work more likely by fostering norms of generalized reciprocity, encouraging people to trust each other, and amplifying reputations.

Since most formal and well-structured organizations were founded in the Western world, this means people have formed the idea that volunteerism originated from the Western countries or developed countries. That notion also contributed to several respondents' comments that the term of volunteerism was a new concept in their countries when comes to the next category which concerned about values, beliefs and motivations.

Clary et al. (1998) proposed a six-factor model for the motivational functions of volunteerism, which were Values, Understanding, Enhancement, Protective, Social and Career. The values function measured a person's altruistic and humanitarian motives for volunteering. The understanding function was related to the motivation to use skills, as well as to develop new skills and perspectives. The enhancement function was a measure of the motivation to develop a positive effect by growing psychologically. The protective function used volunteer work to reduce negative feelings, such as guilt or to manage personal problems. The social function was about how to strengthen one's social relationships. Lastly, the career function was to gain career-related experience through volunteering activities.

Volunteers were motivated by different functions at different levels of experience. In general, values and social functions increased with experience while career function was less important for volunteers with more experience. Since experience was largely related to age, and older people usually had more experience than younger people, it was understandable that young volunteers placed more importance on career, understanding and protective functions (Davila & Diaz-Morales, 2009).

Although Clary et al. (1998) said that values were the most important motivator across all the demographic groups, in this study the motivations were more mixed, and values is not simply altruism or humanitarianism. The religious and cultural beliefs and their values of giving have laid the foundation for people in the Asia and Pacific region to serve others. The need to satisfy these values was posited as a reason for higher level of volunteerism among religious believers (Garland et al. 2008).

Besides religious beliefs and traditional cultural values, young people in Asia-Pacific also have their own motivations and expectations from voluntary work. Referring to Baker's framework (1993, cited in Anheier and Salamon, 1999: 56), Anheier and Salamon (1999) identified three motivational factors for volunteerism: altruistic, instrumental, and obligatory. Altruistic motives include notions of a sense of solidarity for the poor, compassion for those in need, identifying with suffering people, and giving hope and dignity to the disadvantaged. Instrumental motives were defined as a desire to gain new experience and new skills, to do

something worthwhile in one's spare time, to meet people, and personal satisfaction. Finally, obligation motives include moral and religious duty, contributing to the local community, repaying debt, and a political duty to bring about change.

Motivations and expectations rarely occur in isolation, and different combinations could be found among them. The factor that bound these motivations in the past was religiosity. However, the willingness to volunteer is not constant over time and the stage of life a person is in. Individualization and secularization are redefining volunteering. Today, volunteering seems less linked to religion. Instead, it is tied more too specific needs, self-interest, and greater individual choice. This phenomenon is especially obvious among young volunteers. Serow's (1991) study showed that student respondents regarded service as an opportunity to benefit themselves as well; some of the respondents saw community service as a vehicle for developing skills and gaining experience for their future career. In this study, besides "helping society/people", "learning more and gathering experience", "self-fulfillment and own happiness" were also frequently mentioned by respondents when talking about their motivations to volunteer. In this study, one respondent wrote that, "My motivation to be a volunteer is that I need experience in any kind of field. By joining organization we will find more friends, we will know more…" If we compare Table 6, we see that only two respondents mentioned religious reason as their motivation.

Question nine asked respondents whether or not they would like to get a paid job to continue their volunteer activities, and more than 60% of the respondents said yes. To some extent, this question was related to the previous question about motivation and expectation. As has been mentioned before, Serow (1991) concluded that for student volunteers, altruism might be less important than occupational goals and personal relationships in motivating volunteer activity. Even though young people didn't expect any monetary reward from volunteering work, they still hoped to get themselves benefited from doing so. People today, especially the younger generation, are gradually rethinking the role of volunteering and the role of paid work, community service and social responsibilities. Some researchers like Jeremy Rifkin and Ulrich Beck (cited in Anheier and Salamon, 1999: 47) suggested that volunteering work should be elevated to a status equal to paid work, and encouraged to establish some form of social credit system for those doing volunteering work or community service. Once the system established, volunteers could earn "social dollars" which could be spent on their health, educational, or retirement benefits.

The survey shows a strong interest in volunteerism. Four respondents asked for future volunteer activities, for example, one respondent hoped that YPA6 could be held in Myanmar, another said he was looking for an opportunity to be a UN medical volunteer in some conflict areas. Some others (26%) wrote that they were trying to increase volunteerism, and gave very inspiring comments, like "Volunteerism is like opening the door of another world where you can find love and happiness…" "Volunteerism should be one option to change the world from a local act." Six presented problems they faced. Several respondents mentioned the financial problem,

saying that "…only those with financial ability could make it sustainable." One respondent remarked that "Volunteerism should not be commercialized or manipulated by governments." A few (8) specifically said they were motivated by the survey, one respondent commented that "these questions made me want to go out and do some volunteerism activities right now."

Conclusions

Through collecting and analyzing YPA and LBD trainees' opinions and experiences of volunteerism, this research tries to explore the benefits and meaning of volunteering from young people's perspective. The research on this topic is still at an early stage and needs to be intensified. Yet we hope this research can help more young people around the world realize the beauty of volunteerism, get involved in volunteering services and finally make volunteerism a way of life.

References

Anheier, H. K., and Salamon, L. M. 1999. Volunteering in Cross-National Perspective: Initial Comparisons. *Law and Contemporary Problems*, Vol. 62, No. 4, pp. 43-65.

Clary, E. G., Snyder, M., Ridge, R. D., Copeland, J., Stukas, A. A., Haugen, J., and Meine, P. 1998. Understanding and assessing the motivations of volunteers: A functional approach. *Journal of Personality and Social Psychology*, Vol. 74, No. 6, pp. 1516-1530.

Cnaan, R. A., Handy, F., and Wadsworth, M. 1996. Defining who is a volunteer: Conceptual and empirical considerations. *Nonprofit and Voluntary Sector Quarterly*, Vol. 25, No.3, pp.364-383.

Davila, M. C., and Diaz-Morales, J. F. 2009. Age and motives for volunteering: Further evidence. *Europe's Journal of Psychology*, Vol. 5, No. 2, pp.82-95.

Ellis, S. J. and Noyes, K. H. 1990. *By the people.* San Francisco: Jossey-Bass.

Gallagher, S. K. 1994. Doing Their Share: Comparing Patterns of Help Given by Older and Younger Adults. *Journal of Marriage and Family*, Vol. 56, No. 3, pp. 567-578.

Garland, D. R., Myers, D. M., and Wolfer, T.A. 2008. Social work with religious volunteers: Activating and sustaining community involvement. *Social Work*, Vol. 53, No. 3, pp.255–265.

International Federation of Red Cross and Red Cresent (IFRC). 2011. *The value of volunteers: Imagine how many needs would go unanswered without volunteers.* Geneva, Switzerland: IFRC.

Jenner, J. R. 1982. Participation, leadership, and the role of volunteerism among selected women volunteers. *Journal of Voluntary Action Research*, Vol. 11, No. 4, pp.27-38.

Putnam, R. 1995. *Bowling Alone: The Collapse and Revival of American Community.* New York: Simon and Schuster.

Serow, R. C.1991. Students and Voluntarism: Looking into the Motives of Community Service Participants. *American Educational Research Journal*, Vol. 28, No. 3, pp. 543-556.

Shure, R. 1991. Volunteering: Continuing expansion of the definition and a practical application of altruistic motivation. *Journal of Volunteer Administration*, Vol. 9, No. 4, pp. 36-41.

Wilson, J. and Musick, M. 1997. Who Cares? Toward an Integrated Theory of Volunteer Work. *American Sociological Review*, Vol. 62, No. 5, pp. 694-713.

Wilson, J. 2000. Volunteering. *Annual Review of Sociology*, Vol. 26, No.1, pp. 215-240.

Wong, C. M., and Foo, K. H. 2011. Motivational Functions, Gender, Age and Religiosity Influences on Volunteerism: A Singapore Volunteer Organisation Perspective. *Journal of Tropical Psychology*, Vol. 1, pp. 31-44.

United Nations (UN). 2010. *The Millennium Development Goals Report 2010.* New York: UN.

UN General Assembly. 2005. *Report of the Secretary-General: Follow-up to the Implementation of the International Year of Volunteers.* New York: UN.

United Nations Volunteers (UNV). 2002. *Volunteerism and capacity development: Research report.* Bonn, Germany: UNV.

United Nations Volunteers (UNV). 2003. *MDG and volunteerism.* Bonn, Germany: UNV.

United Nations Volunteers (UNV). 2011. *State of the world's volunteerism report—Universal values for global well-being.* Bonn, Germany: UNV.

Ethics and Legality of Euthanasia in Indian Context

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Abstract

The judgment of Aruna Shanbaug case in the Supreme Court of India suggests that passive euthanasia can be considered legal, whereas active euthanasia may not be. In this paper, we try to explore why active euthanasia can also be considered legal. The paper takes the help of the judgment on Aruna Shanbaug's case on euthanasia. Active euthanasia can be as much ethical as passive euthanasia. In this paper we try to address this issue by giving arguments for and against active euthanasia and conclude that arguments against active euthanasia can be refuted and subsequently one can think of accepting active euthanasia as well within the fold of legalized euthanasia.

Keywords: active euthanasia, passive euthanasia, Singer, killing, letting die.

This paper tries to explore the ethical and legal issues pertaining to euthanasia. In this paper, an attempt is made to critically analyze the arguments for and against euthanasia. The paper concludes by making a claim that legality for active euthanasia can be considered as it can be argued that it is ethical.

Recently, in the Aruna Shaunbaug case for euthanasia, the Supreme Court of India gave a verdict that allowed passive euthanasia to be considered legal. The Supreme Court verdict on 7th March 2011 was a landmark judgment with respect to the issue of euthanasia or mercy-killing. Aruna Shanbaug is lying in a vegetative state for 37 years in a Mumbai hospital. The King Edward Memorial hospital and Aruna's friend Ms Pinky Virani were the two parties for the said case. The judgment was centered in the following question, "who is best friend or next friend of Aruna Shanbaug? Who is nearer to Aruna Shanbaug? Regarding KEM hospital as the next friend of Aruna Shanbaug in judgement it is argued that,

It is thus obvious that the KEM hospital staff has developed an emotional bonding and attachment to Aruna Shanbaug, and in a sense they are her real family today. Ms Pinky Virani who claims to be the next friend of Aruna Shanbaug and has filed this petition on her behalf is not a relative of Aruna Shanbaug nor can she claim to have such close emotional bonding with her as the KEM hospital staff. Hence, we are treating the KEM hospital staff as the next friend of Aruna Shanbaug and we decline to recognize Ms.Pinky Virani as her next friend. No doubt Ms.Pinky Virani has written a book about Aruna Shanbaug and has visited her few times, and we have great respect for her for the social causes she has espoused, but she cannot claim to have the extent of attachment of bonding with Aruna which the KEM hospital staff, which has been looking after her for years, claims to have. (Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 2009).

The judgment was a matter of discussion for many a reason. For instance, regarding the issue of whether Ms Pinky Virani can be the person to file a case on behalf of Aruna Shaunbag, the main issue in this case, Rakesh Shukla takes up the issue of guardianship. Rakesh Shukla in his article, "Is the 'Next Friend' the best Friend" writes,

The Supreme Court's ruling in the Aruna Shanbaug euthanasia case seems to be solely based on the views of the nursing staff of the Mumbai hospital who have been looking after her. It totally ignores the patient's interests and turns on the legal concept of "next friend". This concept is in the context of a person who is unable to maintain a suit on her own behalf due to disability and is akin to a "guardian" legally representing a "minor". The Court considered the nursing staff to be Shanbaug's "next friend". The total denial of recognition of the right to autonomy and self-determination of a person incompetent to consent, and the usurpation by guardians or the State of determining the best interests of the patient is a hazardous course of action (Shukla, 2011).

We will try to focus on the ethical and legal aspects of euthanasia with respect to that case. As mentioned the court considers passive euthanasia as legal, whereas it defers the issue of active euthanasia, though it mentions about the issue. The judgment mentioned that.

Active euthanasia is a crime all over the world except where permitted by legislation. In India active euthanasia is illegal and a crime under section 302 or at least section 304 IPC. Physician assisted suicide is a crime under section 306 IPC (abetment to suicide). (Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 2009)

The court also tries to come up with reason as to why active euthanasia is considered illegal. It further says in this regard, "Why active euthanasia need to be considered illegal? "…An important idea behind this distinction is that in "passive euthanasia" the doctors are not actively killing anyone; they are simply not saving him" (Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 2009). The Supreme Court acknowledges the issue involved in active euthanasia but defers deliberating on that issue. It says, "thus, proponents of euthanasia say that while we can debate whether active euthanasia should be legal, there can be no debate about passive euthanasia:" (Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 2009).

Though the Supreme Court has categorically said that there can be no debate about passive euthansia, still, one has to accept that there are quite good number of thinkers who do not accept euthanasia of any form and there are quite a good number of countries that have not legalized euthanasia. But, since the court has already given the opinion that it favoured euthanasia, at least, in this case a non-voluntary passive euthanasia, we shall not go into the details of that. Rather, we would like to deliberate on that issue that has been deferred by the Supreme Court. If passive euthanasia is accepted, why can't active euthanasia be accepted as well? Is there any moral differnece between active and passive euthanasia? We will try to address these issues in this paper.

Before discussing these questions we would like to give a clear picture of euthanasia. Euthanasia is generally defined as the intentional killing by act or by omission of a dependent human being for removing his or her

suffering. The word euthanasia is a Greek word and it literally means 'good death'. Helga Kuhse in her article 'Euthanasia' writes that there are two features of the acts of euthanasia: 1. Euthanasia involves the deliberate taking of a person's life. 2. That life is taken for the sake of that person who is suffering from an incurable or terminal disease." (Singer, *A Companion to Ethics,* 1994, p. 294). Considering the definition of euthanasia Singer writes, "Euthanasia means,according to the dictionary, 'a gentle and easy death', but it is now used to refer to the killing of those who are incurably ill and in great pain or distress, for the sake of those killed, and in order to spare them further suffering or distress." (Singer, 1993, p. 175).

In order to analyze further, we can classify euthanasia into different types on the basis of the consent and on the basis of the action. On the basis of consent, that is, whether the patient is consenting or capable of consenting to death, we can differentiate euthanasia into three types – voluntary, non-voluntary and involuntary euthanasia. If a person has consented to die, then it is called as voluntary euthanasia. It is "carried out at the request of the person killed." (Singer, 1993, p. 176). If the person doesn't want to consent or he/she is not being asked of their consent, then it is called as involuntary. Peter Singer defines involuntary euthanasia as "when the person killed is capable of consenting to her own death, but does not do so, either because she is not asked, or because she is asked and chooses to go living." (Singer, 1993, p. 179) As this brazenly amount to murder, hardly any ethicist subscribes for involuntary euthanasia. If a human is not capable of consenting, then it is called as non-voluntary. (Aruna Shanbaug's is of non-voluntary type) Regarding non voluntary euthanasia Singer writes,

If a human is not capable of understanding the choice between life and death, euthanasia would be neither voluntary nor involuntary, but non voluntary. Those unable to give consent would include incurably ill or severely disabled infants, and people who through accident, illness, or old age have permanently lost the capacity to understand the issue involved, without having previously requested or rejected euthanasia in these circumstances (Singer, 1993, p. 179).

For removing the intense suffering of a person Peter Singer justifies euthanasia particularly voluntary and non voluntary euthanasia. According to Peter Singer euthanasia can be justified in two grounds – voluntary, where the patient has the capacity to choose between life and death and makes an informed decision to die and the other is non-voluntary, where the patient do not have the capacity to understand the choice between continued existence and non-existence and therefore lack the ability to consent to death. (Singer, 1993, p. 201).Along with Singer, there are some other thinkers as well who subscribe for euthanasia. Singer justifies euthanasia from preference utilitarianism standpoint. James Rachel's (1941-2003) views concerning euthanasia are same with the view of Peter Singer. Rachel has given arguments for euthanasia from mercy and from the golden rule.Though Peter Singer and James Rachel's views regarding euthanasia are same their accepting methods are different.

According to the way the euthanasia is practiced, it can be further classified into active and passive euthanasia. In the judgment of Aruna Shanbaug's case active euthanasia and passive euthanasia is defined as: *"Active*

euthanasia entails the use of lethal substances or forces to kill a person e.g. a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment for continuance of life, e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart lung machine, from a patient in coma" (Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 2009).

We need to make these classifications in order to see which forms of euthanasia is justified and which are not. This is more meaningful than the outright rejection/acceptance of euthanasia without making these classifications. When we combine the consent part (voluntary and non voluntary) of euthanasia with the implementation part of euthanasia we get the following combinations.

1. Active voluntary euthanasia
2. Passive voluntary euthanasia
3. Active non voluntary euthanasia
4. Passive non voluntary euthanasia

Among these different kinds of euthanasia, Aruna Shanbaug's case is of the fourth type, which is non-voluntary passive euthanasia. The Supreme Court of India has given approval for this type of euthanasia.

The ethical issue pertaining to euthanasia broadly comes from two different viewpoints - 1. the conservative's view. 2.The liberal's view.

The conservatives argue that euthanasia is morally wrong, because it is contrary to natural law, or against the commandments of God. It violates God's absolute dominion over human life. They appeal to the principle of 'sanctity of human life' and say that the intentional termination of innocent human life is always immoral'' (Satyanarayana, 2010).Regarding liberal view we can mention that, "the liberals maintain that euthanasia is morally acceptable for the reason that it provides an end to the horrible pain and suffering of terminally ill patients. They argue that it is cruel and inhuman to refuse the plea of a terminally ill patient that his or her life be mercifully and peacefully ended to avoid further suffering and dignity (Satyanarayana, 2010).

The Supreme Court in its judgment has taken a liberal standpoint while addressing the issue of euthanasia though it also acknowledged the conservative position in this regard. There are a good number of thinkers who still argue against euthanasia from the Kantian or utilitarian perspectives. Some thinkers who argue against euthanasia are: J Gay Williams, Richard Brandt (1910-1997), Jean Davies, Christopher James Ryan, Grant Gillett (1988), Neil Campbell (1999). As the Supreme Court have already acknowledged one or the other form of euthanasia as legal, we shall not take up those conservatives arguments that go against any form of euthanasia as unethical. Suffice is to say that the conservative arguments that springs from Divine Command theory or Kantian theory or the Utilitarian theory can be countered with suitable counter-arguments.

We shall go one step further to explore why active euthanasia can also be considered when we contemplate on legalizing euthanasia? We would like to deliberate on this issue further with the hope that if the Supreme Court has acknowledged that euthanasia, particularly passive euthanasia can be considered as legal, it can also

consider accepting active euthanasia. The grounds on which it accepted passive euthanasia can be extended and other arguments can be given to support the case of active euthanasia as well. Hence, we try to come up here with more arguments and counter-arguments pertaining to active euthanasia.

Peter Singer, a thinker on ethical issues from a utilitarian standpoint, maintains that euthanasia can be justified as it helps one to annihilate one's pain. In this case, the annihilation of oneself is the process of getting away from one's pain and Singer justifies such an act to be an ethical one. Now, if the issue is to make a suffering being to get rid of one's pain, then, in that case, according to Singer both active and passive euthanasia is justified. For that matter, both Singer and Rachel have justified both active and passive euthanasia. Rachel says, *"Part of my point is that the process of being "allowed to die" can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless"* (Rachel, 1975).

As mentioned in the above paragraph, Singer and Rachels both subscribe to active euthanasia. According to James Rachel there is no moral distinction between active and passive euthanasia James Rachel says, *"I argued against the traditional view, that there is in fact no moral difference between killing and letting die-if one is permissible, then so is the other"* (Rachel,1994) We have already mentioned that ethicist like Peter Singer and James Rachels, there is no intrinsic distinction between active euthanasia and passive euthanasia. Though some ethical thinkers like Singer and Rachels do not find any difference between active and passive euthanasia, still, some others do feel that there is a difference between them. We would like to discuss three of the prominent arguments against active euthanasia.

One of them is of the nature of slippery slope argument type. The slippery slope is a type of an argument that includes different course of implications while we take up the initial position and try to argue that the initial position that we have taken is given to discussion and hence cannot be taken in its face value. R.G. Frey has written about Slippery Slope argument which can be applicable to active euthanasia also**,** *"take step A, and we shall be led to take steps B and C. Step A takes us out onto the slope; steps B and C take us down it. In this form, a slippery slope argument is consequentialist in character: the consequences of taking step A are that we shall take steps B and C. This matter is one of probability, however, so that we need to believe it likely or probable that we shall take steps B and C. For if this probability is low or remote, then fear of steps B and C may recede and step A may be taken; if, however, this probability is high, then the fear of steps B and C may well prevent us from granting the permissibility of step A, even if on other grounds it has passed moral muster"* (Frey, 1998, p. 44).Krupa and Nikunj argued, *"Legalizing voluntary active euthanasia can be very dangerous for society if a party with vested interests intends to misuse it. A terminally ill person is not in the best state of mind to take a decision if he/she should die or not. If legalized, voluntary active euthanasia is likely to be misused by those not suffering from any terminal disease but are psychologically depressed and don't want to live."* (Young Minds Debate Euthanasia, 2011). The same argument can be taken against active non-voluntary euthanasia. Again in the

case of non voluntary active euthanasia, it can also be misused. Non voluntary active euthanasia may also lead to the incidents of murder. The slippery slope argument can be taken as valid or as fallacious argument. We try to propose that slippery slope argument for active euthanasia need not be taken as valid argument unless and until it is well substantiated that probability of the supposed grave consequences to follow is high. At the same time, as the same slippery slope argument is given to euthanasia and as the court has overlooked the argument, by giving verdict in favor of euthanasia, we try to conclude that we can use the same logic for favoring active euthanasia as well.

Betty Kitchener and Anthony F Jorm in their article "*Conditions required for a law law on active voluntary euthanasis: a survey of nurses' opinions in the Australian Capital Territory''* (1999) presented that, to find out in which conditions nurses believe should be in a law allowing acive voluntary euthanasia made a questionnaire survey among the registered nurses. The authors concluded that,

Given the lack of support for some conditions included in proposed AVE laws, there needs to be further debate about the conditions required in any future AVE bills…Although the public have been clearly in favour of changing the law, the members of the lower and upper houses of the Australian federal parliament have not.To what extent should parliamentarians reflect the will of the people. (Kitchener & Jorm, 1999).

Though the cases or empirical studies that we referred to do not pertain to Indian scenario, but, still, the results drawn up from similar study in other countries and culture suggests that there is a good amount of support for voluntary active euthanasia amongst the people, though the parliamentarians have other perspective. While it can be argued that in Indian context, the responses may be different as Indian culture is somehow related to religion and every religion, in one or the other sense, suggests that killing is wrong and as active euthanasia is concerned with direct killing of a patient, it might not be the case that Indians may accept active euthanasia. This argument needs to be tested with the ground realities to subscribe to this position and hence we can say that till it is supported by sufficient empirical study, we cannot conclude that Indians may not be accepting active euthanasia.

The other argument related to euthanasia that can be extended to active euthanasia is that there is always a Chance of getting person cured if we allow him to live and hence there need not be any urgency in to give active euthansia – against this, Singer's argument the worst scenario in Singer's that even some cases go wrong, overall consequences is better.Singer writes,

Against a very small number of unnecessary death that might occur if euthanasia is legalised we must place the very large amount of pain and distress that will be suffered if euthanasia is not legalised,by patients who really are terminally ill.Longer life is not such a supreme good that it outweighs all other considerations. (Singer, 1993, p. 197)**.**

The supreme court's argument that passive is omission, whereas active is commission and in that case it may amount to murder. Moreover their argument that if doctor withholds life saving devices he cannot be found guilty, but, if he injects the lethal medicine, then he may found guilty. This can be argued against by saying that if the aim is to lessen the suffering of patients, then both can be accepted. In this regard we can quote one of Singer's relevant quotation *"…omitting to give antibiotics to a child with pneumonia may have consequences no less fatal than giving the child a lethal injection.Which approach is right? I have argued for a consequentialist approach to ehics. The acts/omissions issue poses the choice between these two basic approaches in an unusually clear and direct way…Having chosen death we should ensure that it comes in the best possble way."* (Singer, 1993, p. 207)

Singer supports both active and passive euthanasia, saying that there is no intrinsic difference between active and passive euthanasia, *"Passive ways of ending life result in a drawn-out death. They introduce irrelevant factors…….into the selection of those who shall die. If we are able to admit that our objective is a swift and painless death we should not leave it up to chance to determine whether this objective is achieved. Having chosen death we should ensure that it comes in the best possible way."* (Singer, 1993, p. 213)

H.J.Gensler says, *"This is especially clear in his discussion about the difference between killing and letting-die. Most non-consequentialists say that,…while it is wrong to kill a defective infant (for example by poisoning it), it is not necessarily wrong to just let it die (for example by refusing to perform an extraordinary operation needed to save its life). Singer disagrees; he sees killing and letting die as morally equivalent, since both have the same result…Singer's consequentialist approach says that the two acts, which have the same result are morally equivalent."* (Gensler, 2009, p. 169)

There are many arguments against euthanasia (is also applicable for active euthanasia) and one of these arguments is from care ethics. Critics say that through palliative care one may waive his or her wish to die. In this regard Singer says, *"Ensure that candidate for euthanasia sees a palliative care specialist. If every patient then ceases to ask for euthanasia, both proponents and opponents of voluntary euthanasia will be pleased. But that seems unlikely. Some patients who want euthanasia are not in pain at all. They want to die because they are weak, constantly tired, and nauseous, or breathless. Or perhaps they just find the whole process of slowly wasting away undignified. These are reasonable grounds for wanting to die."* (Singer, 2003).

Stephen Orlando in his article "An argument for the legalisation of Active Euthanasia"writes, *"One principle in support of active euthanasia is the right to self-determination.The principle of self-determination has been affirmed as far back as early English Law. In the 1960 case Nathason V.Kline, Kanas Supreme Court Justice Alfred Schroeder reaffirmed the principle of self determination when he declared that all individuals are masters of their bodies and have the right to decide what will be done with their bodies, including what medical treatment they will authorize or prohibit. Individuals have a right to choose their own treatment and act as the judge of their own best interest.."* (Orlando, 2010)

The author says that, *"Active euthanasia is simply a more merciful and compassionate extension of passive euthanasia.The distinction between legalized passive euthanasia and illegal active euthanasia is illusory.''* (Orlando, 2010).

The Supreme Court has come up with a landmark judgement in Aruna Shaanbaag case taking into consideration the earlier similar and related cases. The court also acknowledges that it is a difficult issue to tackle and at the same time we should be ready to tackle it.

In Gian Kaur's case (supra) the Supreme Court approved of the decision of the House of Lords in Airedale's case (supra), and observed that euthanasia could be made lawful only by legislation. ...It may be noted that in Gian Kaur's case (supra) although the Supreme Court has quoted with approval the view of the House of Lords in Airedale's case (supra), it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS. This vexed question has been arising often in India because there are a large number of cases where persons go into coma (due to an accident or some other reason) or for some other reason are unable to give consent, and then the question arises as to who should give consent for withdrawal of life support. (Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 2009)

It is a vexed question and it remains so as to who should give consent for life support withdrawl. Similarly, it can also be a vexed question as to how to engage in that act, is it done through omission or through commission? But at the same time, it should also be faced as these sorts of questions are inevitable in the moral and legal realm. Here, through our perception we try to acknowledge the need for alleviating suffering of the patients and hence try to argue for considering as ethical the act of active euthanasia as well.

References

Ethical Principles of psychologists and code of conduct. (n.d.). Retrieved March 2011, from http://www.apa.org/ethics/code/index.aspx

Frey, R. (1998). The Fear of a Slippery Slope. In G. Dworkin, R. Frey, & S. Bok, *Euthanasia and Physician-Assisted Suicide* (pp. 43-63). United States of America: Cambridge University Press.

Gensler, H. (2009). Singer's Unsanctity of Human Life: A Critique. In J. Schaler, *Peter Singer Under Fire* (pp. 163-184). United States of America: Carus Publishing Company.

Kitchener, B., & Jorm, F. (1999). Conditions Required for a Law on Active Voluntary Euthanasia:A Survey of Nurses' Opinions in the Australian Capital Territory. *Journal of Medical Ethics* , 25-30.

Orlando, S. (2010, January 4). An Argument for the Legalisation of Active Euthanasia. *Annual Celebration of Student Scholarship and Creativity* , pp. 1-27.

Rachel, J. (1975). Active and Passive Euthanasia.

Satyanarayana, Y. (2010). *Ethics:Theory and Practice.* New Delhi: Dorting Kindersley.

Shukla, R. (2011, April 30). Is the 'Next Friend' the Best Friend. *Economic and Political Weekly*.

(1994). In P. Singer, *A Companion to Ethics.* Oxford: Blackwell.

Singer, P. (2003, Dec 2003). *Social Science Research Network*.

Singer, P. (1993). *Practical Ethics.* United Kingdom: Cambridge University Press.

Supreme Court's Judgment on Aruna Shanbaug Euthanasia, 115 (The Supreme Court Of India March 7, 2009).

Young Minds Debate Euthanasia. (2011, September 30). *The Times of India* .

A Framework for Advancing Health Equity in Pakistan

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Health has an important role fundamental to human life and liberty. The United Nations recognizes that the enjoyment of the highest attainable standard of health is a fundamental right of all people.

Unlike equality, the word equity has a moral and ethical dimension. It has to do more with values like fairness and is central to the concept of distributive justice. Equity in health means that people's needs rather than their social positioning or social class guide the distribution of opportunities for their well-being (WHO, 1996). Similarly, inequality is not necessarily unfair in all circumstances. On the other hand inequity is a term that almost invariably signifies 'a subset of inequalities that are deemed unfair' (WHO, 1996) Inequity refers to differences that are 'unnecessary' and 'avoidable' (WHO, 1996). What makes these differences unfair and unjust is the fact that they are avoidable. To pursue health equity it is necessary to try to reduce these avoidable gaps in health status and health services. The aim should be to eliminate the health disparities that are systematically associated with underlying social disadvantage. Even though health care providers and policy makers understand the significance of health equity but the real challenge is how to achieve it.

Whitehead, Dahlgren and Gilson describe equity objectives as being of two types: Symbolic, whose main purpose is to inspire and motivate (e.g. human rights protection, etc.) and Action/practical targets which help monitor progress toward equity and to improve accountability in the use of resources (Evan, et al., 2001). A framework for health equity in Pakistan should include both objectives in order to be successful.

This paper attempts to identify a series of steps that should be taken to achieve 'symbolic' as well as 'action' targets in advancing health equity in Pakistan.

1. Inter-Sectoral Cooperation and Sharing of Statistical data

Health equity cannot be concerned only with health, in isolation. [7] It is multidimensional and its reach is immense. It has an economical dimension, an environmental dimension, a political dimension and social dimensions, among others. Therefore, integrated action between health and non-health sectors is required to achieve equity. The global patterns of inequities in health are defined by poverty, illiteracy, social status and social positioning of individuals, both within a family and in the society, urban bias and rural neglect. As a student of bioethics and prospective agents of change, we need to become more sensitive at first, to the nature of these health disparities before we even set down and devise ways to tackle their root causes. Most countries whether rich or poor have national database or national

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[7] *Sen A. Why Health Equity? Health Econ:2002;(11) 659-666.*

household surveys which are an extensive source of information but unfortunately it is severely underused and often unexamined (WHO, 1996). As a first step this data needs thoughtful analysis and sharing these useful facts and figures between central statistical offices, finance and labor ministries and census departments is essential. Another important point is that the data must be broken down or disaggregated according to social groups, geographical location, gender, age and ethnicity in order for it to truly reveal health disparities. Mere distinction within a country of urban and rural population is misleading because there is a vast difference within the urban population itself. Most data is examined only as averages. There are urban slums on one side of the spectrum and very posh localities existing in the same city. Unpacking the data also enables temporal assessment of any changes in these gaps over time. It helps make comparisons and highlights important trends which would otherwise be hidden (WHO, 1996).

The Ministry of Health services in Nepal has produced an Atlas of Population distribution and health facilities. The atlas includes maps and district profiles for each of the 75 districts in Nepal. It includes national, regional and disaggregated district-level demographic information and information on literacy, environmental health, maternal and child health and family planning. This type of data can be used in health planning at multiple levels (WHO, 1996).

Familiar health indicators like life expectancy at birth, low birth weight, malnutrition, maternal mortality, child mortality should be used.

2.   Research and Monitoring

Of course there may be many limitations to the data that already exists because it was not designed for the purpose of monitoring inequities. New research methods and monitoring techniques are to be introduced. Monitoring involves repeated assessment over time. It is an ongoing process and requires methods which are reliable and reproducible (WHO, 1996). Both qualitative and quantitative research is to be done to investigate the connection between particular policies and health equity.

Amartya Sen, welfare economist and Nobel Prize Laureate says that before researchers embark upon a research to measure disparities in health, we need to be very clear as to what we have set out to measure (Evan, et al., 2001). He further raises the question that what kind of information should we rely upon, in order to judge good or bad health? One measure is the internal perspective which is the subjective feeling of the person and not observed by the doctor or any outside expert but by the patient him/herself. It is a sense of well being or of ill health. This is the information that medical anthropologists explore. Another perspective is the 'external' perspective which is what medical statistics are all about. But these are detached from self perception and rely merely on externally observed medical findings.

Fortunately or unfortunately, the allocation of resources is greatly influenced by these statistics. Is that good or bad? Which perspective is actually the true representation of what we want to measure? These are the questions that the researcher needs to answer before designing any strategies. Both perspectives have limitations of their own. More importantly neither should be overlooked. The author very successfully makes a

point that internal perspective describes the suffering and quality of life of an individual which no medical statistics can provide information about.

Analysis of health inequities can be 'enriched' if this perspective is incorporated into the data. The author explains this by giving an example of two states in India. One is considered a very backward state which is Bihar. It has the lowest life expectancy amongst all states, and one would expect greater morbidity rates. But surprisingly studies have revealed that it has the lowest morbidity rates amongst all states. If we follow the internal perspective of good or bad health then it means people in Bihar enjoy better health than that of Kerala which has the best health care access and longer life expectancy? But the paradox is that the same State of Kerala has the highest morbidity. Is it because the internal perspective and social experience of people in Bihar leads them to think they are healthier and do not complain and report illnesses? Or is it because morbidity and mortality rates (mere statistics) often mislead? Self Perceptions matter a lot. He also mentions a term called 'positional objectivity' which means understanding perceptions of reality in terms of the observers' position in relation to the things being observed by him from his point of view. What is the significance of the absolute truth? It can be appreciated only when each and every individual's own location relative to that truth is understood. So the Self is just as important to discover the absolute truth and how it affects us. It is important to socially situate the statistics of self perception of illness (Evan, et al., 2001). This means that when we look at 'low morbidity' rates we should not automatically presume that it is an evidence of good health. It is only when we unpack the data and analyze it, will we be able to understand exactly what it's telling us.

3.   Selectively targeting the population in greatest need

In health economics we learn that equity has two different dimensions. Horizontal equity poses that equals should be treated equally, such as financing in health care and in utilization of health care services. Vertical equity says that un-equals should be treated unequally. This brings us to John Rawls Difference Principle. Rawlsian theory propagates that the social economic inequalities are to be of greatest benefit to the least advantaged people of the society. This is in sharp contrast to the utilitarian thought, which favors distributing benefits to the majority and then expecting it to trickle down to the impoverished. Trickle down effect does not happen in practical terms. Instead it is commonly seen that wealth and resources and benefits get concentrated in those segments of the society which were already well off. The pragmatic arguments against this method is, that if a segment of society is excluded from the benefits enjoyed by others, in this case that of health and health care, the excluded group becomes discontent and may threaten the well being of the privileged group (WHO, 1996). Ignoring equity is ultimately socially destabilizing and results in rise in crime rates (WHO, 1996).

An example of an intervention in the health sector in Aga Khan University is worth mentioning. They created a series of community-based urban primary health care models each serving 10,000 people relying on CHWs. For merely 2.32 USD per person per yr., the project was able to reduce IMR by 56%. An information system tracks about 32 such health indicators over time, so there's

monitoring also (WHO, 1996). This is an example of a non governmental organization achieving a sustained change through simple interventions.

4.   Keeping an eye on Social Determinants of Health

It is important to understand that there are broad underlying determinants of people's health which extend beyond their genetic makeup, including the conditions in which they live and work, their personal habits, lifestyle and social and cultural norms. Many biological factors are responsible for a persons well being. But to promote equity in health status, efforts should be targeted toward modifying those factors which are avoidable. For instance, majority of cases of blindness world wide, are preventable simply by early detection. Same is true for most communicable and non communicable diseases as well. So the environmental factors in achieving health equity, like, sanitation and access to clean and safe drinking water cannot be under estimated. The WHO commission on Social Determinants of Health was set up in 2005 to gather the evidence on what can be done to promote health equity and to foster a global movement to achieve it (WHO, CSPH, 2008). The Commission views certain goods and services as basic human and societal needs- access to clean water and healthcare. Such goods and services must be made available regardless of ability to pay (WHO, CSPH, 2008).

In the outskirts of Karachi, an area called Gadap and nearby Bin Qasim town is in serious need for clean and safe drinking water and sanitation. The inhabitants are falling sick because of water borne diseases and most prominently infectious skin diseases like scabies, and lieshmaniasis. The town nazim claims that this area constitutes almost 65% of the Karachi [8] but when resources are allocated, only the central district is allocated the major share whereas the Gadap area is not allocated enough funds that allow adequate water and sanitation plans to be initiated. Such people have continuous risk to their health due to basic amenities not being available. Lack of running water and no proper waste disposal or sewage disposal make this population prone to dangerous and contagious skin diseases. On top of that, most of inhabitants are daily wage earners and they cannot afford costly healthcare. So their misery is compounded by the threats in their immediate environment. In the past 15 days alone, 4000 new cases of various forms of skin diseases have been reported in Gadap.[8] They live in poor housing conditions, sometimes up to 25 people living in 2- room quarters. This over crowding adds to the unhygienic conditions and many are unable to bathe for many weeks because of lack of access to running water. How can we expect health equity benchmarks to be achieved if the government continuously neglects these citizens and their needs? It is important to note here, that even if we provide them with the state of the art healthcare facilities but leave the water and sanitation issues unaddressed, their overall health will not improve.

5.   Control   the   circulation   of   health–damaging commodities

Currently, tobacco smoking and chewing is the single most health damaging external factor and contributor to rising healthcare costs. In Pakistan, the health care is basically out-of-pocket expense and there's little or no third party payment or insurance trends, therefore the burden on the population in case of sickness is tremendous. Latest statistics indicate that the annual revenue generated from tobacco companies which goes to Government of Pakistan, is currently 8 Billion Rupees.[9] This enormous amount prevents any tight regulation of tobacco advertizing restrictions and marketing restrictions from being implemented. Commercialization of health care increases health inequity. Health should be governed by the public sector rather than being left to the markets (WHO, CSDH, 2008). Equity in health care is also associated with fair allocation of resources i.e. according to the need. It also entails ensuring high standards of real access, quality and acceptability of health services.

It should be a matter of priority for the government, but unfortunately the ground reality in Pakistan is that a meager 0.7% of the Total GDP is allocated to health sector. Under such financial constraints, and with zero accountability of the allotted sum, the money hardly ever successfully reaches where it is required to be invested most.

Corporate social responsibility is also a neglected area which if taken seriously, can generate a lot of funds to address health inequities (WHO, CSDH, 2008).

We learnt from the assigned readings in health policy module, that once the health divide in a country is identified and its root causes have been analyzed then the most important step to devise a strategy to promote health equity, is to identify points of entry for action to eliminate those root causes. We studied the Conceptual model of the main determinants of health as proposed by Dahlgreen and Whitehead in 1991 (Evan, et al., 2001). This model describes the main determinants of health in the form of layers of influence. According to the authors, it is these layers of influence that are actually modifiable by policy making. So the focus should be directed as these in order for any visible change to be observed. The first layer is the personal habits and behavioral factors, such as those mentioned above, smoking habits, personal hygiene, sexual behavior and physical activity. The second layer comprises of the social or community network which affects the individual and vice versa. The third layer constitutes largely environmental factors, living conditions, working conditions, water and sanitation, housing and food.

6.   Reinforce Public sector Leadership and foster Public-Private partnership in achieving health equity

It is the primary role of the state to provide basic services to its citizens. It is a constitutional right. However, this does not take away the responsibility from the private sector. We see that in Pakistan, the major chunk of health care services is being offered by the private sector. Public health centers although have an infrastructure but are Non-functional. Either they are severely under-staffed or the necessary equipment is lacking.

We need to shift our focus on Primary prevention rather than secondary and tertiary care. Two-thirds of the

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[8] *Express News Report. Reporter: Seher Fatima. Karachi.Aired : Dec 26.2009*

[9] *Dr. Parvez Nayani.Personal Communication in lecture Aug 01,2009*

disease burden in Pakistan is that of preventable diseases.

7. Ensure Community engagement and consensus

The key to introducing effective changes depends on health professionals working cooperatively with the local groups and the community. Involving the community gives them a sense of ownership and reassures them that they are valued and their choices are respected and understood. It is always effective to do things 'with' the people rather than 'for' them (Jenkins, 2003). In all stages of development of a health project, the community should be involved. For this purpose, group insiders have more motivating power and they should be involved in consultation process before the policy is devised. It will help accurately establish the needs of the community and will also familiarize the researcher with the community elders concerns and any myths that may come in the way of the implementation of the health project. Group insiders can prove to be a valuable asset in this regard. They are well known in the community and are well informed and serve to be good representatives of the issues that are the priorities for the community. So, they should be involved in situation diagnosis and problem identification, as well as the decision making and program formulation stage (Jenkins, 2003). They can also be of great value in ensuring successful implementation of the health project and serve a leadership role in monitoring and evaluation of the activities related to the health project. A "One size fits all" approach (Jenkins, 2003) should be discouraged, because every community is different and unique and has separate needs and priorities. The culture to be cultivated here is that the communities may have different needs but their goal is the same, to achieve the highest possible standard of health for all the members of the community regardless of race, age, gender and literacy level. Organized community participation can help achieve a flourishing health of all its members. Such pressure groups should be formed which not only create advocacy groups but also serve as the voice of that community which is heard by the policy makers. John Rawls Second Principle of Theory of Justice proposes that the shape of distribution of opportunities should be fair and the social and economic inequalities are to be of greatest benefit to the least advantaged members of the society, which he named the Difference Principle. This means that sometimes, in order to achieve equity, unequals should be treated unequally (Evan, et al., 2001). Resources may have to be distributed unequally in order to achieve equity.

8. Improve Access to health:

The rapporteur on the right of everyone to the enjoyment of the highest achievable standard of physical and mental health [10] as a human right. He laid down four principles which are as relevant to present day planning and policy making in health as they were at the time. The first of which was availability of health care. To ensure that there is an infrastructure, trained manpower and effective and functional healthcare systems in place for

the population. It also requires to determine what are the various stakeholders (both governmental and non governmental) involved in providing delivery of services? If they are collaborating then are the difficulties increasing for the users or are they being relieved? Then it is important to consider accessibility issues that could potentially strain this effort. Accessibility assessment should include, not only physical or geographic accessibility but should also take into account basic human rights principles of Non-discrimination, special populations needs (adolescents and elderly), indigenous population. Acceptability of a program, is tied closely with community "participation" that was mentioned above. If a health project is not culturally sensitive/ appropriate then it will never be successful. It is to be ensured that they are informed by international and nationally acceptable good practices. It is also to be ensured that the information and services are acceptable to all affected populations. Paul Hunt emphasized that the services are to be of good Quality which means that they are to scientifically and medically sound. Perceived low quality of care is a well known barrier to use of health services by the poor and disadvantaged. [11]

9. Promote Gender equity and Empower women

Women comprise about half of humanity. Unfortunately, gender biases are seen in all levels of society the norms and values, entitlements, power and even in the ways organizations and institutions are run damage the health of millions of girls and women worldwide. In order to reduce health gaps it is essential to address gender inequities. This is why gender equity is indispensable to achieving health equity. Both are intertwined.

Gender inequities begin from home. In many developing countries, it is the norm in many households to feed the girl child only after all the family members have had their fill of the meal. Such discriminatory feeding patterns are actually practiced by none other than the mothers. They instill the idea into the girl child very early in her development, that she is a second grade citizen in her own home. Mothers often justify their behavior by saying that men are the bread earners for the family and have to support the family. But this reason is also misplaced, because many such households continuously thrive on unpaid household work, done by the mother herself or the girl child. These are long hours, of laundry, dishwashing, cooking, cleaning and water fetching that these women and girls have to do regularly and without any hope for financial return/compensation. A lot of these girls rear their younger siblings too. This is nothing but unfair division of work/labor. In this connection, the Tawana Project is worth mentioning. It was a project funded by the Government of Pakistan, conducted by Aga Khan University and implemented with the help of local NGOs in response to poor nutritional status of village girls and decreasing enrollment of girls in primary school. Under this program, training was provided over a span of 3 years to community organizers, school teachers and field workers and thousands of rural women to teach them to plan a balanced meal, purchase food, prepare and plan a noon meal for the school at a nominal budget. The results were rewarding. At the end

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[10] *The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health: Looking Back and Moving Forward. International Symposium. IFHHRO. 2008.*

[11] *Braveman P.Gruskin S. Poverty, equity, human rights and health. Health and human rights.*

of the project, enrolment of girls in schools increased by 40% and >76% of all meals prepared, had all three basic food groups in them.[12] Lessons should be learnt form such success stories in our local setup. Agreed, that it would not have been possible, if there was no political will. Success also can be attributed to the three pronged approach of combining nutrition education and empowerment simultaneously. But such efforts should be continued in order to sustain the changes brought about.

As such the social positioning of women in the families is to be strengthened in order to achieve gender equity because they do not have the decision making power, even for matters that are related to their own being. A UNICEF study revealed that education of girls and women is associated with improved nutrition, decreased infant mortality and decreased fertility (WHO, 1996).

Gender inequities are generated by the society and therefore can be changed. We see in everyday life, in terms of employment opportunities, most women are under paid as compared to men even if they have the same qualifications and experience (WHO, CSDH, 2008). Gender inequities are reflected in the manner employment interviews are conducted in certain organizations. There are many well reputed organizations in Pakistan, which have unfavorable outlook toward a candidate simply because of their gender.

10. Take Concrete steps in Legislation to curb all forms of Violence Against Women And Rehabilitation of Victims

Many women are being subjected to domestic violence on a day to day basis, in Pakistan. Such women are not only subjected to violence but also have no means of escaping their abuser, mainly because of a common belief that is seen in victims of domestic abuse that they are themselves to be blamed for the violence. Even if they have an insight that they are a victim of injustice, they feel helpless because they are financially dependant on the abuser and because there is no support from any segment of civil society or the government offered to such victims.

One of the books provided to us as reading material for this module was, Paulo Freire's *Pedagogy of the Oppressed*. In this book the author very beautifully described the unique relationship between the oppressor and the oppressed. He also describes how this psyche of each develops over time. By facing continuous abuse and oppression, the oppressed develops a fatalistic attitude toward her life. The victim reaches a stage where she patiently accepts oppression as her destiny. Paulo Freire identifies that this psyche of the victim develops out of a fear that even though they may recognize that they are being abused, they may not find the path to liberation from the oppressor. Most commonly in our socio cultural set up, it is the economic dependence upon the husbands that women are unable to break away from. It is this very reason why most oppressors in our society would discourage their wives from gaining basic education and seeking employment. The oppressor knows that it is the economic deprivation of the oppressed that will sustain his dominance over her. The

author elaborates further on the modus operandi of the oppressor. The oppression begins when the oppressor starts treating the oppressed human being as a thing or an inanimate object[13] rather than an animate. Since inanimate objects don't have any rights of their own, it automatically strips the oppressed of their rights, hence exercising complete dominance and ultimately total control over the oppressed. This book was very useful in helping understand the complex relationship between the oppressor and the oppressed and emphasizes that both need to find the path to liberation. Paulo Freire proposed education as being path to liberation and freedom. His dialogic invokes in the readers an urge to awaken the critical consciousness through process of investigation. Dialogical process is an instrument for liberation whereas Antidialogics (Tweedie) is an instrument of oppression. While oppression thrives on manipulation and conquest, and cultural disintegration, the dialogical process is based on cultural synthesis, unity, organization, coherence (Tweedie). They have contrasting characteristics. How several successful educational models have been developed on the basis of these dialogical methods is remarkable. These approaches should be adopted at various levels in order to address violence against women and to rehabilitate them. The passing of a recent Domestic Violence (prevention and protection) Bill by the NA in August 2009 has been a victory worth celebrating. According to the Bill domestic violence includes, but is not limited to, "all intentional acts of gender based or other physical or psychological abuse committed by an accused against women, children or other vulnerable person with whom the accuser is or has been in a domestic relationship." [14] The bill gives the aggrieved the right to approach a first class magistrate personally with an application and the court must fix a hearing within the next three days and give a decision within 30 days. In addition, there is a lac rupees fine on the accused and breach of protection will make it non-bail able.[14] The bill is yet to be formulated as a law.

11. Advocate and Protect Human Rights Prevent exploitation of women and children. Gross violation of human rights is a major obstacle to achieving gender equity. Traditional Practices of Swara and Vanni are to be shunned and awareness regarding such practices should be raised. Victims of such crimes should be provided relief and the perpetrators should be brought to justice. These traditional practices further add to the misery of women. Karo Kari is also a cultural practice which has no basis in religion. It is a common way to get hold of a woman's inherited property and to declare her as Kari, so that she will be stoned to death and buried alive in a nameless grave without even her last rights being performed. Such acts are not only to be condemned at the highest possible level of the government but good governance requires that legislations are passed which will ensure proper action against all parties responsible for this crime.

Similarly another move was the amendment in the Hudood Ordinance which incriminated females to the extreme. If a woman was raped and she went to lodge a

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[12] Badruddin SH. Agha A. Peer Mohamed H.Rafique G. Khan K S.Pappas G. Tawana Project-school nutrition program in Pakistan. Its success, bottlenecks and lessons learned. Asia Pac J Clin Nutr. 2008;17 suppl 1: 357-60

[13] Freire P. Pedagogy of the oppressed. Penguin Books. England .1970
[14] Asghar R. NA Bill outlaws domestic violence. Source: http://www.Dawn News.com. Accessed: 05.Aug.2009

complaint but could not produce 4 witnesses to the rape, she was in turn arrested and put in jail for adultery. The court considered the aggrieved party to be guilty until she proves herself innocent. This went on since the Hudood Ordinance was passed in Zia ul Haqs reign in 1979. This ordinance was criticized by the International Commission of justice and other human rights organizations as a gross violation of Human rights. This ordinance was greatly abused and many women suffered in jail because they could not prove their innocence. This Ordinance was also in direct conflict with Muslim Family Laws Ordinance. With the drafting of Protection of women Bill in 2006 it was appealed that the ordinance be amended. Major reliefs included only the sessions court may take cognizance of an adultery case after receiving the complaint. This checked abuse of Zina and Qazaf Ordinance which was often aimed at settling vendettas and denying women basic human rights and freedom.[15]

12.   Eliminate Poverty

Absolute poverty is one of the major risk factors for poor health overall. This is one of the pragmatic arguments for pursuing equity. If segments of a society are constantly excluded from benefits that are enjoyed by the other segments then the excluded groups may become discontent and this may threaten the harmony and result in high incidence of crimes and violence. This is an argument that holds true because pursuing development without reasonable consideration for equity is socially destabilizing.

We need to devise pro-poor policies or policies which address the poor and disadvantaged. Economic evaluation tools aid in decision making in resource allocation and equity efficiency trade-offs. One of the variables to evaluate something based on economic principles is cost effectiveness. It means simply to achieve maximum benefit from minimum effort. In that regard, the most rapid way to achieve cost effectiveness and to observe growth in indicators would be to give more facilities to those who already have more because they are often best equipped to be immediately productive with a given additional input. But this is a trap that most economists tend to fall in while designing strategies. In this manner one can be sure of short term efficiency but in actual, we will be widening the disparities by leaving those in need farther behind. This will limit our long term capacity for development instead of increasing it. And our goal should be to build long term economic capacity and create real productivity which lasts.

One of the lessons we learned from the Global Health Equity Initiative studies was the resulting adverse effects on equity because of policies that focused only on growth. Such country case examples were from China, Russia and Chile (Evan et al., 2001). These countries were apparently undergoing an economic boost, but in reality the health inequities were increasing and there were widening disparities amongst social classes. Studies have shown strong correlations between the size of income gaps in a number of countries and the health of their populations that are not explained by the absolute levels of their income.

13.   Ensure Equitable financing of healthcare

In simple terms, it means that those with least resources pay the least. This will also reduce poverty. The vulnerable will have to spend less on their healthcare expenses. Also, this should increase access to health care for the poor, which would in turn increase their ability to earn a living and would directly lead to reduction in poverty.

14.   Reduce 'red tape' and bureaucracy

Carol Barker points out that the most important role in the implementation of health policy and even before that in every stage of policy making is that of the health manager or the individual at the meso level. The meso level is equivalent to the EDO or the DCO in our local set up. The author is of the view that this meso level is an important position because it is in direct contact with both the macro level policy makers and the micro level (i.e. the masses or the beneficiaries).Because of this unique positioning that the health manager or DCO enjoys, he can serve as a liaison between the masses and the macro level policy makers. The health managers' responsibility is to be proactive and participate in the policy making process by improving communication both ways, and not just follow orders that trickle down to him from the policy makers. The health manager should give valuable and timely input for policy making to the policy makers. It is this lack of communication which results in framing of such policies which may only look good on paper but may not be in the interest of the ultimate beneficiaries, the population or the community for which the policy was intended. This happens because the flow of information is not bidirectional amongst the various levels of policy making.

Merely formulating policies is not enough; they are to be executed through proper planning. Policies are to be implemented and put into operation through planned programs. For any policy to be planned effectively and be successful, it has to take into account all the stake holders involved. This includes the community leaders of that specific population for which the policy is being devised. The polio eradication schemes were being unsuccessful in certain parts of Baluchistan and NWFP because of certain previous myths and fears cultivated form earlier injustices to those populations which were to be addressed. The myths were removed by improving communication and actively listening to their reservations regarding these interventions and public health measures. By concerted efforts, initial resistance which was met with in these provinces has now been overcome, and there are no grievances from any community member. This is an achievement of health managers and it also underscores the importance of community engagement. However, a recent blow to this effort came with a fake vaccination drive conducted by the CIA in order to trace Osama Bin Laden in Abbottabad. It has again created mistrust amongst the locals regarding the motives of international humanitarian organizations. "Save the children" foundation had to shut down its operations because of the backlash. In this way, politics gets in the way of genuine organizations working hard to reach out to such high risk communities. It takes only one such incident to undo several years of consistent and dedicated hard work and nothing but our own national interest suffers as a result.

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[15] *Khan RI. Health Ethics and Related Laws. 2009*

15. Shift Focus to Preventive Medicine, instead of Secondary or Tertiary Care

It is well known that the large chunk of our disease burden is composed of preventable diseases. But most resource allocation takes places toward tertiary care. If the majority of policies address preventive medicine, many preventable deaths and disability can be averted. Greater effort toward vaccine preventable disease, communicable diseases as well as non communicable diseases with modifiable risk factors should be taken as a priority of National Health policy. Plans should be introduced to ensure easy access immunizations, promote healthy lifestyle and to assist public health measures of providing safe drinking water and sanitation to areas where it is much needed. Even simple measures like creating awareness of personal hygiene and washing hands as a habit before having food, can have a major impact on the health of the population.

16. Build Equitable Health care delivery systems

We take pride in the fact that we do have an infrastructure of Basic health care units and Primary health care Units in many remote areas but what is often missed is, that they are dysfunctional at best, and a majority are non functional altogether. Most have to make do without skilled staff and without basic formulary of drugs. Even life-saving drugs are not available for use. Doctors do not want to be posted there and those that are posted do not report for duties and as a result patients do not get medical care even though the building and facility exists. It is not a surprise then that many such patients are left with no other choice than to turn to quacks and unskilled personnel who claim to have special endowments. They end up harming the patient and many even die because of their practices. At the annual seminar conducted by the Pakistan Medical Association in Feb. last year, it was reported that there are currently 6 Lac Quacks practicing in the province of Sindh alone. Most people seeking quacks end up with hepatic and renal failure and then require tertiary care. Such nuisances can be prevented if the government and the civil society both pay attention to providing Affordable basic health care to those who need it the most. It was also reported that in most government run hospitals, life saving drugs like Magnesium sulphate which costs as little as 14 Rs. are not available and many expectant mothers die of seizures. There is a lack of political will and strong leadership which will first allocate a larger share of GDP to health and then strategize and implement effective policies which serve the disadvantaged and result in uplifting their standard of living.

The existing National Health Policy (March 2009) has a core package and an additional /optional package. The Core services include nutrition advice/services, birth preparedness counseling. EPI services, Pre natal/ postnatal Care, Curative treatment of common illnesses and neonatal and childhood illnesses. A bare minimum package should have included obstetric care too, but that is optional. Even laboratory reports for antenatal care is in the optional category. Promotion of iodized salt for prevention of goiter is also in the optional category as well as mental health and psychological rehabilitation.

We have to step back and ask ourselves, is our current national health policy truly as 'fair' and 'responsive' a policy to the poor, as its vision claims to be? It also claims to be aimed at poverty reduction. If we cannot achieve the 'highest attainable standard' for all, we can at least begin by trying to achieve 'acceptable' standards for all. We should still be able to provide all social groups with a basic minimum. This will be a step toward a commitment to health equity, if not the ultimate goal (WHO, 1996). There may be substantial disagreement regarding these basic minimum services but at least it is a starting point.

In conclusion, health equity is a multi-dimensional phenomenon. There are important tiers and components of health equity framework for a developing and resource poor country such as ours. We have seen examples where countries from a similar background and those that have gained independence much later than we did, are better off health wise. Sri Lanka has been struggling with terrorism for decades, but they not only have the best health indicators in the region but also the highest literacy rate. Pakistan is the only country in Southeast Asia whose average life expectancy at birth has actually decreased this year from 63 to 62 years for a male baby born. If we are to succeed in reducing health disparities, we have to learn to rely on the available resources and make judicious use of these resources. We need to pay attention to the social determinants of health where cultural and social norms, environment, politics and education all play a significant role in paving the way to health equity. None of these goals can be achieved by addressing health services alone or health delivery systems alone. The entire mindset and culture of the nation and the government is to be changed such that they should realize health as a value, and not a commodity to be exchanged for money. Health is an intrinsic good that people enjoy. It is also a collective social good that helps communities lead a productive and quality life. The crux of equity in health lies in the Rawls principles of theory of justice. It identifies as unjust all those inequalities in health that originate in the basic structure of the society as a result of social division of labor that is to the benefit of the better-off groups only at the expense of the worst-off (Evan, et al., 2001). The state should recognize its responsibility for providing food, shelter housing, education and a safe environment for its citizens. Polluted and dangerous neighborhoods will breed disease and more poverty and it is a vicious cycle which will perpetuate more such vicious cycles. Only when all these social aspects are addressed together with health is it going to be effective in bringing an observable change. These measures may not guarantee 'health for all', but would certainly provide a 'fair opportunity' for 'health for all'. Finally, one cannot help but agree with Aristotle when he claims that "In Justice is all virtues found in sum".

References

Evan T., Whitehead M., Diderichsen F., Bhuiya A., Wirth M. ed. *Challenging Inequities in Health From Ethics to Action.* Oxford University Press. 2001.

Jenkins CD. 2003. *Building Better health: A handbook of behavioral change. Principles and methods of Behavior change.* PAHO.

Tweedie D. Pedagogy of the Oppressed by Paulo Friere. Source (Accessed: Dec 26.2009): http://www.marxists.org/subject/education/freire/pedagogy/.

WHO 1996. *Equity in health and Healthcare; a WHO/SIDA Initiative.* Executive Summary.

WHO, CSDH, 2008. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health.WHO.CSDH.*

Individual Case Reveals Dilemmas in Just Healthcare

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Ethics exposes conflicting and competing claims among persons. In perceived or actual cases of resource limitations, who shall receive what in relationship to his/her neighbor, is a question of justice. Individuals may claim a right to decide what is better or best for him or her within health care applications consistent with the intention to help or advance physical and psychological well being. There is however the possibility that enshrined in the norm of autonomous choice for the individual self an assumption that all contemporary and useful means to improve health are available from which the individual then chooses the intervention that best suits his or her situation. General concepts e.g. justice, autonomy and human rights require application within individual cases. In an educational setting such as the college classroom, it is useful to take a case and examine the tensions of conflict and competing claims by various stakeholders in order to unpack the ethical issues. In an effort to illustrate how the concept of justice and autonomy may lie in tension, a particular case was chosen based on an article by John Lantos (1).

Briefly, Priscilla was born with Campomelic dysplasia manifested by multiple birth defects, was ventilator dependent immediately after birth and frequently thereafter for the first year of her life, all of which was spent in the hospital. On her first birthday, Priscilla was developmentally 2-4 months of age. She was responsive to nurses but could not sit without someone supporting her. Health care for this one child reached over a million US dollars by the end of a year of hospital based living and created employment for at least four hospital workers. Priscilla's mother was seventeen, unmarried, and unable or unwilling to be trained to use home based ventilation and yet she would not agree to a do-not-resuscitate order (DNR). The staff opposed a DNR when the physician in charge of Priscilla suggested it. Allowing Priscilla to die by withdrawing the ventilator was offensive to the nursing staff who had bonded with the child. Caught between the hospital administration need to limit care for the overall benefit of the hospital and its ability to provide care in a poor neighborhood and the bonded relationship the nurses and mother had to the child the physician feels the weight of dealing with this futile case embodied in a dependent child.

Death of infants is counter-intuitive to parents and physicians. Historically death in childhood was common but today it is rare and exceptional, a shift that has been accompanied by a public expectation that it is unnecessary and ought to be avoided. Technical assistance from feeding tubes and ventilators have made it possible to postpone death. As a child, Priscilla deserves the protection and intervention of adults in the public and medical sphere. Culturally, failure to treat can morph into neglect.

Laws that protect children from neglect enforce care and treatment by parents and doctors alike. Priscilla is a baby, weak and vulnerable and it may be human nature to seek to preserve her life. Priscilla's mother has the legal responsibility to speak for her, to give consent for any treatment decisions which are made as her parent and guardian, and we assume she speaks for the child's best interest. The doctor, knowledgeable of the condition and aware of the most likely progression of her health, is obligated to treat according to the will of the parent but is equally accountable for the responsible use of hospital and communal resources.

Parental rights give parents the opportunity and responsibility to care for their children. Parents may lack knowledge and experience in medicine especially to inform them of the most beneficial choice and we take it as a given that the doctor will educate the parent about relevant details that will help her act responsibly. The best interest of the child is for the parent more life, and while doctors are obligated to care for their patients they must recognize the futility in cases like this one.

Norman Daniels names "moral importance of health care" as the facilitation and protection of a person's "normal functioning" which allows the individual to "participate in the political, social, and economic life" of society (2). The goal of health care is then providing the person with assistance that attains health sufficient to be an active citizen. If this is the basic health care standard from which justice is to be adjudicated, there are diseases and conditions that preclude a person from the conversation simply because such debilitating conditions cannot be reversed or improved enough for social participation. The Priscilla case illustrates the fine line between a vulnerable person and the obligations we owe them in end of life care decisions even when the best medicine can do is sustain not improve life.

It is easier to theorize about the importance of equal provisions of health care than to create practical systems that limit and extend access in ways that ensure everyone has sufficient help to be functioning. Equitable distribution (distributive justice) aims to give to each person according to need and yet must admit to a triage. How much is to be allocated to a very needy person such as Priscilla when resources are limited is a hard question. If stepping into the position of treating physician, caring nurse, or concerned parent, the highly personal dimension of the allocation strategy takes on new hues of significance. Quality health care ought to be just and equitable. This does not mean all life-prolonging interventions are therapeutic, that is they will not restore the patient to normal functioning. If costly interventions are used in futile cases, it will reduce their availability for those whose lives can be restored or improved.

Spending over a million USD on Priscilla means money was pulled from state funding that could have been spent to improve schools, or other social needs. La Rabida Hospital is a non-profit facility but it still is a business. Responsible use of funds is essential. Lantos articulates the reality as he places the doctor in charge of the case in his office, late in the evening, wrestling with the dilemma. Looking out his window he sees behind the hospital the neighborhood elementary school with its windows covered with bars, playground covered with

broken glass, no nets on the basketball hoops. Upstairs in the pediatric unit, Priscilla is receiving expensive extended care.

It is easy for the reader to sympathize with Priscilla's mother and caretakers and narrow their focus to Priscilla and her needs. Priscilla is vulnerable. Vulnerability marks the limits of individualism. The human body is vulnerable to illness, disability, and death. Anyone can feel vulnerable and it is the feeling that opens us to empathy and compassion. The helpless child, Priscilla, lying in the pediatric bed smiling at nurses, crying when in pain, is capable of evoking feelings in nurses, parents, and distant observers. We can feel compassion welling up inside for all involved and it makes us glad to be at some distance from the decision that begs resolution. Even so, if we are willing, it can reveal our common humanity and that is the value of vulnerability (3).

What can medical technology offer? Expensive treatments may be justified in individual cases but it is not clear how decisions can be made to reject one child when the physician faces the newborn with the problem, the frantic and grieving young mother, and anxious attendants. Who will decide how to allocate resources when we have come to expect modern miracles in matters of life and death, no more emphatically than in the case of a child?

Nations in the industrialized world assert the importance of autonomy. Priscilla's mother has the "right to decide" and the nurses are quick to point out "it is a personal decision – we can't impose our views on her" (1). The right to exercise autonomy by the parent is so honored that the extravagant cost of care is disregarded, at least in the weeks following birth. It is only at the end of the year when the bill is so large and the health status so far from the "functioning" criteria of Daniels that the physician is struggling with the tension between autonomy and justice.

Respecting autonomy as a negative obligation except when we recognize the vulnerable person which tends to shift our sense of obligation to one of protection. Priscilla has no capacity to decide and there is a question about how much functional autonomy her teenage mother has. One wonders when reading the case, if the doctor is not the most competent in terms of assessing the potential for good yet his obligation to serve her interests restricts him and opposes efficient allocation of resources.

Priscilla's case exemplifies the difficult situation when medical care/standard of care is possible but disproportional to the benefit sought. In the case of an infant we may demand life-supporting options while neglecting to offer preventative care even if the alternative is more cost effective (4). Insistence on the best possible care for the one restricts and obstructs greater access and just distribution of effective care to many.

Individuals have rights, interests and obligations and collectively as a community expect fair and just distribution of goods. Socially the response to Priscilla's case is too emotional, too human, while our material response to travesty and injustice for entire groups of people are not humane enough. However unintentionally strong we feel an obligation to protect we are equally responsible to do justice for all who may benefit from medical care and not squander resources on futile cases. Seeing the distinction is difficult and using cases such as

this one can help students understand the particularity of a case within the conceptual context of autonomy and justice.

References
1. Lantos, John. "Seeking Justice for Priscilla." Cambridge Quarterly of Healthcare Ethics 5: 485-492, 1996.
2. Daniels, Norman "Justice, Health and Health Care." IN Contemporary Bioethics, Jessica Pierce, and George Randals. New York: Oxford University Press, 2010.
3. Hoffmaster, Barry, "What does Vulnerability Mean?" Hastings Center Report 36 no. 2 (2006): 38-45.
4. Lantos, John, "Hooked on Neonatology," IN Narrative matters, ed. Fitzhugh Mullan, Ellen Ficklen and Kyna Rubin, Baltimore: Johns Hopkins University Press (2006): 41-47.

Valuing Individuals within a Social Justice Framework

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Elements of universalism provide the grounding for agreements such as the Universal Declaration of Human Rights, and international agreements for human subject research such as the Helsinki Declaration. Pluralistic interpretation or application of rights and principles embedded in Helsinki Accord suggest that there are concepts that transcend culture and time but are differentially understood within culture and time. Ethical moral theories purport a universal normative standard which need not be prescriptive, but merely offer a conceptual framework for dialogue.

The conversation may break down or fail when a moral position to taken to a logical extreme and its proponents push so far that they ignore a renewal of the intent of the theoretical framework. For example, in Hobbes Leviathan the power and position of his "philosopher king" is pushed forward by an egocentric focus, but while moving toward prosperity for the individual, nevertheless remains dependant on a legal framework designed to keep order within the social milieu. Any particular case or set of circumstances which defy the legal boundaries the moral worthiness of the proposed action risks a negative judgment despite anticipated positive consequences. The good therefore as a universal claim relies on the law to set boundaries within which persons agree to live.

Universal Declaration of Human Rights was formulated after WWII and its attendant horrors. Wars continue, with horrific suffering by combatants and civilians in what politically is justified by collateral damage. As weapons zero in on targets, the mechanism of war becomes more and more sophisticated without reducing the human toll of suffering. Can human rights rescue innocent victims from war's damage and danger? It seems not to be the practical reality, today. Fifty years ago when the Declaration was proposed, all nations (including the United States) did not ratify or give legal status to the document's universal potential. "Rights" became an official matter of rhetoric—a rhetorical stage from which the actors could carry out their ethical modalities: "The U.N. Declaration of Human Rights was shaped by a small group of philosophers, thinkers, and statesmen very much imbued with natural law concepts, with a taste for universal moral truths, and with a belief in certain basic

and underlying human needs and desires, true for all times and places."(1)

Embedded in Natural Law moral theory, the Declaration of human rights claimed a particular importance for individuals for their humanness – that is because they have "humanity" inherent in their Being, they are endowed with necessary protections as humans. The good claimed as respect for humanity asserts that the attributes of reason and cultivation toward virtue gives human status "above" other animals. The claim therefore is that all humans have rights, declared universally, and that individuals with particular ethical signatures are individuals with varying degrees of merit and social value, intelligence and physical characteristics that suit them for social purposes.

However, we also see that, even with respect to a theory like Virtue ethics, universal claims are necessary; Aristotle makes the claim that *universally* the virtuous paragon is one that fulfills A, B, C and D, and any deviation from that renders one "not-quite-virtuous." Aristotle's ethical masterpiece, the *Nichomachean Ethics* begins precisely where all ethics since then maintains an odd sense of harmony—*all* humans have, in their best interest, the desire to pursue the good, and that pursuit defines humanity as distinct from all other creatures with life (2). Out of the ever confounding crease created by Aristotelian virtue ethics, and the *Summa Theologica,* arose the *need* for a definition of the Good— consequently producing a Declaration of rights which presumably refers to those ideas of the good. If the concepts posited in the Declaration attain the status of law, Hobbes and egoists generally would find putatively also declare them good.

The human right to health is articulated in the Declaration of 1948 in article 25 [each human being] "has the right to a standard of living adequate for the health and well-being of himself and of his family, including food clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (3). The right to health care achieved the status of international law for which individual nations have the responsibility of ensuring such rights are respected, protected and fulfilled in the 1966 International Covenant on Economic, Social and Cultural Rights which makes it a duty of the state to secure the highest attainable standard of health for its citizens (4). The United States has not yet ratified the economic covenant of 1966 a telling situation in the context of our current healthcare debate, despite efforts in the current administration to reform and provide universal coverage for all citizens.

Natural Law and Egoism share a common sense that the individual human person has primary status. The two theories share a tendency to embrace human rights perhaps as a logical extension of that claim of primacy. However, it is not clear that the conception of rights can alone achieve its claim when different cultures and societies value life of different individuals on the basis of an individual's social worth or physical abilities. One certainly could offer numerous examples, including but not limited to how we view the innocent civilians within war zones, or sick individuals who have more disease than access to medical care.

It is not clear that law is so moral as to guide our reasoning rather that our sense of moral priority and purpose ought to help craft the legal frameworks within which we agree to live. Egoists like to claim the freedom generated by a minimalist legal framework so that each individual has the liberty to pursue their goals without interference. However, one persons' freedom to pursue their goals often influences the freedom and the "rights" of others. War is never equal and it is increasingly evident that medical care is rarely equally available and applied for all persons.

In our modern world we have ideals buried within our moral theories that appeal to reason and yet are used to misallocate resources thereby creating injustice. Good therefore is an ideal which eludes our public discourse and gets pushed into dark damp corners in order to pursue the claims of a greater good, too often meaning simply an individual good. Regrettably, students are more often resisting heartily the fatalistic relativism in ethics debates that hold so tightly to individual principles that the universal notion of personhood are lost

Having students adopt moral theories to gain a sense of common ground in ethical case discussions in harder today than a decade ago. Students assert that the theory leads to reductionism because the posited ideal of the good contained in the theory gives way to no alternatives. Thus ethics becomes paradoxical as the student's sense of agency is in perpetual conflict with an inner sense of morality. The umbrella of moral demands weighs heavily on us all the time. Necessity then becomes about perception and perception is guided phenomenologically. Ethics and ethical theories also then yield to perception.

This claim is difficult to discredit, if indeed it should be, because the claims of moral higher ground give way to political rhetoric and resource allocation wars of words. In the medical care domain of social solidarity in the United States, resource allocation is constantly being debated. Limited resources and demand exceeding resources require some distribution strategy, and while "rationing" is a disliked term in current debate. Rationing exists in that Congress passed a bill in 1972 that provided Medicare coverage for treatment of kidney failure (dialysis). Medicare is an age based universal coverage system within the nation however fiercely universal coverage for all ages is rejected. Rationing therefore will be a policy decision taken out of the hands of doctors and their individual patients. Ironically few people deny that health care expenses are unsustainable. How to control costs and deliver medical care in equitable and effective ways continues to be debated with many "solutions" aimed at a group other than mine.

Reform legislation has done nothing to stem the steady stream of expensive drugs that offer an estimated two or three months of additional life to cancer patients while costing fifty to one hundred thousand dollars. Evidence based analysis of therapeutic options surely should take into account the efficacy and cost. However, it is difficult to imagine how individual doctors will say no to patients on the basis of cost containment. Someone would have the funds to buy the drug out of pocket leaving efforts at cost control on the patients without private funds. A reasonable discourse in a deliberative democracy should make it transparent that some form of rationing is necessary. Hysterical rhetoric that holds the patient-

physician relationship private and safe from any and all government interference assumes that there are funds to secure the best medical treatment available. If the decision about when and how to treat each and every patient is a case by case individual decision, social justice collapses under the weight of individual autonomy. So long as faith in better and better advances in medical technology are linked with an expectation of longer and better lives, it is difficult to see how an individualistic culture laced with skepticism about the role of government in health care can provide a socially just system that limits allocation in order to provide the best affordable healthcare for all. Dan Callahan rightly observes, "The rationing problem in the end is that we have a culture and politics that invite evasion of hard ethical dilemmas, outrage and shouting instead of deliberative democracy…" (5)

Agency and morality are intimately connected and contingent and yet philosophically in terms of healthcare, both polar and mutually exclusive. Agency for self or a dependent child in need of expensive health care stimulates emotional responses born of the relationship and the human condition. Healthcare is at the center of social well-being but when I or my child is sick, the focus of decision making shifts from the larger social order to my sphere of influence. I want care for myself or my child…NOW. However difficult it is to conceive, the society is also an agent, in that a stable healthy society has to provide the availability of healthcare options for individuals to choose. What parent at the bedside of a dying child would have the clarity of reason to appreciate limited consumption of resources? The state / government must on behalf of the welfare of all its constituents establish fair and sustainable limits because it cannot be fair or wise to leave those choices to the individual in dire circumstances.

Futility gets little or no attention in the current debate, but it is relevant. Medical conditions that cannot be treated successfully, that is, in ways that restore human functioning, ought to be recognized as futile. Expensive attempts to turn a futile situation into a therapeutic one are deceptive and unethical. It raises the hopes of the patient and/or those whose lives are relationally connected without empirical support. Trusting medical research to determine efficacy ought to allow medical experts the option of determining futility as well, so that the patient is not reduced in the status he or she holds as a person in decisions that limit interventions to those known to be therapeutically useful.

Students in ethics class often aver that morality is relative to individual background and culture, which is to say particularity trumps universal claims in normative thought. However, they are also very prompt to assert their individual right to a particular thing that is desirable without extending the same to all persons. It seems intuitively obvious to me that all persons would prefer wellness to illness, and life to death, but that means seeing oneself in the context of a much larger vision of humanity, perhaps clinging to an ideal with broad dimensions such as the concept of human rights.

References

1. Callahan, Daniel. "Universalism and Particularism: Fighting to a Draw." *Hastings Center Report* 30 (1) 2000:37-44.

2. Aristotle, *The Pocket Aristotle, Nicomachean Ethics,* Book 1, (ed) Justin D Kaplan, New York: Washington Square Press, 1958, p 160.

3. Universal Declaration of Human Rights, Article 25; 1948, http://www.un.org/en/documents/udhr/index.shtml#a25, last accessed Dec 10, 2010.

4. United Nations Committee on Economic, Social and Cultural Rights, available at http://www.unhchr.ch/tbs/doc.nsf/E.C.12.2000, last accessed Dec 10, 2010.

5. Callahan, Daniel. Rationing: Theory, Politics, and Passions. *Hastings Center Report* 41 (2) 2011: 23-27.

Cooperation: Among siblings or also among non-siblings?

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Ever since in 2009 Robert May pointed to the difficult question of origin and growth of cooperation among group living (gregarious/quasi-social/social) species to be explained in terms of the Darwin's Theory of Natural Selection, active discussion has been going on among evolutionary biologists and sociologists. As has been said in an earlier review (Verma, 2010b), the discussion mostly centres around two different views, viz. the group living concept, and the genetic relatedness concept; the latter is also referred to as the kin-selection theory or the inclusive fitness theory.

As per the group living concept, among members of a population of a group, living species cooperation develops due to reciprocity and advantages of coordinated group action. To elucidate this concept, Verma (2010b) has mentioned the case of the digger wasps, *Bembyx*. The females of this wasp make hole-like nests in the ground to rear their larvae. Generally a number of females make their nests close together, and thus a 'village' of nests is formed. If there is a predator or a parasite approaching the nests, the females fly 'en masse' to drive away the intruder, a feat a single female could not have performed alone. Seemingly the female wasps, cooperating to do this joint action, are mostly non-siblings.

According to the genetic relatedness concept or the kin-selection theory, kins are prone to take on cooperative and altruistic behaviour; more than the genetic relatedness among the kins, greater is the extent of cooperation tendency among them. In support of this concept the case of eusocial insects (ants, bees, wasps, and termites) is generally pointed out. In a colony of such a social insect species, workers are siblings, and they show well organized cooperative behaviour.

Nowak et al. (2010) said that there was no empirical support for the kin-selection or the genetic relatedness concept. But in earlier reviews (Verma, 2010b, and Verma & Saxena, 2011) two convincing evidences for this concept in sperm competition and in the case of ant supercolonies have been pointed out. Recently more empirical evidences for the two concepts, the group living concept and the kin-selection theory, have appeared;

hence this fresh review (previous reviews: Verma, 2010a, 2010b, Verma & Saxena, 2011)

Evidences for sibling/non-sibling cooperation.

Harrison and Whitehouse (2011) point out that mixed species flock formation is a common phenomenon among birds. It has been observed under different ecological conditions, and at different latitudes. The flock formation affords certain advantages to the birds, viz. proper utilization of available resources, and protection from predators. Besides, the different species, in a flock, may choose different microhabitats. Such avian flocks are a support to the group living concept, as the participants in a flock are not kins.

Jetz and Rubenstein (2011) have surveyed the global biogeographic pattern of cooperative breeding in birds, and have noted a strong indication of this that environmental uncertainty has led to cooperative breeding among birds. In this study also there is no support for the kin-selection concept.

Kingma et al. (2011) have reviewed and discussed the recent observations by German and Australian researchers on cooperative breeding by birds in tropical Australia. They point out that fairy-wrens are cooperative breeders, and the breeding birds are helped by assistants, which are the non-breeding birds from the previous nests made by the same breeders. Thus the helping birds help bringing up their own siblings. But in purple crowned fairy wrens, and also in many other cooperative breeding species, the helpers help more, when there are chances of "inheriting the current breeding territory" are more. Thus in purple fairy wrens and similar breeding species the assistants offer more of assistance, when chances of 'reciprocation' through availability of the breeding territory are brighter. As has been mentioned earlier, reciprocation is an operative factor in the group living concept. Thus in this review there is support for both, the kin-selection concept and the group living concept.

Levitan et al. (2011) have studied spawning time in three species of the of coral reef building *Montastraea annularis* species complex. They point out that the spawning (i.e. release of gametes) simultaneously by conspecifics is important, as it results in a high degree of fertilization success and prevents hybridization. They have observed that clone mates in neighbourhood spawn more synchronously than non-clone conspecifics. Clone mates have the highest level of genetic relatedness. This observation of Levitan et al. (loc. cit.) provides a good empirical support for the kin-selection concept.

On basis of their observations during a six year long field experiment Eilts et al. (2011) have noted that presence of clonal (i.e. rhizomatous clonal) species has a strong and consistent negative effect on species richness in a chosen plot. An obvious inference from these observations: Clonals or siblings cooperate to exploit the field resources at the cost of other species, the non-siblings. This is another empirical support for the kin-selection concept.

Greenberg et al. (2010) have studied collaborative behaviour in chimpanzees. They have observed that one partner offered assistance to another in a collaborative activity significantly more often, if they have collaborated earlier. In this behaviour reciprocity is involved. The authors have studied this behaviour among conspecifics, and presumably not among siblings.

Quenouille et al. (2010) have studied present distribution ranges of marine organisms in tropical seas. Those organisms have also been investigated by them phylogenetically. The authors have inferred from this study that phylogenetic relatedness has led the related species in changing from allopatry to coexistence or sympatry. These observations support the notion of cooperation being promoted by genetic relatedness.

Dejean et al. (2011) have described a unique case of a neotropical plant, in which a generation, after death, provides protection to their own offspring, and to those of their siblings. The plant *Chelonanthus alatus* grows in patches, and interspersed among the patches are dead hollow stems of the same plant species of the previous generation. The flowers of the living plants of this species are pollinated during day hours by some species of ants, which are attracted by their circumfloral nectaries, and during night by bats. The ant pollinators not only pollinate the flowers but also provide protection to them from herbivores. The hollow stems of the dead plants, which remain standing for years, provide dwellings to the pollinator ant species, and thus the dead stems altruistically cooperate with the following generation by giving shelter to the symbiotic ants. Thus in this case a generation offers altruistic help to the next generation across a generation gap (indirect fitness). The authors have regarded this as an instance of kin-selection.

In *Nature Vol. 471* (24 March 2011) there is a series of brief communications, in total from 115 authors, all contradicting Nowak et al. (2010), who, as has been pointed out earlier, have said that there is no empirical evidence in support of the kin-selection concept. Among the authors of the brief communications, a specially notable is the one by Ferriere et al. (2011), who have included in their communication a figure (their Figure 2), based on the data from Le Gallard et al. (2003). This figure clearly shows that the extent of altruistic cooperation is positively related to the extent of genetic relatedness among the members of the population.

Cooperation among humans

Cooperation in human groups has been discussed at some length in two earlier reviews (Verma, 2010b, Verma & Saxena, 2011). Reciprocity and advantages of coordinated group action do promote cooperation and altruism in a human population. Besides there is a "wider range of enforcement mechanisms" among humans, promoting "higher levels" of cooperation (Melis and Semmann, 2010). Among the mechanisms that may be mentioned:

(i) Ethical teaching by different religions.

(ii) A fine and detailed distribution of labour in a human settlement.

(iii) Accumulation of wealth, to guard which wealthy people cooperate (Chadefaux and Helbing, 2010).

(iv) Imitation of cooperative and altruistic behaviour by others in a population.

(v) On seeing a person deviating from altruistic/cooperative norms, the erring may be punished. The punisher gets "reputation", and it has been inferred from computer simulations "that punishment can directly evolve through a simple reputation system" (dos Santos et al., 2011).

(vi)Harrison, F. et al. (2011) have hypothesized that in a human population social nearness plays an important role in promoting cooperation and altruism. To test the hypothesis the authors have prepared a questionnaire, and have collected responses from "members of real-world social groups". The net inference from this study: The social tie/proximity promotes cooperation in a similar manner as "biological relatedness".

In the foregoing discussion several evidences in support of the genetic relatedness/kin-selection concept, contradicting the views of Nowak et al. (2010), have been briefly described. But when we think of this concept in human context, we get an uneasy feeling, mainly because many nation states have genetic heterogeneity among their citizens. For India, for example, Reich et al. (2009) have reconstructed the population history, and they find that there are two divergent groups, the 'Ancestral North Indians' (ANI) and 'Ancestral South Indians' (ASI). In addition there are broad hybridization zones. In view of this genetic divergence a problem that comes up is how there can be altruistic and cooperative relations among the citizens. How such relations can be established has been discussed by Verma (2010b). In development of personality and thinking pattern in a human individual cultural inheritance is almost as important as the genetic inheritance. The cultural inheritance is due to an extra-long period of psychological immaturity in the development of a human individual, long post-natal association with parents and family, and institutionalized learning. Hence the possible negative effect of genetic heterogeneity on development of cooperation and altruism may be made ineffective through enlightened parenthood and moral based education, including a judiciously tailored bioethical syllabus. As Gachter et al. (2010) have opined, cultural effects have a role in shaping cooperative and altruistic behaviour.

On what is moral and what is immoral/wrong, active and scholarly discussion is going on among specialists (Orr, 2011). But in a simple way it may be said that the human species has an intricate and well organized social structure, and all such thoughts/behaviour as are helpful in maintaining and strengthening the social fabric, at present and in future, are moral, and all such activities and thinking pattern as are contrary to cooperative and altruistic relations in the society are wrong or immoral.

Concluding remarks

In view of the various evidences, discussed in this and two previous reviews (Verma, 2010b, Verma & Saxena, 2011), it would be appropriate to conclude with the inference that the group living concept (i.e. cooperation developing among group living non-siblings and siblings) and the genetic relatedness concept/kin-selection concept (i.e. cooperation developing among genetically related or siblings) are both well supported by empirical evidences, and often both are operative together. In the human context the possibility of genetic diversity having a negative effect on development of cooperation and altruism, may be nullified through cultural upbringing of individuals with emphasis on the bioethical principle that cooperation and altruism are imperative for growth, progress and integrity of a society.

References

Chaudefaux, T., and Helbing, D., 2010. How wealth accumulation can promote cooperation. *PLoS ONE*, 5(10): e13471 (doi: 10.1371/journal.pone.0013471)

Dejean, A., Corbara, B., Leroy, C., Delabie, J.H.C., Rossi, V., and Cereghino, R., 2011. Inherited biotic protection in a neotropical pioneer plant. *PLoS ONE*, 6(3): e18071 (doi: 10.1371/journal.pone.0018071)

dos Santos, M., Rankin, D.J., and Wedekind, C., 2010. The evolution of punishment through reputation. *Proceedings of the Royal Society B,* Aug. 18, 2010, published online (doi: 10.1098/rspb.2010.1275)

Eilts, J.A., Mittelbach, G.G., Reynolds, H.L., and Gross, K.L., 2011. Resource heterogeneity, soil fertility, and species diversity: Effect of clonal species on plant communities. *American Naturalist*, 177(5) (May 2011): 574 – 588.

Ferriere, R., and Michod, R.E., 2011. Inclusive fitness in evolution. *Nature*, 471:E7 (doi: 10.1038/nature09834)

Gachter, S., Herrmann, B., and Thoni, C., 2010. Culture and cooperation. *Philosophical Transactions of the Royal Society(B)*, 365: 2651 – 2661.

Greenberg, J.R., Hamann, K., Warneken, F., and Tomasello, M., 2010. Chimpanzee helping in collaborative and noncollaborative contexts. *Animal Behaviour,* 80(5): 873 – 880. (doi: 10.1016/j.anbehav.2010.08.008)

Harrison, F., Sciberras, J., and James, R., 2011. Strength of social tie predicts cooperative investment in a human social network. *PLoS ONE*, 6(3): e18338. (doi: 10.1371/journal.pone.0018338)

Harrison, N.M., and Whitehouse, M.J., 2011. Mixed-species flocks: an example of niche construction? *Animal Behaviour*, 81(4): 675 – 682. (doi: 10.1016/j.anbehav.2011.01.013)

Jetz, W., and Rubenstein, D.R., 2011. Environmental uncertainty and global biogeography of cooperative breeding in birds. *Current Biology.* 21(1):72 – 78. (doi: 10.1016/j.cub.2010.11.075)

Kingma, S.A., Hall, M.L., and Peters, A., 2011. Multiple benefits drive helping behavior in a cooperative bird: An integrated analysis. *American Naturalist*, vol. 177 (April, 2011). (http://www.asnamnat.org/node/79)

Le Gallard, J.F., Ferriere, R., and Dieckmann, U., 2003. The adaptive dynamics of altruism in spatially heterogeneous populations. *Evolution*, 57: 1 – 17.

Levitan, D.R., Fogarty, N.D., Jara, J., Lotterhos, K.E., and Knowlton, N., 2011. Genetics, spatial, and temporal components of precise spawning synchrony in reef building corals of the *Montastraea annularis* species complex. *Evolution*, 2011. (doi: 10.1111/j.1558-5646.2011.01235.x)

Melis, A.P., and Semmann, D., 2010. How is human cooperation different? *Philosophical Transactions of the Royal Society(B)*, 365: 2663 – 2674.

Nowak, M.A., Ternita, C.E., and Wilson, E.O., 2010. The evolution of eusociality. *Nature*, 466:1057 – 1062. (doi: 10.1038/nature09205)

Orr, H.A., 2011. The science of right and wrong (a review of the book, "*The Moral Landscape: How Science Can Determine Human Values",* by Sam Harris, published by Free Press, 2011?). *The New York Review of Books*, May 12, 2011.

Quenouille, B., Hubert, N., Bermingham, E., and Planes, S., 2010. Speciation in tropical seas: allopatry followed by range change. *Molecular Phylogenetics and Evolution*, 58(3): 546 – 552. (doi: 10.1016/j.ympev.2010.12.009)

Reich, D., Thangaraj, K., Patterson, N., Price, A.L., and Singh, L., 2009. Reconstructing Indian population history. *Nature*, 461: 489 – 494. (doi: 10.1038/nature.08365)

Verma, K.K., 2010a. Darwinism and cooperation. *Eubios Journal of Asian and International Bioethics*, 20(5): 149 – 150.

Verma, K.K., 2101b. Evolution of cooperation. *Bionotes*, 12(4): 110 – 112.

Verma, K.K., and Saxena, R., 2011. Cooperation controversy. *Bionotes*, 13(1): 4 – 6.

Learner's Attitudes to be Cultivated through Clinical Ethics Case Studies: with Reference to the Method of Psychotherapy Diagnostic Interview

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Abstract

Clinical ethics aims to provide practical approaches identifying, analyzing and solving moral problems in clinical settings. Educators of clinical ethics commonly do case studies as a useful educational method. Some authors have recently advocated a specific and unique way of case study, which regards a clinical ethics case as a literary story that should be interpreted by making full use of literary imagination. Based on this standpoint, we explore what kinds of attitudes learners should build through clinical ethics case study course. It seems helpful to refer to the method of psychotherapeutic interview at the first contact, core characteristics of which are placing importance on individuality and creating a hypothetical interpretation of the aspects of the patient. These two hold true of working of the clinical ethics case study. Clinical ethics case studies involve drawing a hypothetical image of the case by interpreting the characters of all the people involved and the circumstances in the case. Thus from an analogy between the way of psychotherapeutic interview and perusing cases in clinical ethics case study, we realize that learners of clinical ethics should attempt to throw imaginative light on and depict the case by focusing on the life history of characters in the case and by detecting what they do not understood yet in the given case, without eliminating their own subjective impressions. Through such touch working learners, at the same time, must effort to look deep inside and objectify themselves.

1. Background

Clinical ethics is a practical discipline of systematically identifying, analyzing, and solving ethical issues in clinical settings. Its methods vary from the top-down method that deductively applies ethical principles to cases, to the case approach conducting probable, tentative moral judgments by taking the specific state of each case into consideration in accordance with individual context.

To organize and examine the state of individual cases based on the case approach, Jonsen's four topics method sheet or something similar is widely used (Jonsen, 2010). This method is also often used in clinical ethics education case studies for students and health care providers. Yet, another method has been proposed that regards a clinical ethics case as a literary story that should be interpreted using literary imagination, rather than thinking of the case description as a collection of facts (Hattori, 2010). However, not enough debate has been conducted on this specific method. The author will closely examine it from the standpoint of interpreting cases using literary imagination and explore what attitudes learners should built in clinical ethics case studies. The method of psychotherapy diagnostic interview (PDI) broadly used in the field of clinical psychiatry and the attitudes it requires in therapists seem to be useful for our study as analogical references. While it has long been asserted as necessary to incorporate human understandings in the field of psychiatry into clinical settings (Noble, 1932), there has been no specific discussion of how this relates to case study methods in clinical ethics.

2. Case Understanding Ability

The study of clinical ethics does not deal with cases to illustrate general and abstract issues; rather, it always considers cases as an intricately intertwined complex of individual specific circumstances regarding the patients and their families with proper names. Hattori (2010, p.53) maintains that the essence of clinical ethics education is fostering the ability to understand cases. The ability to understand cases involves "before conducting moral judgment [...], participants perusing, comprehending and interpreting cases while using their imagination to search for the true motives and connections of those involved in specific contexts and situations." In effect, to properly make a moral judgment in individual cases, it is vital to focus on, peruse, and comprehend individual contexts. The contexts include the feelings, personality, history, and values behind the words of people who appear in the case before conducting rational reasoning based on ethical theories and principles. Any discrepancies in this first step will be amplified by the time one reaches the final judgment stage, causing significantly distorted reasoning (Hattori, 2012, p.88). Identifying and examining the ethical issues in a case requires the ability to understand that case.

3. Perusing Cases and the Method of Psychotherapy Diagnostic Interview in the Field of Psychiatric Interview

What does case understanding ability entail? The method of PDI seems suggestive and helpful as a reference in order to identify this ability. Psychiatrists usually conduct PDIs on patients to accurately understand their status, comprehend the relationship between the patients and their environment, identify how much their illness is impeding their lifestyle, and closely examine attitudes of patient and family to regarding treatment. It does not aim to dissect and examine patients, but to gain an overall understanding of them in their most natural state as a unique human being (Doi, 1996, p.119; Sullivan, 1970, pp.16-17). Proper PDI can provide an outlook for diagnosis, prognosis and treatment. A similar concept called case formulation exists in the field of clinical psychology (McWilliams, 1999). However, it differs from PDI as it provides a systemized framework and procedure for understanding patients.

PDIs are basically the similar as medical interviews for physical illnesses. At the initial examination, before moving onto detailed testing after medical interviews and

examining physical findings, a differential diagnosis is given, a general testing and a treatment plan is devised. The patient may be given an estimated prognosis. If it is later revealed that a case has progressed just as the doctor had roughly predicted, the doctor is said to have good judgment. This is fundamentally the same as PDI and is natural that irrespective of the theories or standpoints psychiatrists adhere to, they will conduct interviews in this manner.

While the general framework of PDIs and interviews for physical illnesses is alike, important elements and points of focus differ because psychiatry targets human mental phenomena. Thus we will focus on these characteristics. As is mentioned below, understanding cases in clinical ethics case studies is overlaps with performing PDIs on many levels. Giving suggestion to the qualities of PDI and the attitudes it requires in therapists plausibly seems to provide specific insight into the nature of clinical ethics case understanding ability. Therefore, this study will first give an overview of the core characteristics of PDI before considering the basic attitudes required in psychiatrists conducting actual PDIs. Then, the suggestions that can be gained by placing the method of PDIs within the context of case-oriented clinical ethics education, will be discussed.

4. Core Characteristics of Psychotherapy Diagnostic Interview

The method of PDI is basically underpinned by two points: placing importance on individuality and hypothetical understanding. These two points, which are also heavily involved in debate regarding case study learning objectives in clinical ethics, are outlined below.

4-1 Placing Importance on Individuality

Placing importance on individuality is the heart of PDI. One must grasp the individual state of the patient including both their diseased and healthy parts and determine how to specifically address them. PDI is an extremely individually tailored process (Doi, 1992, p.41).

Indeed, psychiatric diagnosis by means of operational diagnostic categories has recently become the mainstream in clinical psychiatry. This process classifies the diseased portions of the patient using pre-determined rules such as diagnostic criteria and gives them medical names, dissimilar from PDI. Various theories and standpoints exist in psychiatry, but no standardization of these has been observed. Therefore, it is natural that diagnostic disparity and bias due to differing standpoints and theories are considered problems and attempts would be made to increase diagnostic reliability by creating more objective and universal criteria. Thus, in 1980, the American Psychiatric Association published the DSM-III operational diagnostic criteria. These criteria then spread worldwide and have subsequently undergone multiple revisions. The popularization of the DSM led to the classification and identification of diseases conducted by comparing DSM diagnostic criteria with the patient's condition being considered equivalent to a diagnosis. However, such a diagnosis is only based upon the status of the patient observed during the examination. The patient's distinct life characteristics and life history are not included in the diagnostic criteria and, excluding exceptions, are not reflected in the diagnosis.

Meanwhile, PDI considers it best to first put aside all pre-existing theories and doctrines including operational diagnostic criteria such as the DSM-I and its revised versions. When theories or operational scheme are applied in order to understand patients, the delicate nuances that constitute their individuality tend to spill over and fall.

4-2 Interviews for Hypothetical Understanding

Another core characteristic penetrating the method of PDI is hypothetical understanding. PDI involves creating a hypothetical interpretation of the patient and their situation.

PDI does not provide an absolute and definite understanding because of two limitations. One is the fact that it is conducted under restricted conditions. In the interviews, information that can be acquired is restricted by time limitations and the depth of the affinity and connection between patient and therapist. The second limitation is the fact that it is impossible to grasp the entire state of the patient. These may appears paradoxical to the objective of PDI. However, psychiatric medicine is aware that human knowledge cannot come up with a theory that can completely understand humans themselves. Despite this, PDI attempts to create a hypothetical image that thoroughly represents the patient with the problem, their family and their surrounding situation in its entirety based on the necessities of treatment (Sullivan, p.68).

Psychiatrists are also aware that hypotheses can always be mistaken. Therefore, psychiatrists review and revise their hypotheses over repeated interviews of patients. Repeatedly creating hypotheses and revising them throughout the process of PDI improve the accuracy of this process.

5. Attitudes Required in Therapists for Psychotherapy Diagnostic Interview

The preceding section indicated that the core of PDI involved placing importance on patient individuality and forming hypothetical interpretations in order to understand the patient's situation. Next, we will examine what kind of specific attitudes psychiatrists should assume when actually conducting PDIs.

5-1 Not Eliminating Subjective Impressions

Subjectivity is unavoidable in PDI. In effect, understanding and evaluating the entire state of a case requires the consideration of subjective and individual judgments. This is because the subjective internal world and experiences of the patient are the subject of interviews and patient speech and conduct can only be understood through the subjectivity of the therapist. Non-objective elements are very important in the formulation of hypothetical interpretations. For example, a therapist attempts to sense non-verbal impressions created by the atmosphere that envelops the patient in their entirety during interviews. Furthermore, whether to view a certain action or situation as kindness, irresolution, cautious or dullness is a judgment based on the therapist's subjective impressions and therefore varies between therapists (Murakami, 2003, pp.404-405).

It is considered important for therapists to be able to precisely sense these subjective impressions of non-verbal impressions and certain actions. The precision of

this ability, called the "alertness" by Sullivan (1970, p.68), greatly affects the precision of PDIs. It appears that the awareness of the need to improve and exhibit this sense is universally observed among those who place high importance on interviews in the field of psychiatry.

5-2 Placing Importance on Life History

Patients' life history provides particularly significant insight when conducting PDIs. There are two major reasons for giving serious regard to life history. The first is because this information is vital in order to understand the character of the patient. Character, which is composed of personality and thought, is the state of how the patient lives their life.

It may be a consequence of environment and education and appears in how the patient has reacted to life events and changing situations in their life up until now. The current state of the patient could be expressed as the function of their current environment and past life history. Reaching a diagnosis without knowing what the patient has felt, lost and been discouraged by or, in other words, how the patient has lived, is like ignoring a part of the function. The second major reason for life history being given serious regard is because it is an important reference point for predicting the patient's course. Diagnosis and treatment planning requires one to predict a patient's actions. How the patient themselves has reacted in the past has far greater value as reference material for this prediction than scientific evidence based on the statistical processing of numerous past cases (Seki, 2008).

Questioning life history is, indeed, not only necessary to psychiatry; it is also required in interviews for physical illnesses. However, psychiatry more widely deeply questions life history and gives it a different status (Menninger, 1962, pp.22-24). When investigating physical illness, family history including hereditary disposition, smoking, alcohol consumption and work history are questioned solely in order to find out whether these factors may have caused the disease. For example, liver disease risk is calculated from how much alcohol is consumed each day over what period, while the possibility of silicosis is considered if the patient has a history of work involving tunnel construction or coal mining. Meanwhile, life history is questioned much more widely and in more detail in psychiatry. Question items include circumstances at birth, childhood environment, siblings, academic background, grades, work history (type of work and any job changes), parents' occupations, marriage/divorce, the death of close relatives, economic circumstances and changes and critical points in these aspects of daily life environment. For example, when examining alcohol consumption, points such as whether patients drink alone or with friends, at home or at bars, all day or just at night and whether they buy the alcohol themselves or a member of their household provides it are focused on rather than quantitative inquiries about volume and period of consumption.

What is even more characteristic of psychiatric interviews is the fact that great concern surrounds how patients have reacted to, judged and acted in response to life events and changes in their environment. For example, how long they grieved when faced with the death of a relative and whether this resulted in changes to their job or daily lifestyle activities. A person's character significantly affects how they act in response to an event. Focusing on each action and situation illustrates the individuality of the patient. Accordingly, paying attention to the patient's life history is the starting point for understanding the patient's character and forming a hypothesis that can be used to predict their future development.

5-3 Detecting What is Not Understood

As stated above, psychiatrists create hypothetical interpretations based on their subjective impressions of the patient and how the patient describes their life history and internal world. At this stage, it is important to clearly distinguish between what one does and does not understand in order to detect what points one cannot comprehend. Psychiatric interviews carefully proceed through what one 'understands' and 'does not understand' (Doi, 1992, p.33), or 'knowing' and 'not-knowing' (Casement, 1985, pp.3-5). If, as mentioned previously, the essence of PDI is hypothetical understanding, the interviews themselves signify a never-ending quest for the purpose of depicting an appropriate image representing the patient's situation. An endless quest such as this requires one to constantly seek out areas that they do not understand. If one tries to depict, comprehend, and adhere to only the parts that they understand, the image of the patient will become one-sided. Although this may seem paradoxical, therapists communicate with patients while not completely understanding them. They are likely to ask themselves whether there are parts that they don't understand, and consider multiple possibilities in order to carefully depict an image of the patient including both the parts that they do and don't understand. Distorted hypotheses based on forced interpretations can be avoided by constantly inquiring and confirming what one does not understand and opening up the possibility for different hypotheses (Ogden, 1999, pp.206-207).

5-4 Objectification of the Therapist

Therapists must constantly endeavor to objectify and have insight into themselves in order to clarify what they do and do not understand about the patient. Paying heed to one's own internal world is vital in understanding the inner workings of human nature and influences the quality and precision of PDIs. Some justifiably argue that the aptitude of psychiatric and clinical psychology professionals is determined by the richness of their internal world. Objectifying oneself encourages one to move away from familiar ideas, conduct self-control, acquire different viewpoints and understand one's influence on the patient. Self-objectification can be conducted by listening to one's internal voice. This can be done by asking oneself, "How am I feeling? Why am I feeling this way? Why am I feeling this way now?" Another method is reflecting on one's clinical practice through the examination of case reports. This can prevent therapists from being tempted to become fixated on one interpretation, which can be biased and stereotyped (Ogden, 1999, pp.203-205).

6. Clinical Ethics Case Studies and Psychotherapy Diagnostic Interview

The preceding section gave an overview of the concept of PDI and the attitudes required in therapists that were significantly relevant to the subject of this paper. Next, we will discuss the insights that can be gained by placing the method of PDI within the context of clinical ethics education.

6-1 Using Case Studies as Training for Hypothetical Understanding

The essence of case studies in clinical ethics education is very similar to that of PDIs. The learner confronts the case like a therapist facing a patient. They are required to imagine the character and the way of life of the patient and their family, the problems they face, creating a hypothetical blueprint of the case in its entirety. This process is not the creation of an image based on the learner's haphazard notions or fantasies. Rather, the hypothetical case image is drawn with the greatest precision possible by focusing on case individuality, considering the potential meaning of seemingly trifling information and connecting these pieces of information. This is exactly what is conducted during PDIs.

The discussion of clinical ethics case studies should begin by comparing these hypothetical case images created by each learner. Clinical ethics case studies require that learners seek the more appropriate case interpretation through examining the multiple images held by other learners. Continually improving the precision of one's hypothetical understanding is an important objective in clinical ethics education.

Here we should admit there is an important gap in an analogy between PDI and clinical ethics education. While the therapist deepens their understanding of the entire state of the patient and revises their hypothesis with each interview when conducting PDIs, this is impossible in the case studies generally conducted in clinical ethics education. Case studies in clinical ethics education have no other choice but to remain the stage of hypothetical understanding. Learners examine cases during certain phases of their clinical course and cannot actually be involved with patients over time. Therefore, clinical ethics case studies can only hypothetically interpret cases, making it necessary to stop at the hypothesis stage, resisting the temptation to assert the single interpretation.

6-2 Learner's Attitudes cultivated through Clinical Ethics Case Studies

If, as indicated in the preceding section, clinical ethics case studies are an opportunity for practicing hypothetical understanding, the attitudes learners should build should naturally be the same as those required in therapists conducting PDIs.

6-2-1 Clinical Ethics Case Studies and Subjectivity

Subjectivity plays an important role also in clinical ethics case studies. When attempting to comprehend the patient in order to understand the case, the impressions and interpretations of learners of the non-verbal atmosphere generated by the patient, their words and attitudes as described in the case report can only be understood through the subjectivity of the learners influenced by their personal experiences and knowledge. Meanwhile, medical professionals and students are inclined to consider data only to be as valuable as it is objective, and arguments based on subjective

impressions as pointless. With clinical ethics case studies as well, seemingly objective data described in the case is likely to be considered self-evident without a doubt, and information that cannot be understood objectively is prone to be ignored as insignificant. Attitudes such as these, however, inhibit interpretation in clinical ethics case studies.

Are the feelings verbally expressed by characters in the case objectively the true feelings of the patient? If so, the subjective judgment of the interviewer has to support the fact that these words can be trusted as the feelings of the patient. This subjective judgment is based on the context radiated by these words. Exactly the same words could have different significance and shades of meaning depending on the character of the patient. Therefore, it is simplistic and superficial to refuse to utilize subjective judgment, to imagine the hidden meaning behind the words, and to considering their literal meaning directly as indicating the patient's intentions. Only picking up and relying on what can be confirmed as objective in cases could be likened to coloring over delicate gradation with one primary color, leaving no room for individuality.

What is important is that subjectivity does not oppose facts and truths. Using one's subjective imagination is essential to examine case individuality and attempt to sincerely perceive the state of a human being.

However, interpretations based on the subjectivity of each learner must be carefully examined when discussing cases. What were their subjective impressions of the case and what kind of hypothetical image did they come up with? Discussing these things between participants ensures multifaceted opinion, allowing self-indulgent interpretations to be avoided. Listening to subjective interpretations based on other peoples' experiences and incorporating the opinions of others increases the breadth and depth of human understanding. Thus subjectivity plays an important role in clinical ethical case studies.

6-2-2 Clinical Ethics Case Studies and Life History

What is the significance of focusing on life history in clinical ethics case studies? As empirical knowledge in psychiatry has indicated, one can speculate on a person's character through their own life history. The character of a people appearing in clinical ethics cases greatly influences various decisions made by themselves within the critical situation depicted.

For example, even when occupation alone is considered, elements such as industry (manufacturing, finance or agriculture), occupation type (technical or clerical), position (managerial or general), workplace scale, continuous years of service will cause people to have different reference points and opinions when making decisions and consider their relationships in different ways. Essentially, these elements lead their lives differently. Habits learnt through one's job help to form one's character and often spill over into other aspects of the person's life. Company managers who work under fluorescent lighting leading their subordinates probably have different values to people involved in agriculture who are in contact with dirt and water every day and physically use their body to work with nature. People brought up in large families are also likely to have different family values to those who were not. Differences such as these probably greatly affect the perceptions,

decisions and hopes of patients regarding therapy including how much they want to know about their physical state, acceptance of illness, how they hope to end things and how involved they want their family to be. These differences will lead to people desiring different types of medical treatment and care. If the heart of clinical ethics is solving moral problems by paying as much attention to patient's values and the way of life as possible, learners should not ignore patient's life history.

Moreover, the words and actions of characters that have not been given in the case description can be just imagined using the vivid and real image of the characters carved out of the case based upon perceived life history. This then aids in predicting future development and increases the precision of the case image. This could be likened to when a lead character in a novel with a carefully shaped life history becomes concrete and naturally starts spouting lines not at first intended by the author herself.

6-2-3 Detecting What is Not Understood and Objectifying Oneself

Just as in psychotherapy diagnostic interviews, detecting what is not understood is important in clinical ethics case studies. More appropriate case images can be built by actively searching for parts that do not fit rather than forcibly connecting superficial parts of the case.

Detecting parts that are not understood has the same significance as questioning why characters in the case, including patients, their families and medical professionals, speak and behave as they do and the context and feelings behind this. Each learner probably asks different questions in this case. This is because learners peruse clinical ethics cases based just on their own previous experiences and within the scope of the breadth and depth of their human understanding without applying specific theories. The deeper their insight into the subtleties of human nature gained from their experiences, the more aware they will be of details of the case, which naturally gives them the ability to raise many questions. The depth of one's self-insight is proportionate to the depth and quality of case understanding.

Therefore, it is clear that even outside the realm of case studies, to what extent each learner is routinely familiar with their internal world and whether they are living introspectively is important. Case studies inevitably expose the depth of learners' own daily introspection and can lead to even deeper introspection. Learners sometimes will discover mixed emotions in themselves from which they want to turn their eyes away. Learners may become resistant when directly faced with their true self and become psychologically defensive. This will result in them organizing dry, objective data only and to apply theories to humans. While case studies do not exist for this purpose, the state of the learner themselves is naturally exposed through their interpretation of the case. When learners then turn away in an attempt to protect their familiar world, opportunities for self-objectification and being open to other interpretation of the case are lost and their understanding of actual living humans is reduced.

7. Conclusions

We clarified some attitudes learners should cultivate in case-oriented clinical ethics education by indicating the analogy between the method of PDI and understanding cases of clinical ethics case study. Clinical ethics case studies involve drawing a hypothetical image of the case by interpreting the character of people appearing in the case, the values they hold and their problems from the case description. In other words, it is an exercise in hypothetical understanding. This requires that learners focus on life history, do not eliminate subjective impressions from their discussion and take notice of non-understood parts that could be inhibiting their formation of a case image. In order to find out what is not understood, learners need to make an effort to routinely objectify themselves, deepen their introspection and gain insight into the subtleties of human nature.

While attitudes required in learners were clarified in the argument put forth by this paper, we would like to close this paper by lastly outlining ideas regarding the role of educators. First, all of the same attitudes learners should build through case studies are required in educators. Educators must be able to read cases deeply in order to encourage learners to reflect on issues that they have missed through discussion. They must also emphasize the importance of verbalizing ideas and interpretations through case studies and give learners opportunities to do this. Greater verbalization ability leads to a deeper understanding of the case. Verbalization ability also underpins general understanding. The attempt to express the interpretation in words gives solid shape to vague impressions and obscure ideas regarding the case. Conversely, the inability to verbalize one's interpretation indicates insufficient understanding. Verbalization ability is also necessary self-objectification. Therefore, it is likely to be effective to give students time to write up an understanding of the case when first embarking on the case study or to summarize their thoughts in writing at the end of the case study.

Finally, if hypothetical understanding is considered to be taking an overall view of the patient's situation and problems by hypothetically comparing them with something else, it could also be described as the literary action of discovering a metaphor that expresses the situation of the patient well. The author tends to agree with the position that mastery of hypothetical understanding in interviews requires one to utilize literary materials from reading groups and visual materials from paintings and movies that depict human nature and to repeatedly view, consider and interpret them.

References

American Psychiatric Association Web site. Retrieved January 13, 2013, from http://www.psychiatry.org/practice/dsm

Casement, P. (1985). *On learning from the patient.* New York: Routledge.

Doi, T. (1992). *Hoho to shiteno mensetsu – rinsho ka no tameni. [Interview as method: for clinicians].*(New ed.). Tokyo: Igakushoin.

Doi, T. (1996). *'Mitate' no mondaisei [Mitate: the problem of clinical Judgment]. Seishin Ryoho,* 22(2), 118-124.

Hattori, K. (2010). *Rinsho rinnrigaku to bungaku [Clinical ethics and Literature]. Annals of the Japanese Association for Philosophical and Ethical Researches in Medicine,* 28, 49-57.

Hattori, K. (2012). *Rinsho-rinrigaku kyoiku to kokugo-ka bungaku kyoiku [Clinical ethics education issues elaborated by*

comparison with longstanding disagreements about how to teach reading literature in primary and secondary schools]. Journal of Japan Association for Bioethics, 23, 86-93.

Jonsen, A.R., Siegler, M., & Winslade, W.J. (2010). *Clinical ethics: A practical approach to ethical decisions in clinical medicine.* (7th ed.). New York: McGraw-Hill Companies.

McWilliams, N. (1999). *Psychoanalytic case formulation.* New York: Guilford Press.

Menninger, K.A. (1962). *A Manual for psychiatric case study.* New York: Grune & Stratton.

Murakami, Y. (2003). *Kehsu kanfaransu to chiryohbunnka no keisei. [Case conference and climate of psychiatric treatment]. Seishinnka Chiryogaku,* 18(4), 403-407.

Noble, RA. (1932). The place of psychiatry in medical education. *The British Journal of Psychiatry*, 78, 793-802.

Ogden, T.H. (1999). *Reverie and interpretation—sensing something human.* London: Karnac Books.

Sullivan, H.S. (1970). *The psychiatric interview.* New York: W.W.Norton & Company.

Seki, Y. (2008). *'Hitogara' wo haaku suru to iukoto [Understanding the personality]. Seishinnka Chiryogaku,* 23(6), 685-690.

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