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The Earth is a Living Being: We have to treat her as such!

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Abstract

The earth is not just a piece of rock, water and soil; she is a living being. This fact is demonstrated by millennia of her life's history, growing in ages, having tempers, moods and seasons, and allowing all forms of life living on her and interacting with them and their interactions. Recent natural disasters and accidents, caused by humans in their drive to cultivate and to control, have again brought the powers of the earth and the land to our attention. A new dimension in the visions and virtues of cultivation needs to extend on a global scale the Hippocratic 'do no harm' virtue and principle from the singular doctor-patient interaction towards all forms of life, including the life of the earth.

This paper interprets the Bioethical Imperative, developed by Fritz Jahr in 1927, into land ethics and earth ethics; it also discusses the concept of cultural geography of Ernst Kapp, 1845 in Germany, and the land ethics of Aldo Leopold, 1949 in the USA. Of particular new moral and cultural concern is the risk of radiation to the genetic heritage of all forms of life, to livable biotopes and interactive environments. The Bioethical Imperative includes Land Ethics and the Earth: "Respect mother earth with all her forms of life, whether natural or man-made, basically as goals in themselves and treat them, if possible, as such."

"The guiding rule for our actions may be the Bioethical Demand: Respect every living being on principle as an end in itself and treat it, if possible, as such!"

- Fritz Jahr (1927)

The Bioethical Imperative

The Bioethical Imperative as a term, an academic discipline and as a virtue and principle was coined by Fritz Jahr, a Protestant pastor and teacher in Halle an der Saale, 1927 in the annual editorial of the leading German language science journal *Kosmos*. Influenced by Buddhist and Hindu thought via Schopenhauer and by Wilhelm Wundt's empirical comparative studies in physiology and psychology of plants, animals and humans, he formulated the Bioethical Imperative "*Respect every living being on principle as an end in itself and treat it, if possible, as such*"[1]. In presenting a new imperative for moral orientation and action, he deliberately and expressively criticized Immanuel Kant's Categorical Imperative, which had called for the exclusive recognition of fellow humans as ends in themselves: *"The*

[1] Fritz Jahr (2010) Bio-Ethics. Reviewing the ethical relations of humans towards animals and plants (1927), English translation in: *Jahr: Selected Essays in Bioethics and Ethics*, ed. H. M. Sass, Bochum: Zentrum Med. Ethik 2010, p. 4; cf. H. Sass (2009) Asian and European Roots of Bioethics: Fritz Jahr's 1927 Definition and Vision of Bioethics, in: *Asian Bioethics Review* 2009, 1(3):185-197

moral law is sacred (inviolable). The person is not sacred, but humankind in his person must be recognized as sacred. Everything in the entire creation, if one wants and has power over it, can be used as a means only; only the human person and with it every intelligent being is an end in himself. He is the subject of the moral law, which is sacred, based on the autonomy of his will" (Kant: A156). For Jahr the "*sanctity of life*" is the foundation of the 1927 Bioethical Imperative, while for Kant the "sanctity of the moral law" is the foundation of the 1788 Categorical Imperative.

The Bioethical Imperative of Jahr changes the primary focus of European philosophy and ethics since the Age of Enlightment away from an anthropocentric focus towards a cosmocentric vision and strategy. Such a necessary change was influenced in the midst of the 19th century by translations of classical Asian literature into German and English and by new scientific knowledge of similar neuronal, psychological, and physiological reactions in plants, animals and plants. Jahr also was aware of the interdependence of forms of life, habitats, struggle for life, good life, and survival[2]; he thus called for balancing values, visions, and interests among living beings. All forms of life have to eat and breathe, live together, share the environment, survive and enjoy life and living. Thus the former formal rigorist ethics of Kant becomes situational, content-rich and integrative in vision and action.

The most basic moral intuitions for the Bioethical Imperative are compassion and solidarity, living together in interaction, integration, and harmony. Jahr strongly supports legal protection of animals and rare species of plants and animals; he also voices concern about breaking plants and flowers just for fun and without a civilized and morally justified purpose. In regard to eating animal protein, he observes that in colder climates people eat animal protein, but they should raise and slaughter animals in a respectful way. He explains the interaction of egoism and altruism also for social policy: *"For example, what is spend on social welfare and in support and improvement of national competitiveness, comes back with interest income, since the state and the economy have a greatest interest to have trustworthy public servants, good workers, financially well to do consumers, good development of the youth, in general the wellbeing of the entire nation"*[3]

The Earth is a Living Being

Cosmos and earth are not just physical preconditions for life and living environments on this globe. Cosmos and earth are living entities themselves. Sakyo Komatsu, influenced by the great earthquake of 1923 on Honshu Island which resulted in over 140,000 deaths and severe destruction in Yokohama and Tokyo, wrote a thrilling novel "Japan sinks"[4]. Onodera, the major figure in this thriller asks his wife while escaping by ship: Can you see Japan? No, she answers. It must have sunk. Can you see smoke?, he asks. No, she answers, I cannot see anything. - Since 11 March 2011, we have experienced for real that the earth as a living entity, mostly friendly and supportive, sometimes wild, extremely wild, inhuman, cruel killing is real, not just the material for a thriller story.

The earth is dark at night and light during the day, cold in the winter and warm in the summer. Some areas such as deserts or the poles are hostile and not supportive of most forms of life; other zones are full of life and living environments of mutual support, fight for life, cooperation and consumption. Climate changes are occurring over decades and centuries and millennia. We seem to be in a long-term warming period; there were warmer periods in Europe in the early 19th century, colder times during the Protestant reformation in the 16th century. We had ice ages and ten thousands of years of hot tropical conditions in Europe. Elephants were roaming where there is permafrost in Siberia now; coal deposits in Europe and North America remind us of millions of years of tropical plant life in these areas during earlier life ages of the earth.

The Bioethics Imperative translates scientific knowledge about life and life cycles into behavioral and attitudinal moral and cultural responses, i.e. into respect and compassion and solidarity with other forms of life. This includes, of course, the Kantian position, respecting fellow humans and sentient and (hopefully) responsible beings. But Jahr goes far beyond those limits of inter-human morality. The recognition of nature and earth as a living being calls for moral protection and cultivation primarily. But recognizing the living nature of plants, animals, environments and the globe itself also calls for accepting naturalness where it cannot be changed. Do we want to ride wild tigers? Do we want to build houses on sand? Do we want to hike lightly clothed in icy weather? Do we want to produce alpha, beta and gamma radiation which we might not be able to fully control: radiation of iodine 131 with a half-life period of 8 days, cesium 137 with 30 years and plutonium 239 with 24,390 years? Do we want to venture leisurely into unknown jungle territories or unsafe and unknown social environments? Do we want to grow cultivated crops in unsupportive soil or climate? Do we want to build nuclear reactors on geological fault lines? Do we want to produce pollution, which the globe cannot handle, which will make us sick and the environment suffer? Do we want to build megacities, which in situations of biological or other emergencies we will not be able to be kept alive and livable?

It is in recognition and respect to the living powers of the earth, that we will not be able to change the seasons of the year or a global warming or cooling over decades or centuries or millennia, if this is the fate and life cycle of the living earth. However, we can change the pollution levels of our cars, avoid the construction of genetically modified plants and animals which might do harm to our health and the health and harmony of the environment; we are challenged to do it for the protection and cultivation of livable natural, social, and cultivated environments. As bioethics per se is integrative, we might add another field of bioethics not yet seen by Jahr and

[2] Jahr (2010) *Egoism and Altruism. Two moral problems, their contradiction and unification in social life* (1929), engl. translation Jahr: *Selected Essays in Bioethics and Ethics*, Bochum: Zentrum Med. Ethik 2010: 11-15

[3] Jahr: Egoism and Altruism.., p. 14.

[4] Sakyo Komatsu (1976) *Japan Sinks,* New York: Harper & Row 1976

others: geo-ethics or earth-ethics. A geoethical version of a content-rich Bioethical Imperative, i.e. the Geoethical Imperative in the Kantian tradition would read: "*Respect mother earth with all her forms of life, whether natural or man-made, basically as goals in themselves and treat them, if possible, as such*."

Such an understanding of geoethics integrated into bioethics in its original and full sense comes close to the definition and application of biocosmology recently presented in *Eubios* by Khroutski[5]. "Restore the original notion of 'cosmology'… a study of the Universe in its wholeness (including life processes)… a definite rational resolution of the issue about active (driving) forces in the cosmic whole, which foremost cause wholesome evolutionary processes in relation to the conscious subjects, including ontogenesis of each person and ascending cycles-stages of the evolutionary process of social and ecological development… a definition of fundamental (universal) laws in respect to both physical (non-organistic) phenomena and processes and equally, - in relation to life (organistic) phenomena and processes, and, herein, - universally referring to all spheres of life (biological, ecological, anthropological, psychological, personalist, social, culturological, etc)."

Cultural Geography and Land Ethics: respecting, interacting, cultivating

What we today may call Geoethics, in the 19th century was called Cultural Geography by Carl Ritter and his younger contemporary Ernst Kapp, a Hegelian scholar and liberal democrat who had to emigrate to Texas after his involvement in the German revolution 1848. Cultural geography was intended to bridge the gap between classical geography and human interaction with land and environment. Philosophical geoscience (Erdkunde)[6] was described as a necessary new philosophy of science and a useful analytical tool in science, ethics, and politics: "Geoscience alike history can be dealt with in a philosophical manner. Philosophy from Vico to Hegel has produced some remarkable books in philosophy of history. They have earned a special prize for that, as they themselves have been recognized as historical powers, a praise which could have even been higher if they had given more attention to the *geographical existence of the nations*. This deficit is their weakness… *Geography* is ingrained into *every place* of history, into every action of human will in his special spatial limits towards its potential realization... *Therefore philosophical geoscience is the indispensable condition of all true history science*. History in its highest form is philosophy of history or politics in a broader sense. Philosophy of earth science therefore can be defined as a *preparatory school for politics*. All roots of political formation are in man; they are developed by man; the process of this development is history. Geography, however, as with and under history developing, is *anthropological*. As such, she is naturally very close to man, because the destination of man is the liberation of his spirit by overcoming nature. We call this process of emancipation history, and via this process the *education* of humankind completes itself as well. The anthropological aspect of philosophical geoscience in this sense, therefore, relates to the task of self-recognition of humankind - via the conscience embodied in history and always renewing itself in it. From a philosophical point of view, geoscience, therefore, is political science as well".

A century after Kapp's vision of cultural geography and 20 years after Jahr's formulation of the bioethics imperative, Aldo Leopold envisioned a new cultural and moral understanding and interacting with nature in its entirety, land, plants, animals, environments, - humankind not as dominant exploiter and conqueror but as a partner, interactive, "an individual as a member of a community of interdependent parts".[7]

If Fritz Jahr would have known Kapp's earlier concept and ethics of cultural geosciences and his humanist vision of transfiguration of nature, and Leopold's imperative of humans not to be conquerors of the earth, rather plain members and citizens of the land, just similar to sands, soils, waters, plants and animals in huge land community, he most likely would have made cultural geoscience or land ethics one of the other fields universal and integrative bioethics. Fritz Jahr, of course, also would have strongly supported and signed the *Eubios Declaration* of March 1, 2002, in particular the new and broad description of bioethics, the role and importance of personal commitment, and the protection and interaction of life as a whole[8].

First of all: Do No Harm (to the Earth and to the Land)

The *primum nil nocere* principle and virtue in Hippocratic medicine of doing no harm in the first place, i.e. balancing minimal or low risk with good success and supporting or healing outcome, can and must be extended to all forms of life in the global dimension of land ethics, cultural geography and integrative bioethics. The earth in general can and has been hurt by humans; goat herding has changed the Mediterranean vegetation

[5] Khroutski KS (2010) Biomedicine as the all-embracing science: biocosmological perspective. *EJAIB* 20: 54.

[6] Kapp E (1845) Philosophische oder vergleichende allgemeine Erdkunde als wissenschaftliche Darstellung der Erdverhältnisse und des Menschenlebens nach ihrem inneren Zusammenhange. Brauschweig: Westermann, p. VIff. – Cf. Sass HM (1973) Die philosophische Erdkunde des Hegelianers Ernst Kapp. *Hegelstudien* 8:163-181

[7] Aldo Leopold (1949) A Sand County Almanac, Oxford : Oxford U Press.

[8] *Eubios Declaration for International Bioethics*: http://eubios.info/eeidec.htm1. - See particularly: "(1) Bioethics is an interdisciplinary field that needs to be nourished by debate among all disciplines and people, not limited to any academic specialty or professionals. (7) Every person has a lifelong responsibility to develop his or her own bioethical maturity and values. We could define bioethical maturity as the ability to balance the benefits and risks of ethical choices, considering the parties involved and the consequences. At the societal level, public policy and law need to be developed, which requires a social mechanism for balancing conflicting ethical principles. (8) International cross-cultural bioethics should be developed, including studies and discussions, which respect individual cultures as long as they do not conflict with fundamental human rights. (13) We recognize the dependence of all life (biota) on intact, functioning ecosystems, and the essential services that ecosystems provide. We urge action to halt environmental damage by humans that reduces biodiversity or degrades ecosystem processes."

for millennia, shipbuilding by the Romans and particularly the Venetians indiscriminately cutting trees along the Istrian coastline of the Adria not followed by reforestation has washed out most soil over the centuries and resulted in meager vegetation. Earth and land are strong and can take quite some abuse and exploitation. Earth and land can and have recovered from severe natural disasters such as meteoric impacts, severe earthquakes, fires, newly modified microbes and predators changing established and well integrated and interacting environments.

The genetic code of life forms has modified itself accidentally and uncontrolled, subsequently changing the check-and-balance of survival and interaction of various forms of life, as Darwin has described. Genetic codes of "cultured" plants and trees and of "cultured" animals, hybrids and crossbreeds produced indirectly by selective breeding, have also changed plant life and animal life together with entire agricultural landscapes. Microbes and retroviruses have been bred strategically in order eradicate deadly diseases or improve therapy. Hybrid plants, some still controversial, will increase food supply and might or might not be more friendly to the environment. The term *culture* originally comes from the Latin word *cultivare*, i.e. working the ground, weeding out unwanted growth, supporting the good and edible and healthy crops and fruits, selectively breeding for even better use. One of the first moral cases related to the culture of deliberate breeding is reported in the Old Testament[9]. Jacob was herding the herds of his father-in-law Laban for no pay, but he requested to be given all crossbreeds after a year or two; so he led the purebred herds be together at the watering places and a longer times, so they could breed across breeding lines. This 'unprofessional' behavior of Jacob was not part of the oral contract between the two partners and was considered immoral by Laban, of course. The Bible reports that Jacob became rich beyond all means; an indication that genetic manipulation and re-manipulation was existing and producing new ethical issues already around 500 BC.

Jacob did no harm to the animals and their offsprings; he was unfair to the father of his wife. Modern forms of genetic manipulation are more controversial in regard to life and happiness of those new forms. Purebred pigs having one rib more, do produce more and better meat, but are said to be extreme nervous and scared; thoroughbred milking cows cannot give birth anymore and have severe pain if not milked in short intervals; we don't know of hybrid corn having different biochemical processes might have a different plant psychology, would suffer or 'scream' differently. Enormous powers of radiation unintentionally set free could emerge if we had uncontrolled or uncontrollable nuclear warfare. Biological and other disasters will cause major changes in genetic change in all forms of life. Thus, the extreme risk of increased radiation is not only related to unfortunate deaths and cancer of those exposed, but even more so to real changes in the DNA setup of all forms of life. This in turn will change the interaction of individual and species life, of biotopes and balanced or slowly changing environments. Some new forms of life will survive or even dominate, others will do harm, will suffer themselves and will hurt others. Those uncontrollable events will cause a new high-speed struggle for life, never envisioned by Darwin or anyone else before.

To expose all life, the land and the earth in general to an unimaginable increase in genetic modification runs against the visions and virtues of respecting life, making this earth the home and house of human civilization, of cultivation and of stewardship, - against the bioethical imperative. To play with fire and with radiation in an uncontrolled and uncontrollable way harms all forms of life, not only fellow humans. It is the opposite of cultivation; it is uncontrollable destruction and severe irresponsibility. Do the recent experiences with nuclear energy disasters meet these standards of irresponsibility and a quest for radical change? *The 'do no harm' imperative, virtue and principle is a central component of the Bioethical Imperative, and as such has to protect and to respect all forms of life on the land and on this earth.*

Bioethics of Land and Earth: Respect and Cultivate the Earth as a Living Being

The bioethical imperative calls for respecting all forms of life as ends in themselves, i.e. recognizing and respecting their individuality, including strengths and weaknesses, limits and capabilities. Such a respect does not exclude to use, to manipulate and to cultivate co-lives for human and cultural purposes. But there are limits to manipulation and cultivation which are related to the limits of every form of life to change or be changed, to feel pain, to be degraded or to be extinguished for no reasonable and morally defendable purpose. In regard to most animals, plants and environments, universal bioethics calls for respecting, for stewardship, and for cultivation. But in regard to Mother Earth and to wild animals, it also calls for accepting what we cannot change, accepting uncontrollable capacities and unpredictabilities. In regard to deadly microbes in hospitals and houses, the bioethical imperative calls for killing and eradicating.

The future of the cosmos in general and of the earth in particular is unpredictable and far beyond our powers of manipulation and cultivation. Of course, we have the powers to harm and to kill many fields of this earth, even to make the earth in its entirety uninhabitable for humans and many species. But the respect for the earth as a living being and for all that is living on, and in it, calls for good protection from harm.

There is definitely a prudent aspect of the bioethical imperative to respect powers, which we cannot change. The moral imperative in those situations requires staying clear from danger and risk in a similar way as we would not ride wild tigers or hug polar bears or infect ourselves with deadly viruses. Rather, the prudent and ethical response is to reduce risk and exposure. Respecting the earth as a strong and powerful living being includes to not build nuclear reactors on geographical fault lines or in other risky places, to discontinue technologies with low probability but highest risk features, to cultivate and not to destroy natural and agricultural environment, to limit genetic and other forms of manipulation to lowest

[9] Genesis 30: 25-36

possible risk including the risk of wrong risk prediction under uncertainty.

The *Bioethical Imperative* in its most universal and integrative form is a good instrument to not only respect and cultivate natural and social environments, microbes, plants and animals, but also the earth in its individuality, its seasons and ages, as a home and support of all forms of live, in its unpredictability and danger. Our interaction with the earth and cosmos includes respectful and careful recognition of powers beyond our influence and to adjust and to act prudently and morally for our own protection and cultivation and for the protection and cultivation of our natural and social environments. Riding wild tigers and playing with nuclear radiation contains extreme risks and dangers and runs counter to the Bioethical Imperative to respect and to support all forms of life and to prepare for dangers and disasters caused by living volcanoes and hurricanes, by earthquakes and the shifting of continental plates, by new or old deadly viruses attacking in pandemic proportions, - for the protection of fellow humans, for protection of the land and for protection of the earth as our house and home. *This earth is the only one we have, so if we do not respect her for what she is, we should do so for our own sake and for the wellbeing of our fellow humans and cultures.*

The need to develop a Qur'anic ethical framework for bioethics: An introductory paper

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Introduction

Rapid progress in areas such as medically assisted procreation, genetic screening, and cloning among many others are raising important issues relating to human intervention in the natural process. Moreover, rapidly developing medical technologies such as life ventilators, dialysis machines, organ transplants as well as cardiopulmonary resuscitation, new drugs and surgeries have saved lives. These same technologies have not only prolonged the dying process but also, at times, given a perception that their use is doing something *to* patients instead of doing something *for* them. Furthermore, these biotechnological advances evoke high expectation for new therapies and drugs. However, they also bring about profound concerns about fundamental norms, values and beliefs. In response to these issues, bioethics as a discipline was born.[10]

One central concern in this field is to search for the 'good' one ought to strive for and the 'evil' one ought to avoid. To begin with, the bioethicist searches answers for fundamental questions such as this related to the essence of human existence. This is in order to define the scope in which biomedicine can take place. This is of course an ethical and philosophical exercise but it has crucial practical implications. The first is whatever boundaries are defined by the bioethicist, the question remains as to 'what should one do under a particular circumstance?' This is a decidedly contextual question concerned with the individual decision of the practitioner, the biomedical problem and the state of the patient. The second is, 'who should one be under the circumstance?' This is the domain of character, i.e., is the practitioner skilled enough? Does he/she possess appropriate moral insight? What ethical and/or religious values does the practitioner hold? Finally, the last implication is 'what kind of communities are we to become through our decisions, practices, and policies?' This concerns the type of a society we wish to conceive and build for the betterment of humanity. Once these types of fundamental enquiries are completed, the bioethicist is in a position to deliberate appropriately.

Recently, however, new questions are being raised. There is recognition within governmental bodies in Western Europe of a concept of governance through partnership between citizens and the state that involves people accepting responsibility for each other. This responsibility is defined as improving social cohesion to protect vulnerable, poor and excluded members of society that are affected by rapid environmental, technological and social change. The overall ethos of such a concept is to encourage civic responsibility amongst all citizens to enhance justice, awareness and stability in a given society. In order to achieve this ethos, all sections of the society will have a part to play in developing the sense of mutual responsibility and interdependence that is necessary for social cohesion. Bioethicists will also have to be cognizant of this fact of working towards a shared social goal that aims for stability, harmony and responsibility. [11]

The second challenge is in the area of moral pluralism and religious contributions to bioethics. As a discipline, bioethics is characterized by ethical relativism which reduces the scope of transcendental morality, spirituality and universal religious ethics. The notion that bioethical theories do not operate according to an overall truth or overarching theological framework according to divine

[10] Bioethics came into existence in a rudimentary way in the 1950's, accelerated in the 1960s and began to assume worldwide dimension by the 1970s. By the 1990s, it was a strong force in the life sciences and in general policy deliberations. Bioethics has come to refer to the broader terrain of the life sciences encompassing medicine, biology, some aspect of environment and social science. In contrast, medical ethics focuses on the professional ethics of the physician and the doctor/patient relationship. See Boyd, Kenneth et al. *The New Dictionary of Medical Ethics.* London. BMJ Books. October 1997. P 1-33.

[11] European Committee for Social Cohesion (CDCS). *A new strategy for social cohesion* - revised strategy for social cohesion, approved by the Committee of Ministers of the Council of Europe on 31 March 2004. http://www.coe.int/t/dg3/socialpolicies/socialcohesiondev/source/RevisedStrategy_en.pdf

texts means bioethicists are free to determine values within a human-centric view of the world, rather than God-centric. The fact that bioethics is deliberating on central issues of human existence heightens the need to engage in dialogue with religious traditions who equally have a stake in the direction of humanity.[12] As Andorno states, *"The enterprise of setting common standards in the biomedical field, although difficult, is possible because international human rights law presupposes that some basic principles transcend cultural diversity. Of course, the major challenge is to identify those universal principles with regard to biomedical issues, but it is possible through promotion of an open and constructive dialogue between cultures. This would explain why international organizations, in which different cultural traditions and values are represented, seem to provide the ideal arena for the discovery of such common criteria."*[13]

As Muslims and academics working in the field of bioethics, our focus in this article is to introduce the potential of the Qur'anic ethical framework within the scope of current bioethical principles and issues. The aim of this is to further engage Islamic scholarship in bioethics as there are still very few Muslim contributions to rapidly emerging biogenetical advancements.[14] In traditional Islamic scholarship, particularly those of seminaries, *fiqh* (jurisprudence) and *kalam* (theology) are regarded as essential subjects. Whilst they have their place as classical disciplines, there is a need to expand Islamic sciences to include bioethics because of the questions posed by contemporary developments that affect the purpose and stability of human existence. Arguably, there is a burning need to acquaint traditional scholars with such developments hence the format of this paper.[15] The second aim of the article is to introduce the Qur'anic ethical worldview of humanity to scholars from other traditions and fields to acquaint them with some foundational ethical concepts that can be a source of fruitful and mutual dialogue. Our methodological approach is introductory but interdisciplinary and schematic so as to achieve an overview of the ideas we would like to discuss and illicit initial responses for further development. The first part of our article will give an overview of current bioethical issues and the Beauchamp and Childress framework. The second part will introduce Qur'anic ethical concepts and compare them to ethical concepts currently used in bioethics.

Biomedical issues that dominates bioethical discussions

The first issue is the profound concern regarding the extent the individual should be allowed to control the reproduction process. This issue has arisen because of the development in reproductive technology and knowledge of assisted reproduction.[16] Should there be unrestricted freedom for individuals to decide as to how these technologies and knowledge of assisted reproduction ought to be used? Some argue that the extent of controlling reproduction is a private matter and it is up to each individual to decide. This is an aspect of individual autonomy. Whilst others promote the idea that the state should have the right to set the extent of controlling reproduction. The challenge is to determine the balance between individual autonomy and state intervention. Bioethicists are also concerned about the extent to which we should permit human life to be created in the laboratory. An impregnated human embryo has life in it but is that embryo a person? When does a human being come into existence? Does an assemblage of cells constitute a human being? These are the questions at the heart of bioethics debates, particularly at a time when stem cell research, genetic therapy and cloning are progressing at a rapid rate. We will now provide an overview of the developments.

a.) Stem cells can grow into any kind of tissue with the potential to cure many diseases. Scientists argue the best stem cells for research come from human embryos. These embryos are created but not needed in fertility clinics. However, scientists have also reported creating embryos solely for the purpose of harvesting stem cells for research and some are also trying to clone human embryos as sources for stem cells. The discussion is on balancing two very profound ethical imperatives. On the one hand to accord respect to our earliest biological beginnings (human embryos) and on the other hand to develop cures for those of us who are sick. Diseases, however, are not the only concern for scientists. The ability to change biological characteristics of human life based on mere individual preference is adding an aesthetical dimension to biogenetics. There are technologies available to modify life created in the laboratory through the techniques of pre-implantation diagnosis and prenatal genetic diagnosis, sex determination for fetal selection, gene therapy and human cloning.[17]

b.) Pre-implantation genetic diagnosis (PGD) has been successfully performed to detect a variety of heritable diseases in embryos. Consequently, the couple may choose to discard transferring embryos to prevent the birth of a severely handicapped child without the need to induce abortion. A model of this pre-implantation screening is the detection of diseases such as Down's syndrome and haemophilia. Is giving the choice of pre-

[12] Dell' Oro, Roberto. Theological Discourse and the Postmodern Condition: The Case of Bioethics. Netherlands. *Medicine, Health Care and Philosophy 2002. 3:127-136*

[13] Andorno, Robert. Biomedicine and international human rights law: in search of a global consensus. *Bull World Health Organ.* 2002. Vol.80, no.12, p962. http://www.who.int/bulletin/archives/80(12) 959.pdf

[14] Arguably, the only systematic text book about Islamic bioethics is by Abdulaziz Sachedina called, *'Islamic Biomedical Ethics: Principles and Application'* (2009, Oxford University Press).

[15] See Motahhari, Mortaza., 'The Fundamental Problem in the Clerical Establishment' in Walbridge, Linda., *The Most Learned of the Shi'a: The Institution of the Marja Taqlid* (Oxford, 2001), p. 175.

[16] The availability of assisted reproductive technology has enabled the individual to control the dissociation of their sexual and reproductive activities, together with the involvement of third party interventions in the reproductive and sexual acts. This has challenged established ethical, social and legal traditions.

[17] Stem Cell Basics. http://stemcells.nih.gov/info/basics/basics3.asp

implantation diagnosis a good thing or not? The answer to this question depends on whether one views an embryo with an inherent autonomy and corresponding duties upon us to respect it. Some believe that genetic selection ought to be permitted because it allows parents to have healthier children.[18]

c.) Prenatal genetic diagnosis (PGD) has made it possible for early selection of the sex of the embryo. This poses the ethical question of the right of the mother or the couple to choose the sex of the baby. This opens up a wide debate around non-ethical discrimination against female foetuses in favour of males. Non-therapeutic fetal sex identification and its implications on reproductive self determination, gender demographics and sociological manipulation are becoming key concerns for both bioethicists and law-makers.[19]

d.) Gene therapy is made possible because of the advances in genetic technology that has facilitated the precise diagnosis of genetic disease. More than 6000 heritable diseases have been identified in human beings.[20] An important development is the introduction and the application of gene therapy for correcting genetic defects in the embryo before its transfer in the uterus. There are at least four well known categories of human gene therapy in the scientific literature. These are the somatic cell gene therapy, the germ line gene therapy, enhancement genetic engineering and the eugenic genetic engineering.

e.) Somatic cell gene therapy refers to a situation when a genetic defect in the somatic cells or body cells of the patient is corrected. The germ-line gene therapy is when a genetic defect in the germ or reproductive cells of the patient; namely the egg, sperm or the early embryo are corrected so that the offspring's of the patient would not suffer from this defect. Enhancement genetic engineering is when a gene is being inserted in order to try to enhance or improve a specific characteristic such as increasing height. The fourth human gene therapy is eugenic genetic engineering when genes are inserted in order to try to alter or improve complex human traits that depend on a large number of genes as well as extensive interactions with the environment such as personality, character and intelligence. The core concern about germ line gene therapy is that changes in germ-cells would affect the descendants of patients. Genetic manipulation is, of course, desirable to remedy genetic defects. However, serious ethical questions begin to arise when genetic manipulation shifts from therapy to the creation of new human types.

f.) Cloning came into focus when Ian Wilmut and his team of researchers announced in February 1997 from the Roslin Institute in Scotland that a cloned lamb named Dolly the Sheep had been produced. This was done by transferring the nucleus of an adult mammary cell from a sheep into an emptied-out egg cell and implanting it. This type of cloning is known as 'Nuclear Transplantation from Somatic Cells.' There is another type of cloning, which is a non-reproductive cloning not aimed at producing an animal or a person. It is limited only for laboratory use to grow a certain tissue line or an organ but not a replicate of the donor of the nucleus. Some of the therapeutic implications are to develop appropriate stem cell cultures for repairing human tissues and development of organs for transplantation. These provide insights into how to induce regeneration of damaged human tissues and for treating very severe cases of infertility. As far as human reproductive cloning is concerned, all major international organizations have totally banned it on moral, scientific, legal and religious grounds. At present, many feel that if cloning is allowed and widely practiced in its limited concept of producing a human being, it will break family ties, genetic links between parents and their offspring and allow procreation in single women. Furthermore, cloned individuals are likely to have a shorter lifespan; suffer from early ageing and gave greater susceptibility to cancer. There is also a concern about whether they would be fertile or not and if so, whether they or their offspring would suffer from an abnormal rate of genetic abnormalities.[21]

The Beauchamp and Childress bioethical framework

In light of the aforementioned issues and more, four seminal principles have been formulated by Beauchamp and Childress as a means to offer a practical ethical framework to solve moral dilemmas in medical and biomedical practice. These are respecting:

- Autonomy (the obligation to respect the decision-making capacity of autonomous persons);
- Beneficence (the obligation to provide benefits and balance benefits against risk);
- Non-maleficence (the obligation to avoid the causation of harm); and
- Justice (the obligation of fairness in the distribution of benefits and risks).[22]

Respect for autonomy means self-regulation. Here, one gives oneself the 'rule' by which one chooses to live. However, it is essential to distinguish between actual or empirical autonomy and moral or normative autonomy. Actual autonomy concerns with our mental and physical capacity to act. Our actual autonomy may be impaired due to illnesses such as clinical depression, severity of pain, delirium, fatigue and existential sufferings. Respect for autonomy of patients, grounds such ethical concerns as the prima facie obligations to obtain *informed consent*[23] from patients before doing things to them, not

[18] Munné, Santiago et al. Preimplantation genetic diagnosis for advanced maternal age and other indications. *Fertil Steril.* August 2002. 78 (2): 234–6. http://linkinghub.elsevier.com/retrieve/pii/S0015028202032399.

[19] See Baruch, Susannah et al. *Genetic testing of embryos.* John Hopkins University, Washington. September 2006. http://www.dnapolicy.org/resources/PGDSurveyReportFertilityandSterilitySeptember2006withcoverpages.pdf

[20] Bellenir, Karen. *Genetic disorders sourcebook.* Canada. Omnigraphics Inc. 2004. P1-10

[21] Weldon, Dave. Why Human Cloning must be banned now. *Dignity*. Spring 2002. http://www.cbhd.org/content/why-human-cloning-must-be-banned-now

[22] Beauchamp, Tom and Childress, James. *Principles of Biomedical Ethics.* Oxford University Press, New York. 1994, 4. See also*:* Gillon R. Ethics needs principles – four can encompass the rest – and respect for autonomy should be 'first among equals'. *Journal of Medical Ethics* 2002. 29:307-12

[23] Agreement by a patient to undergo an operation or medical treatment or take part in a clinical trial after being informed of and having understood the risks involved.

to deceive patients and the obligations to maintain *confidentiality.*[24] Moral autonomy, however, is rooted in the conscious and free will of human beings to choose actions based on their inherent rational dignity. When actual autonomy is not impaired in anyway, it is presumed an individual has absolute choice over his/her existence.[25] Beneficence is the moral obligation 'to do good.' This is a positive principle and requires a healthcare worker to actively promote the well-being of patients, in terms of their health and overall life. A wide variety of prima-facie obligations stem from this obligation. These include the obligation of medical competence and the obligation to keep up to date with knowledge to produce better medical procedures in order to ensure minimum harm and provide maximum benefit to the patient. Non-maleficence, however, is the twin negative principle based on a 'do not harm' notion. A healthcare worker must abstain from acting in ways harmful to patients. Here, respect for non-maleficence is a 'hands off' principle.[26]

Finally, justice refers to the fair and equitable treatment

in light of what is due or owed to person. Within this, distributive justice refers to the appropriate distribution in society determined by justified norms that structure the terms of social cooperation. Justice is a *prima-facie* obligation which is a common feature of many moral theories but in the context of healthcare ethics, justice is important in the distribution of scarce resources to meet patients' needs, produce beneficial health outcomes, avoiding waste, equality of patience access and ultimately, patient care.[27] In Beauchamp's and Childress' bioethical framework, there are three noteworthy characteristics. Firstly, it broadly identifies four ethical principles that are drawn predominantly from the works of major Western philosophers, in particular Immanuel Kant, John Stuart Mill and John Rawls. Secondly, each of these principles was referred to as *prima facie*. Thirdly, these principles place a particular emphasis on the good for society at large, i.e. the greatest good for the greatest number of people. At the same time, there is an inherent dignity of the individual which is to be respected which is exemplified through the principle of autonomy. In this respect, it contains both utilitarian and deontological dimensions. This framework has remained with us since 1979 and been presented to various international institutions on bioethics as universal principles applicable to any culture and society. In other words, these principles could be used in a pluralistic, multi-cultural society where no one's ethics should be imposed on others.

No doubt, these principles deserve our appreciation in laying a practical ethical framework to determine medical and biomedical dilemmas. However, 30 years on, one needs to ask whether its application in a range of circumstances have provided satisfactory outcomes.[28] Some reject the four principles as culturally exclusive and claim that they are limited in scope.[29] Others argue that they are largely unhelpful even within the culture in which they were formulated precisely because they are too broad.[30] Our specific question is whether these principles have chimed a chord with our inner feelings regarding our purpose in life and what essentially makes us happy as human beings. This is, of course, a deeply metaphysical, philosophical and moral question, but one which is practically relevant because any working ethical principle must produce an outcome that human beings are normatively satisfied with. If there is no normative goal in an ethical principle, it can become procedural and leave room for subjectivity.

There are several examples of the subjectivity in applying these principles, which has led to decisions that exclude the sanctity of life itself. This is evidenced by the high rates of abortion worldwide and increasing efforts in many countries to legalize euthanasia.[31] We also find a commercial dimension to the concept of life with women selling eggs to couples that cannot conceive children. This is in order to pay debts, student loans and living expenses.[32] Interestingly, the converse development that life itself is considered to be the highest value and must be sustained at all costs is also of concern. It medicalises

[24] Entrusted with somebody's personal or private matters.

[25] Beauchamp, Tom and Childress, James. *Principles of Biomedical Ethics.* Oxford University Press, New York. 1994, 121.

[26] Beauchamp, Tom and Childress, James. *Principles of Biomedical Ethics.* Oxford University Press, New York. 1994, 189.

[27] Beauchamp, Tom and Childress, James. *Principles of Biomedical Ethics.* Oxford University Press, New York. 1994, 327.

[28] The basic contention is that respect for persons, justice, and beneficence are fundamental principles in a formal sense. How we view these principles in practice will depend on our particular culture and experience and the kinds of meta-ethical criteria we use for interpreting, applying, and justifying these principles and others we may derive from them. See Thompson, Ian. Fundamental ethical principles in health care. London. *British Medical Journal.* December 1987 Vol: 295, 1465.

[29] See Wulff, HR. *Against the four principles: a Nordic view.* 1994. Cited in Gillon, R. *Principles of healthcare ethics.* Chichester: John Willey & Sons. 1994, 277-86.

[30] See Harris, John. In praise of unprincipled ethics. *Journal of Medical Ethics* 2003. 29 (5):303-6.

[31] The European perspective includes quite different laws on euthanasia and PAS (Physician assisted suicide). Most states uphold a ban despite the fact that in 2002, euthanasia and PAS were legalised in the Netherlands and euthanasia was legalised in Belgium. In 2003, the Council of Europe issued a controversial report on euthanasia in the light of Article 2 (which concerns 'right to life') of the European Convention on Human Rights. In the UK, a House of Lords Select Committee recently reviewed the evidence that has been submitted following a private bill on assisted dying for the terminally ill that would legalize both euthanasia and PAS, providing certain criteria were met. In November 2005, an amended Bill was introduced to allow PAS only. It is worth noting that in June 2005 the British Medical Association dropped its long-standing opposition to euthanasia and PAS, and adopted a neutral position. There is mounting pressure towards legalization in other European countries too. See - Materstvedt, Lars. The EAPC Ethics Task Force on Palliative Care and Euthanasia. *European Journal of Palliative Care*. 2006: 13(5)

[32] See the article reported by Dominiczak, Peter. Woman advertises her eggs on internet to pay student debt. London *Evening Standard.* 4th May 2010. http://www.thisislondon.co.uk/standard/article-23830313-woman-advertises-her-eggs-on-internet-to-pay-student-debt.do

the dying process and plays into the hands of the technological imperative, i.e., if we have the technology, we must use it. As a consequence of this widespread notion, we may observe a more dramatically reshaping of the way we care for the dying.[33]

The central moral issue in both removing life and prolonging life is the disproportionate emphasis on individual rights. When we say human beings are autonomous, this is not just related to the capacity of the individual to act. It also relates to the social life of that individual, his/her family, friends and community. If we are to be fully autonomous, therefore, we must also be socially autonomous and free from the consequences our actions have on other people. This is practically impossible because human beings cannot live without each other. One wonders if individual rights are as powerful as they appear to be. Realizing our limitations also has a reflective dimension which transcends our social life. Death is a fact of life and our lives are marked by joy and suffering, pain and pleasure, disease and disability. Within these constantly changing aspects of our lives, we acquire the means to our growth and deeper understanding of who we are, what we see as our purpose and what gives us contentment. However, we will never fully appreciate the breadth of our existence when life itself is regarded as a utility. The fact that two opposite developments take place in the medical world, removing and prolonging life, points to the lack of inherent direction to the ethical principles we are using. What precisely is it that drives us to prolong or take away life? If we want to cure diseases, then to what end? Is our existence grounded in anything more fundamental than autonomy and justice?

Of course, the mere mention of transcendence, religion, revelation and God in the field of science raises eyebrows because there is an apparently deep-rooted contradiction in making revelation-based claims in the empirical subject of science. Many pages can be written on this debate from scientific realties that are present within the Qur'an, definitions of science and revelation and recent discoveries by scientists that were relayed by Prophet Muhammad in Arabia fourteen centuries ago.[34]

Our aim, however, is not proselytize nor to engage in this issue because it requires another paper. Our goal is to show how religion and specifically, the Qur'an, is an important source of ethical concepts that need to be part of the bioethical dialogue taking place today. Without considering what revelation (from all traditions) has to offer, we would be discarding a source of knowledge that continues to give inspiration to millions of believers around the world and which contains their 'ethical principles' of life.

The Qur'anic ethical worldview of humanity

In Islam, principles and actions come from two foundational sources. One is scriptural – the Qur'an embodying the message revealed by God to Prophet Muhammad. The second is the extension and interpretation of that message by the Prophet's actions and sayings, collectively called the *sunnah*. For Shi'a Muslims, the *sunnah* extends beyond the Prophet to the Twelve Imams, starting with 'Ali ibn Abi Talib, the Prophet's cousin and son-in-law, 1st Shi'a Imam and fourth Rightly-Guided caliph. For all Muslims however, episodes of the Prophet's life, his words, actions and habits represents an enduring model to emulate in their daily lives. For Islamic scholars, it has assumed an authoritative role in explaining and complimenting the Qur'an. Therefore, the message of the Qur'an and the example of the Prophet's life remain inseparable paradigms for proper ethical behaviour.

In the Qur'anic ethical worldview, Allah stands at the very centre of the world of being. All other things, human and non-human are His creatures or creation. This is clearly reflected in the vocabulary of the Quran where the literary focus is on the attributes of Allah which empower and guide everything. Whilst ontologically the Qur'anic world is theocentric, the practical preoccupation of messages in the Qur'an is directed to humankind, its nature, conduct, psychology, duties and destiny. Therefore, one may argue that the Qur'an is primarily concerned with the salvation of humanity through an enduring relationship between God and human beings.[35] Fundamentally, it is the consequences and the realization of this relationship which gives birth to a *muttaqi* (pious) community that responds willingly to the call of One God and shows thankfulness to Gods favours. This is the Qur'anic concept of *tawhid* (the Oneness of God) which is inculcated within the human spirit and manifested outwardly both individually and collectively through moral and spiritual conduct.

At least three layers of ethical discourse are distinguished in the Qur'an:

1. A layer that describes the ethical nature of God
2. A layer that describes various aspects of fundamental attitude of man towards God
3. A layer that refers to rules of conduct that regulate the ethical relations among individual human beings

The first layer encompasses God's attributes such as Benevolence *(rahman),* Merciful *(rahim),* Forgiving *(gafur)* and Just *('adil)* which describes His ethical nature. These are known as the names of Allah which are 99 in

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[33] G Bosshard et al, *A role for doctors in assisted dying? An analysis of legal regulations and medical professional positions in six European countries* - Law, ethics and medicine. "if people know that death on request is permissible, they will come to think that they have not only a right but a *duty to die,* and this would be an intolerable outcome.
It is argued, however, that to request death and receive assistance to die from a sense of duty is not something to be abhorred. It may be a genuinely desired *good death* for someone who has lived his life, partly at least, seeking *the interest of others"* See - Mary Warnock, *A duty to die?* OMSORG 4/2008

[34] Interestingly, in 2009, the British Science Council redefined the field of science. It stated that, 'science is the pursuit of knowledge and understanding of the natural and social world following a systematic methodology based on evidence.' Contrary to many definitions which only emphasise the role of empiricism and observation, this definition brings the natural and social world closer together and includes a broader notion of evidence. One could interpret 'evidence' to possibly include historical and philosophical deliberations, as long as they are systematic. See http://www.sciencecouncil.org/DefiningScience.php.

35 See Izutsu, Toshihiko. *God and Man in the Quran*. Islamic Book Trust. August 2002. 75-79

total and form the basis of Divine ethics. It is perhaps aptly reflected in the verse which Muslims recite daily, *'In the name of Allah, the Beneficent and Merciful.'* The second layer defines the basic ethical relationship of man to God. God responds to man in an ethical way through His attributes and man in turn is expected to respond in kind. This is exemplified by the following verse, *'And when My servants ask you concerning Me, then surely I am very near; I answer the prayer of the suppliant when he calls on Me, so they should answer My call and believe in Me that they may walk in the right way.'*[36] The third layer relates to the moral attitude of humans to his/her fellow human beings. An individual must reflect on the Divine attributes which he/she sees in His Creator and which has been manifested in the *fitrah* (natural inclination towards God and morality) of human beings, towards all members of his/her community. This is reflected by the verse, *'O you men! Surely We have created you of a male and a female, and made you tribes and families that you may know each other; surely the most honourable of you with Allah is the one among you most careful (of his duty); surely Allah is Knowing, Aware.'* [37] The Qur'anic ethical worldview, therefore, expects the actions of an individual to achieve unison between all three layers which are rooted in acknowledging the will and guidance of God. In this sense, human ethics depends wholly on the ethical nature of the Divine being which is reflected by the verse, *'Those among you, who are bountiful and persons of means, should not swear on oath that they would withhold their help from their relatives, the indigent and those who have left their homes for the cause of Allah: they should forgive and forbear. Do you not wish that Allah should forgive you? And Allah is Forgiving and Merciful.'*[38]

The ethical multidimensionality of human beings in the Qur'an

According to the Quran, a human being is a multidimensional creature possessing spiritual, rational, moral, aesthetic and physical aspects to his/her existence. The story of Prophet Adam, the first human being, is instructive in order for us to comprehend this multidimensionality. Adam is distinguished from the angels, who are asked to bow down to him. God addresses the angels, *'And when I have formed him fully and breathed into him of My spirit, fall you down before him in prostration.'*[39] Here we can observe that the material and spiritual elements of creation are combined together which is further substantiated by the verse, 'and then He shaped him and breathed into him of His spirit, and He endowed you with hearing, sight, and hearts: What little thanks do you return?'[40] The first dimension that presents itself, therefore, is a human being's spiritual and transcendental trait which gives him/her a point of origin and enduring connection with his/her creator.

Secondly, the rational dimension is observed by virtue of Prophet Adam's divinely endowed knowledge of the 'names' which is not accessible to the angels: *'And when your Lord said to the angels: I am establishing upon the earth a successor. They replied: will You put there one who will do corruption and shed blood, while we are going swimmingly and gratefully to Your desire and are in dedication to You. He said: assuredly I know what you do not know. And He taught Adam the names, all of them; then He presented them unto the angels and said: now tell me the names of these, if you speak truly.'*[41]

Thirdly, the very setting in which this episode takes place, the garden, provides the aesthetic and beautifying qualities of human beings: *"We said, 'O Adam, dwell with your mate in the Garden, and eat thereof freely when cesoever you wish; but do not approach this tree, lest you should be among the wrongdoers.'"*[42] The ability to experience beauty but also to be lured by it is part of a human being's composition. There is a need to direct the aesthetic dimension to what is moral so that beauty is not corrupted.

Fourth, the physical dimension is exemplified through Adam's punishment in transitioning to earth and engaging in physical struggle. Human beings have physical bodies that are suited to survive in the earthly environment. When Adam and Hawwa are ordered 'to get down', the entire humanity commences its descent towards the physical-spatial-temporal stage of existence on earth. This is accompanied by a pointed caveat 'being enemies of one another' which means that life in this physical world will be a struggle: *'Then Satan caused them to stumble from it, and he dislodged them from what they were in; and We said, 'Get down, being enemies of one another! On the earth shall be your abode and sustenance for a time.'*[43]

Fifth, the moral dimension presents itself through Adam being seduced by Satan. The aforementioned verse clearly warns us that the creative capacity within us carries with it an obligation not to exceed set limits. Satan in the Qur'an exemplifies conduct beyond limits since he disobeys God's command to honour and bow before Adam. In time, Adam too fails to live within the limits set by God, loses his honourable status, which he must attempt to recover subsequently by struggling with and overcoming his propensities on earth, the arena that allows for choice and action. Islam views Adam as recovering his former status by attesting to the capacity to return to the right course of action through understanding his failure and by repentance. Those who struggle and follow His guidelines shall have no fear: 'We said, *'Get down from it, all together! Yet, should any guidance come to you from Me, those who follow My guidance shall have no fear, nor shall they grieve.'*[44]

From the above verses, one may argue that human ethical personality functions in spiritual, rational, aesthetical, physical and moral dimensions. For it to grow and give effect to its full potential, all five dimensions need to be pursued in a balanced manner, grounded in the reality of Tawhid. Under Tawhid, an individual's basic function is to worship the One God as His vicegerent and as a fully integrated being that is harnessing these

[36] The Qur'an, 2:186
[37] 49:13
[38] 24:22
[39] 15:29
[40] 32:9
[41] 2:30-33
[42] 2:35
[43] 2:36
[44] 2:38

dimensions to create a *muttaqi* community. Vicegerency is arguably ethical and creative empowerment by God to human beings. They are entrusted to look after the earth just as God is looking after them: *'Lo! We offered the trust unto the heavens and the earth and the hills, but they shrank from bearing it and were afraid of it. And man assumed it. Lo! He hath proved a tyrant and a fool.'*[45] At the disposal of human beings is the whole of creation that is in the heavens and earth so that he/she utilizes these blessings responsibly and completes his/her growth towards his/her own Godly perfection: *'It is God who has made the sea subservient to you, so that ships might sail through it at His behest, and that you may seek to obtain [what you need] of His bounty and that you might have cause to be grateful. And He has made subservient to you, all that is in the heavens and on earth. Surely in that, there are signs for a people who think.'*[46]

In the Qur'anic ethical worldview, therefore, the aim is to create 'a community of the middle way' that 'witnesses to humankind, just as the Messenger (Muhammad) is a witness for you.'[47] This community's function is to actively promote piety and justice. This process begins with one's self through an internalized *jihad* (struggle) to morally purify oneself in order to become more Godly. The outward manifestations of one's highest behaviour then radiates onto others living in the community which becomes the basis upon which to command the right and prevent wrong. This is where the fruits of one's moral struggle can be realised as an individual's good behaviour touches others to equally awaken the goodness in them. Through this reciprocity, a human being's ethical multidimensionality becomes balanced and grows for the betterment of society.

Having outlined the Qur'anic ethical worldview, we would like to compare autonomy, beneficence, non-maleficence and justice to corresponding ethical principles in the Qur'an. The aim is to offer a contrasting perspective from revelation to these ethical principles (at a theoretical level) as well as comment on the uniqueness that revelation can offer in bioethical deliberation. Our comparative approach is decidedly conceptual and linguistic in the style of an overview for two reasons. The first is given to the limit of the word count of a journal paper, it would be unfair to give a detailed assessment that fails to cover each and every aspect of these principles. The second reason is to provide a basic insight into what drives the bioethical and Qur'anic ethical principles in order to initiate a framework for the future, rather than provide one here. Given the Islamic ethos described above, one may get the impression that concepts such as autonomy are alien to the Qur'an. The reality, however, is that once one gets past the differing use of language and paradigms, one would be able to see not only a clear semblance between Qur'anic ethics and bioethical concepts but also the potential for a distinct contribution stemming from revelation.

Comparing autonomy, beneficence, non-maleficence and justice with corresponding Qur'anic ethical concepts

a.) Autonomy

Autonomy literally means self-rule. This means that one has the capacity for self-rule and others must respect it. When we come to examine autonomy as an ethical concept, we find it is fundamentally rooted in the concept of human dignity.[48] Although there is no agreed definition of human dignity[49], it indicates on the innate self-worth of human beings which manifests itself through the faculties of rationality, moral agency and free-will. Autonomy is directly connected to the dignity of an individual because it presumes that an individual's right to self-determination and decision-making must be respected. Each of us are rational agents in our own respect and apart from being entitled to our own thoughts and actions, we also have a duty to respect the very same entitlement in others.

In healthcare, the prime issue is how to determine the autonomy and agency of the patient. Whilst in sane and relatively healthy patients this is not a problem, it becomes a huge concern in the case of children, elderly and mentally ill patients. Coupled with this is the increasing knowledge and access to knowledge that patients have about medical problems. Since the 1990s, patients are less willing to accept the prescription given to them by their doctors. There is a growing tendency towards a more 'horizontal' relationship between the healthcare practitioner and patient, where power and information have to be evenly shared. [50]

Bioethics is no different. In fact, it is crucial that as gene technologies develop, the amount of knowledge patients have about such 'beneficial' technologies or the authority a healthcare practitioner can exercise over the patient, becomes an increasing concern. Autonomy and knowledge become fused in determining the right biomedical procedures. More than this, human dignity needs further discussion as according to Kantian thought, we may very well question whether human beings are being used as ends in themselves or as a means to an end. As Andorno comments, *"Perhaps the two most distinctive features of international instruments relating to biomedicine are the very central role given to the notion of "human dignity" and the integration of the common standards that are adopted into a human rights framework. This is not surprising if we consider that human dignity is one of the few common values in our world of philosophical pluralism. Moreover, in our time, a widespread assumption is that the "inherent dignity ... of all members of the human family" is the ground of human rights and democracy. It is indeed difficult, if not impossible, to provide a justification of human rights without making some reference, at least implicitly, to the*

[45] 33:73
[46] 45:12-13
[47] 2:143

[48] See UNESCO *Universal declaration on the human genome and human rights*. Available from: URL: http://www.unesco.org/ethics and *Council of Europe Convention on human rights and biomedicine*. Available from: URL: http://www.legal.coe.int/bioethics/gb/html/txt_adopt.htm

[49] See The President's Council on Bioethics. *Human Dignity and Bioethics.* Washington DC. March 2008.

[50] Kennedy, Ian. *Patients, doctors and human rights in Human Rights for the 1990s - Legal, Political and Ethical Issues*. London. Mansell publishing. 1991. 85.

idea of human dignity. This notion is usually associated with supreme importance, fundamental value and inviolability of the human person. In the words of Kant, dignity means that people must always be treated as an end in themselves and never only as a means. Of course, attempts to explain and justify human dignity will encounter enormous theoretical difficulties in our post-modern world. However, it seems that, at least for practical reasons, we desperately need this notion if we want to ensure a civilized social life. As Dworkin argues, anyone who professes to take rights seriously must accept "the vague but powerful idea of human dignity."[51]

By contrast, in the Qur'anic language, autonomy is referred to as *hurriyah* (freedom), which is ultimately rooted in the concept of vicegerency of God (*khilafa*). In comparison to the Western ethos described above, human dignity does not stem from human beings but from God Himself. Just as God created Adam as His vicegerent on earth, so are we vicegerents that obtain dignity through the characteristics and dimensions God has granted us. In the Qur'an, human beings are the noblest beings (*ashraful makhluqat*) granted with free-will and moral consciousness as a trust from God: *'We have honoured the children of Adam and We carry them in the land and the sea, and We have given them of the good things, and We have made them to excel by an appropriate excellence over most of those whom We have created.'* [52] However, with this autonomy and excellence, comes the duty to choose an action with '*ilm* (knowledge). Knowledge is in fact an imperative for Muslims. In a famous *hadith* (narration), the Prophet Muhammad states, *'To acquire knowledge is obligatory on every Muslim. Lo! Allah loves those who have longing for knowledge.'*[53] Not only is knowledge cited as a part of the creation of human beings but it is a principle that God reminds human beings of through the various derivatives and symbols of the word *'ilm.* For example, the word *alim* (the knower) has occurred in 140 places, while al-*'ilm* in 27.[54] Even symbols of knowledge are used such as book (*kitab*) and pen (*qalam*). *Qalam* occurs in two places[55], *al-kitab* in 230 verses, among which *al-kitab* for Qur'an occurs in 81 verses.[56] Therefore, in Islam ones decision ought to be respected if it is taken autonomously with *'ilm*'. However, the effect of this freedom is that he/she should accept the consequences of his/her autonomous decisions.

The ethical perspective of the Quran places responsibility squarely on the individual making choices and carrying out the decision. The reason for this is twofold. Firstly, this ability to make a choice, like all our abilities, is given to human beings as a trust (*amanah*). Secondly, the goal of our *amanah* is to serve God as vicegerent (*khalifah)*. Hence, we are here for God's purposes and not for our own self interest or ends. Human beings are to exercise their autonomy in a constructive manner, working with and developing the world, protecting the harmony between existence and humanity, reaping the bounties of the Earth and Heavens for the benefit of humanity, trying to raise the hue and flavour of life to a more humane level within the framework of the Creator's orders and rules. This is the true nature of a vicegerency and human dignity in the Qur'an. For a conscientious vicegerent, therefore, autonomy is not only a question of controlling the immense power that he/she has but rather how that power can be used to respond to God. This provides the basis for establishing 'responsible autonomy' as a substantive universal principle that incorporates *taqwa* (piety or God-consciousness) as a basis upon which one's conduct is based. At a conceptual level, one may observe that the Qur'an accepts the innate self-worth of human beings and the notion that human beings should exercise their autonomy according to their rational and moral agency. The difference is that their agency has its origins in God, reflects His attributes and exists to serve Him.

b.) Beneficence and non-maleficence

The principle of beneficence guides us to do what is good. Specifically, it suggests acts of altruism such as mercy, kindness and all such acts that promote the well-being of others. When used as a principle to define the moral content of an action it becomes a moral obligation; it becomes a duty, code of conduct and practice. However, the root of beneficence is benevolence, which is the uncompelled and selfless ability to act for the benefit of others. This is a virtuous act known as benevolence. At the same time, non-maleficence is the twin principle 'to do no harm.' If a human being cannot show benevolence, the least he/she can do is not to cause harm to others. It may be better to do nothing in a given situation than to do something that risks causing more harm than good.

In bioethics and healthcare in general, both beneficence and non-maleficence remind the healthcare practitioner and other health care providers that they must consider the possible harm that any intervention might do and beyond this, the possible good they can achieve. As can be observed, benevolence is a different concept from beneficence, which is the primary moral obligation in healthcare. It is far easier to do good for others if one feels benevolent towards them and therefore, benevolence towards patient is a highly desirable attribute. However, the obligation upon a healthcare worker to provide care and benefit for the patients exist independent of whether he/she feels benevolent towards them and applies equally to all as a matter of virtue. It may at times be easier to simply show non-maleficence because one is absolved of the virtue to be benevolent and undertake the responsibility of the well-being of the individual. Non-maleficence is of course a duty that still takes into account the condition of the patience and reminds the healthcare practitioner not to make the patient's condition worse. However, non-maleficence can equally be considered as a principle that

[51] Andorno, Robert. Biomedicine and international human rights law: in search of a global consensus. *Bull World Health Organ.* 2002. Vol.80, no.12, p960. http://www.who.int/bulletin/archives/80(12)959.pdf

[52] 17:70

[53] Kulayni, Mohammed. *Al-Kafi.* World Organisation for Islamic Services. Qum. 1978, Vol 1, Part 1, p73.

[54] Ruhani, Mohammed. *Mu'jam Al-Ihsaai Al-Faadh Al-Qur'an Al-Karim.* Mashhad. 1987, letter 'Ayn.

[55] Ibid, letter Qaf.

[56] Ibid.

reduces the responsibility owed to the patient thus reducing patient care. A brief comment on three influential Western philosophers would highlight the tension in mediating between the two principles. Beneficence has been a central notion in various ethical theories, particularly through benevolence. For example, David Hume defends benevolence as an original feature of human nature. He uses the term benevolence to designate goodwill, generosity, and love directed at others and manifested as friendship, charity and compassion. Principally, he sees human nature in the domain of moral conduct as a mixture of benevolence and self-love motivated by a variety of passions, both generous and ungenerous which vary from person to person.[57]

In contrast, John Stuart Mill argues for a single standard of beneficence that allows one to decide objectively what is right and wrong. He declares that the principle of utility or the 'greatest happiness principle' is the basic foundation of morals. The principle of utility states that actions are right in proportion to their promotion of happiness and wrong if they produce the opposite. The action is right if it leads to the greatest possible balance of beneficial consequences or to the least possible balance of bad consequences. He also holds that the concepts of duty, obligation, and right are determined by what maximizes benefits and minimizes harm. For him, beneficence is translated as maximising happiness but this is within the framework of utility, not necessarily human motivation.[58]

Immanuel Kant rejects Mill's understanding of promoting morality through utility. He develops his ethical theory based on universally valid principles of duty. For him, a motive of benevolence based on mere utility or sentiment is morally unworthy unless the motive of benevolent action is a motive of duty. Everyone has a duty to be beneficent, i.e. to be helpful to others according to one's means, and without hoping for any form of personal gain. To what extent such duty applies to conflicting situations is not clear but he makes a point that while we are obligated to some extent to sacrifice some part of our welfare to benefit others without any expectation of recompense, it is nonetheless impossible to fix a definite limit on how far this duty extends. We can only say that every single person has a duty to be beneficent, according to that person's means.[59] What the above shows is the acceptance of beneficence as fundamental principles for human care, development and stability. Any reduction of beneficence is not in humanity's interest because it is against our nature to be harmful, it does not benefit the overall good of society and we would gradually fail in performing our duty to the best of our ability for the sake of others.

The Qur'an equally emphasises the continual duty to think and act benevolently. It contains a number of concepts in its vocabulary that signify 'doing good.' Three ethical concepts can be identified here: *'khayr', 'ishan' and 'salih*.*'* All of these signify goodness and are used within the scope of ethical action: *'I swear by the time, Most surely man is in loss, Except those who believe and do good, and enjoin on each other truth, and enjoin on each other patience.'*[60] Let us look at each of these words so as to understand their significance. *'Khayr'* is a comprehensive practical term meaning valuable, beneficial, useful and desirable actions, work or conduct: *'(Rest assured that) Allah has full power over everything: establish the Salat and pay the Zakat. you will find with Allah whatever good (khayr) you send forward for your future; Allah is watching everything you do.'*[61] In another verse, God states, *'...instead, (He gave each of you a Law and a way of life) in order to test you by what He gave you. Vie, then, one with another in good works (khayrat). Unto Allah is the return of all of you; and He will then make you understand the truth concerning the matters on which you disagreed.'*[62] From the above verses, one can ascertain that *'khayr'* has wide applications which the Qur'an gives examples of such as charity, being good to one's parents, guiding others and helping the sick.[63] *Ihsan* is a key ethical term in the Qur'an which means inner perfection and beautifying things. It is related to the beauty of one's character and the purity of one's intention. One whose character is the exemplar of beauty is one whose intentions are beautiful. He is called *muhsin*: 'They said: Are you indeed Yusuf? He said: I am Yusuf and this is my brother; Allah has indeed been gracious to us; surely he who guards (against evil) and is patient (is rewarded) for surely Allah does not waste the reward of those who do good *(muhsineen).* (12:90) As Ayoub puts it, *'from the preceding discussion it should be clear that not every Muslim is a man or woman of faith (mu'min), but every person of faith is a Muslim. Furthermore, a Muslim who believes in all the principles of Islam may not necessarily be a righteous person, a doer of good (muhsin), but a truly good and righteous person is both a Muslim and a true person of faith.'*[64]

Finally, the word *'salih'* means 'righteous.' Apart from *salih* being the name of a Prophet, it refers to the culmination of virtuous intentions, character and deeds of an individual. It is a deeper concept than *khayr* because it relates to the inner motivations, heart and soul of the believer. It encompasses *ihsan* because one can only be a righteous person with sincere intentions. In particular, *salih* has a close relationship with faith *(iman).* One of the most frequently used examples found in the Quran is the expression 'those who have faith and do good work.'[65] When the Quran uses two *iman* and *salih i*n such a close relationship, it signifies that one's faith can only have value if it is accompanied by good deeds. Theoretical knowledge *(al-nadhari)* must be accompanied with practical knowledge *(al-amali)*.

What we find the above verses is the dimensions of good and specifically, beneficence. Since human beings

[57] See Beauchamp, Tom et al. *Enquiry concerning the Principles of Morals*. Oxford University Press 1998.
[58] See Mill, John Stuart. *Utilitarianism*. Chicago, IL: University of Chicago Press. 1906.
[59] See Kant, Immanuel. *Grounding for the Metaphysics of Morals.* Hackett Publishing. 1993.
[60] 103:1-3
[61] 2:110
[62] 5:48
[63] See 2:83
[64] Ayoub, Mahmoud. *Islam: Faith and History*. Oneworld publishing, London 2005. p. 54
[65] 103:1-3, 2:62, 2:82 and many others.

are to reflect the beneficence of God in their actions, they must understand how to develop pure intentions, implementation of those intentions and practical situations in which these intentions can be realised. The principle of beneficence, at least in Qur'anic language, is firmly present but a major difference in its framework is the emphasis on the intention of the individual. Acting beneficent is secondary to the intention and the ultimate aim is to produce a salih individual – in the actor and recipient. The constant focus on exerting beyond one's capacity through *jihad* (struggle) to become a *salih* individual minimises the concept of non-maleficence in the Qur'an. This provides us a door into formulating the principle of duty of care from Qur'anic ethical concepts.

c.) **Justice**

Justice and fairness are closely related terms that are often used interchangeably. There have, however, also been more distinct understandings of the two terms. While justice usually has been used with reference to a standard of rightness, fairness often has been used with regard to an ability to judge without reference to one's feelings or interests. In *Justice as Fairness*, John Rawls said, *'[Suppose that a group lets] each person propose the principles upon which he wishes his complaints to be tried with the understanding that, if acknowledged, the complaints of others will be similarly tried, and that no complaints will be heard at all until everyone is roughly of one mind as to how the complaints are to be judged. Each person will propose principles of a general kind which will, to a large degree, gain their sense from the various applications to be made of them, the particular circumstances of which being as yet unknown.'*[66]

Rawls regards justice as the first virtue of social institutions and so justice as a virtue is actually ambiguous as between individual and social applications. This is where we must make a distinction between fairness and justice. Fairness is associated with the procedural ability to judge, apply, distribute and operate according to a consistent set of principles, which at the least, accords with a basic sense of human justice.

Justice, however, is a comprehensive term related to the virtue of a human being and society. It means giving each person what he or she deserves or, in more traditional terms, giving each person his or her due. Plato in the *Republic* treats justice as an overarching virtue of individuals (and of societies), meaning that almost every issue he (or we) would regard as ethical comes is under the notion of justice. In this sense, justice is about self-improvement, deeds, harmony between individuals and the moral elevation of society. In bioethics and healthcare in general, obligations of justice are subdivided into three categories: fair distribution of scarce resources (distributive justice), respect for people's rights (rights-based justice) and respect for morally acceptable laws (legal justice). Here, justice is interpreted as fair, equitable and appropriate treatment in the light of what is due or owed to persons. In this regard, the emphasis on justice is in a procedural capacity rather than virtue-based capacity.

From the Qur'anic perspective, two ethical values underpin all human conduct in all its dimensions: *taqwa* (piety) and *adl* (justice): *'O you who believe! be patient and excel in patience and remain steadfast, and be careful of (your duty to) Allah, that you may be successful.'*[67] According to 'Ali ibn Abi Talib, the success of individuals and society as a whole rests on these twin values: *'No individual is lost and no nation is refused prosperity and success if the foundations of their thoughts and actions rest upon piety and godliness and upon truth and justice.'*[68] The term taqwa occurs over two hundred times in the Qur'an.[69] It represents, on the one hand, the moral grounding of human action, while on the other, it envelops human conscious in the presence of God. It literally means 'God-consciousness.' In a wider social context, taqwa becomes the universal moral mark of a human community which is seen as the instrument through which Qur'anic ideals and commands are translated at the social level. In other words, the community is the custodian through which the covenantal relationship with God is sustained. Individuals within it become trustees through whom a moral and spiritual vision is fulfilled in personal life. Each individual is accountable to God, the community and oneself.

Adl is the twin ethical value that human beings are exhorted to constantly strive for in their lives. 'Ali ibn Abi Talib defines justice as 'putting each thing in its proper place.'[70] In the Divine reality, the principle of justice implies that God has created and guided everything to where it should be. In order to translate this Divine conception of justice into a human context, we have to make an effort in the human plane to put everything in its proper place – to make our society reflect the perfection with which God has created all things. This is why in his famous letter to his governor, Malik al-Ashtar, 'Ali bin Abi Talib states the first act of justice is towards yourself: *'Remember that the best way to do justice to your inner self and to keep it out of harm is to restrain it from vice and from things which the 'self' inordinately and irrationally desires.'*[71] Then an individual must be just to all the relationships he/she forms in society: *'So far as your own affairs or those of your relatives and friends are concerned take care that you do not violate the duties laid down upon you by Allah and do not usurp the rights of mankind, be impartial and do justice to them because if you give up equity and justice then you will certainly be a tyrant and an oppressor.'*[72] Justice, therefore, is a relationship, which operates vertically and horizontally.

These two fundamental ethical principles of the Qur'an are imbibed universally within all practical concepts espoused in Islam. For instance, the duty of

[66] Rawls, John. *Justice and Fairness.* Philosophical Review. April 1958. 67 (2): 171-2.

[67] 3:100

[68] Sermon 21. Radhi, Sharif. *Nahj Al-Balaagha (Peak of Eloquence): Sermons of the Commander of the Faithful, Imām 'Ali b. Abi Talib.* Tahrik Tarsile Qur'an Inc. 1986. http://al-islam.org/nahj/

[69] Ruhani, Mohammed. *Mu'jam Al-Ihsaai Al-Faadh Al-Qur'an Al-Karim.* Mashhad. 1987, letter Taa.

[70] Letter 53. Radhi, Sharif. *Nahj Al-Balaagha (Peak of Eloquence): Sermons of the Commander of the Faithful, Imām 'Ali b. Abi Talib.* Tahrik Tarsile Qur'an Inc. 1986. http://al-islam.org/nahj/

[71] Ibid

[72] Ibid

zakat (to purify, grow and increase) is emphasized in the Quran as a corresponding obligation with salaat (prayer).[73] In time, zakat became an act of charity and ultimately, an act of taqwa to the extent that it became a fundamental pillar of Islam, along with prayers, fasting and pilgrimage. An individual, therefore, must accompany prayers and meditation with spending his/her wealth on relatives, orphans, the homeless, slaves and the poor. The act of zakat defines a Muslim's responsibility to develop a social conscience and to share individual and communal resources with the less privileged. By underpinning taqwa and 'adl through practical actions such as zakat, the Qur'an sought to abolish usury and commercial self-interest in the mercantile community of Makkah and Madinah: *'O you who have faith! Be maintainers of justice and witnesses for the sake of Allah, even if it should be against your selves or (your) parents and near relatives and whether it be someone rich or poor, for Allah has a greater right over them. So do not follow your desires lest you should be unfair…'*[74]

Another example of the practical influence of both concepts in creating a moral community is the elevation of women's rights. It became unjust to treat women as objects and perform female infanticide. More than that, women began to have inheritance, ownership and marital rights with polygamy being restricted to four wives. Taqwa and adl, therefore, were not exclusive for men or a particular group in society. Everyone was expected to act pious and just and actively elevate the status of society from a base existence to a Godly one. Perhaps the best example of this elevation is Prophet Muhammad's attitude to different faiths and cultures. As the Muslim polity took shape, Jews and Christians who are referred to as the 'People of the Book' *(ahl al-kitab)* were granted a protected status. They were to be subject to a poll tax and their private and religious property, law, and religious practices were to be protected. The Qur'an recognises the particularity of all religious communities, favouring common moral goals over mutually divisive and antagonistic attitudes when possible: *"For each community, we have granted a Law and a Code of Conduct. If God wished, He could have made you one community, but he wishes rather to test you through that which has been given to you. So vie with each other to excel in goodness and moral virtue."*[75]

Therefore, the concept of justice in the Qur'an is coupled with God-consciousness. Although the end result is to translate justice on the social plane through practical actions, institutions and procedure, it is driven by the covenantal relationship with God. The whole idea is not just to elevate policies and methods but to elevate the consciences behind those strategies. Hence, when we refer to the discipline of bioethics, we can make an interesting comparison with the social harmony that it discusses as new technologies emerge. Social harmony is driven by equity and appropriate distribution of resources. However, who or what is the purpose behind this distribution in the mind and heart of the individual? The Qur'an puts emphasis on this latter question in its formulation of justice.

[73] See 19:31, 73:20, amongst many others.
[74] 4:135
[75] 5:48

Conclusion

This paper has sought to provide, briefly, the Qur'anic ethical worldview of humanity. It has also given an insight into corresponding notions of autonomy, beneficence, non-maleficence and justice. At the least, the discipline of bioethics can engage in fruitful dialogue with ethical principles from the Qur'an not just because of their semblance but also because of the transcendental, reflective and spiritual dimension they offer. Given that we live in multi-faith communities, there is a need to incorporate transcendental notions of these concepts. If bioethics is deprived of effective contributions from the Qur'an or other religious texts, bioethics would be less rich and less aware of concepts and views stemming from religious scholars. The general approach to issues within Western bioethics is ethical deliberation within a pluralist paradigm that places emphasis on human dignity (to varying degrees) and rational agency of both the practitioner and patient. Islamic bioethics, if we can call it such a term yet, is mainly juristic with emphasis on providing legal opinions in the form of permissibility and impermissibility.

The demand of today, however, is to develop interdisciplinary Islamic scholarship on bioethics, allowing respectful debate amongst a diverse group of Muslim scholars as well as scholars from other traditions. We believe that this interdisciplinary attitude can provide a far richer understanding of the complexities of the issues from which to then craft appropriate guidance from the Qur'an and *sunnah.* Beyond the scope of the Qur'an, the concept of revelation can remind scientists of the metaphysical dimension of life that are often ignored in biogenetical issues. It might call for an examination of the assumption that we must pursue every avenue available to us in the great desire to relieve pain and suffering or develop humanity for the sake of scientific advancement. Ultimately, the Qur'an can be a resourceful tool to engage in ethical dialogue with fellow bioethicists and to reduce the gap between religious and science. After all, according to the Islamic tradition, the Qur'an was an intellectual miracle for human beings to reflect over. It cannot be categorised as a theological, legal or scientific book but a book that inspires concepts through its literary, intellectual and aesthetic arrangement. 'Ali ibn Abi Talib interestingly states, *'The Qur'an consists of a book inscribed, between two covers; it speaks not with a tongue, it cannot do without an interpreter'*[7677] and *'the prophet of a man is the interpreter of his intellect.'*[7879] He also says, *'the intellect is the messenger of the Real.'*[8081]

[76] Sermon 125. Radhi, Sharif. *Nahj Al-Balaagha (Peak of Eloquence): Sermons of the Commander of the Faithful, Imām 'Ali b. Abi Talib.* Tahrik Tarsile Qur'an Inc. 1986. http://al-islam.org/nahj/
[77] Sermon 125. Radhi, Sharif. *Nahj Al-Balaagha (Peak of Eloquence): Sermons of the Commander of the Faithful, Imām 'Ali b. Abi Talib.* Tahrik Tarsile Qur'an Inc. 1986 http://al-islam.org/nahj/
[78] Tamimi, Wahid (n.d.), *Ghurar al-Hikam.* Dar al-Murtada:
[79] Tamimi, Wahid (n.d.), *Ghurar al-Hikam.* Dar al-Murtada: Lebanon. Vol 1, p595, no.2
[80] Ibid, Vol 2, p954, no.33
[81] Ibid, vol 2, p954, no.33.

What these narrations show is the explicit connection between a human being's intellect and Divine revelation but more than that, there must be a dialectical and creative movement in interpreting the revelation. Perhaps this is the real value of the Qur'an in inspiring Muslim scholars to innovate Islamic sciences and engage with scholars from other disciplines and traditions.

Hospital Ethics Commitees (HECs): Patient's Rights Ethics Committees (PRECs) in Israel and Organisational Ethics

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"*The hospital world is neatly ordered. Ethicists ethicise, doctors doctor, nurses nurse, patients suffer, goldfish swim (till they die) and polishers polish, as Ishmael does while listening to Kate Bush's debut album."* [1]

Hospital ethics committees (HECs - also known as CECs)[1], are a relatively new phenomenon (about four decades in the USA, and in other countries it is even more recent). As ethical issues in contemporary medicine become more complex, especially with technological advances, it is believed that HECs can anticipate constant new challenges. It has also been suggested that a major function of HECs is to provide ethical consultation in the clinical setting [2-5]. However, while HECs are taking hold worldwide, the structure, scope of activities and mandate of these bodies has remained unclear. In an editorial in this journal, Sheila Mclean [6] observes that while in the USA CECs *"have become an integral part of the organisational infrastructure of hospitals"*, in the UK, these committees *"remain essentially ad hoc bodies, generated for a variety of reasons and with different goals, structures, membership, methods of working and functions"* [6]. Tan [2] suggests that while HECs may be "a well-established component of institutional healthcare in the United States, it is questionable whether the American model can work everywhere, since cultural, political, constitutional and other characteristics have been shown to influence the functioning of those committees" [2]. Finally, in a recent study of hospital ethics committees in Canada, Gaudine et al. [7] observe that while HECs in Canada have become more regularized and formalized over time, more research is necessary *"to better know how best to define what the scope of activities of CEC should be in order to meet the needs of hospitals (in Canada and elsewhere)."* [7]. This paper reviews some of the models of HECs that have developed in chosen parts of the world (not exhaustively) before focusing on the Israeli model.

Hospital ethics committees in the world

In the US a recent study (2009) gives a picture of HECs in the State of Louisiana, compared with other states [5]. Of the 194 hospitals identified by the Louisiana State Hospital Association, 88 hospitals completed the survey, pointing out that an HEC was present in 69 of these hospitals. The growth rate of HECs increased in the early 1990s. Larger institutions tended to have a higher frequency of HECs. Teaching hospitals and larger hospitals tended to have a higher frequency rate of HECs. Membership was most often multidisciplinary. Like most US HECs, the Louisiana state's committee's primary functions included case consultation, education, and policy review. According to this study, Louisiana's HEC construction and function appear similar to committees found in other US hospitals [5].

In Canada around 85% of hospitals over 100 beds seem to have established CEC (but the authors admit this rate might be somewhat inflated). There is a wide variation in the size of committees and the composition of their membership. Meetings of CEC have become more regularised and formalised over time. However, 24% of committees reported that they met six or fewer times a year. CEC continue to be predominately advisory in their nature, and by 2008 there was a shift in the priority of the activities of CEC to meeting ethics education needs and providing counselling and support with less emphasis on advising about policy and procedures. There are fewer administrators and board members, more bioethicists (66% vs 41%) on committees in 2008 compared with 1989, and more lawyers (49% vs 36%) compared to 1984. Ethics education for CEC members and health professionals is a key function of CEC, followed by counselling and support for healthcare personnel. The majority of CEC (88%) reported that their role was primarily advisory, with 94% reporting that their decisions were not binding [7].

In Germany, a study of HECs in 36 university clinics observed that in Germany only a minority of hospitals, often members of the Protestant or Catholic Hospital Associations, have founded HECs [8], while in the US all health care institutions must provide some structure to handle ethical conflicts in everyday patients' care. Nursing directors (N) estimated the need for additional support of their staff in ethical issues higher than medical directors (M). Improvements in interdisciplinary teamwork, further education in ethics and ethical guidelines were identified in order to improve ethical professional performance. However, N mentioned the lack of time and the low priority of ethics more often than M as problems in implementing these measures. According to this study (2004), information about HECs in German university hospitals lags behind; working methods and chances for further development of HECs are neither known nor used in the majority of German university hospitals [8].

In Japan, an eight-year follow-up national study of medical schools (80) and general hospital ethics committees (with over 300 beds; n = 1457 in 1996 and n = 1491 in 2002) suggests that HECs in Japan focus mostly on research ethics [9]. The overall structure of HECs in Japan is interdisciplinary; and the frequency of annual meetings has increased significantly for both

medical school and hospital ethics committees over the eight years.

But the primary activities for medical schools and HECs were research protocol reviews and policy-making. There was a significant increase in the use of ethical guidelines, among both medical schools and HECs. Overall, there was a greater recognized degree of responsibilities and an increase in workload for Japanese ethics committees [9].

Table 1: Examples of Hospital ethics committees

Country	Legally required	Present in all institutions	Member-ship	Tasks
UK	No	No	Unclear	Advice to health professionals and patients on ethical issues.[6]
Canada	No	No	Multidisciplinary Between 5-25 members	Case discussion; development of policies; provision of education in ethics.[7]
USA (State of Louisiana)	No	No	Multidisciplinary	Case consultation ;education in ethics; policy review.[5]
Japan	No	Unclear	Multidisciplinary	Research ethics; ethical guidelines. [9]
Germany	no	No	Unclear	Unclear(No working methods). [8]
Belgium	Yes (since 1994; partly overruled in 2000)	No	8-15 Mostly physicians + a lawyer and a nurse Limitations: Heads of the hospital cannot be members	Research protocols review; guidance Ethics consultation (not legally required since 2000).[10]
Croatia	Yes (since 2000)	No	Five members (mostly): Three physicians; two from other fields.	Analysis of research protocols (mostly).[3]
Israel	Yes (since 1996)	No	Five members: chairman: a judge; 2 physicians, a psychologist or social worker; a member of the public or religious rep.	Not functional.[4] (separate committee for the analysis of research protocols)

In Croatia, ethics committees are legally required in all healthcare institutions by the 2000 Law on Health Protection [3]. But in 2006 only 46% of the healthcare institutions in Croatia had an ethics committee. Eighty nine percent of the ethics committees had five members, three of whom were from medical professions and two came from other fields. 49% of those committees stated that their main function was the analysis of research protocols [3]. Only a small fraction of the ethics committees sent in standing orders, working guidelines or other documents that were connected with their work. Thus, although there are legal provisions for ethics committees in the healthcare institutions in Croatia, there were discrepancies between the practice and the Law on the Health Protection, "suggesting the need for revision of the law." The authors conclude that there is a need for creating separate networks of HECs and IRBs in Croatia [3].

Table 1 shows a summary of comparable data about Hospital ethics committees in chosen countries. As Table 1 shows, there are two major categories of HECs: Ethics committees that are not legally required (USA, UK, Canada, Germany, Japan), and HECs that are required by legislation (Begium, Croatia, Israel); Further analysis of the final group shows that in Croatia and Belgium, HECs function mostly as IRBs. In contrast, HECSs in Israel are not functional; but there is a separate system (Helsinki committees) for the approval of research protocols. The rest of this paper will focus on Israeli HECs.

HECs in Israel

Israel has the distinction of having ethics committees legally required by a Patients' Rights Act since 1996. Appointed by the Director-General (of the Ministry of Health), Patient's Right Ethics Committees (PRECs) comprise five members as follows: (1) a person qualified to be appointed District Court Judge as Chairman of the Committee; (2) two specialist physicians, from different specializations; (3) a psychologist or social worker, and (4) a representative of the public or person of religious authority" [11]. The Israeli statutory ethics committee is a multidisciplinary committee and has decision making authority. In 2002, however, a study showed that six years after the legislation of the Patients' Rights Act, only one third of general hospitals in Israel had an ethics committee; with committees concentrated in larger facilities [4]. According to this study, hospitals without committees tended to lack any structure to handle ethics issues. However, one-third of patients' rights ethics committees (PRECs) never convened, and most committees had considered fewer than ten consults. Furthermore, access to the consultation process and the consultation process itself varied substantially across committees. Some PRECs attempted to solve cases, others only rendered decisions. 'Informal' HECs, if present, often refused to consider cases within Patients' Rights Act jurisdiction. The study concluded that despite the statutory requirement, many Israeli patients and clinicians did not have access to ethics committees, that the scant volume of cases showed "serious discrepancies between practice and Patients' Rights Act regulations" and, that there is "the need for education or revision of the law' [4].

HECs in Israel - revisited

Eight years after the above description (and 14 years after the legislation of the Patients' Rights Act) the situation of PRECs in Israel, remains unchanged. The director of a large hospital in Jerusalem (Shaarei Tzedek), talking to the attendants of the international conference on Hospital Ethics Committees (held in Zefad in May 2009), admitted that the PREC in his hospital had convened only twice during the past 13 years [!]. Further discussions with other physicians revealed that this phenomenon is recurrent in Israeli hospitals (personal communication). Interestingly, the proposal of the director of Sharei Tzedek to activate PRECs in Israel is to merge these bodies with the Helsinki committees. This certainly would make the situation of HECs in Israel similar to the other countries in which HECs are legally required (Sweden and Croatia), since the analysis of research protocols is the main preoccupation of the HECs in these countries. In other words, merging the function of PRECs with the Helsinki committees could make Israeli PRECs appear 'as functional as' in Sweden and Croatia. Yet it is clear that this proposal does not resolve the problem of (inexistent) ethics consultation in the settings of Israeli hospitals (neither in Sweden nor in Croatia).

There seems to be an 'unfriendly' perception of HECs in hospitals; which is not unique to Israel. Borovecki et al. point out that in Croatia "the role of ethics committees is often not well perceived in a hospital environment." [12] McLean notes that *"only a small percentage of professionals admitted that they had used ethics services in the UK when they were available."* And, that one of the reasons for this might be that professionals may resent third parties *"'muscling in' on an area which has hitherto been their primary domain."* [6] Gaudine et al. point out that *"even if physicians generally supported the idea of hospital ethics committees, they also supported the tradition of physicians having primary decision-making power for ethical decisions."* [7] Although this attitude may remain *"open to discussion"* (as Mclean puts it) [6] it is not implausible that in Israel one of the reasons for the poor rate of consultation with PRECs is that these bodies are chaired by a person from the judicial system (a judge or its equivalent). Secondly, the rule of Israeli PRECs is binding. Thus PRECs in Israel do not 'just' offer ethical advice or are a 'space' for ethical consultation and/or ethical deliberation. Plainly, PRECs are (or supposed to be) ruling bodies. Finally, but not least, the consultation with PRECs does not remain confidential; which makes physicians (more) vulnerable to liability. Hence, it is hardly surprising that physicians in Israeli hospitals do not address PRECs for ethical consultation. Moreover, the growing numbers of cases brought to the Israeli courts (not necessarily by PRECs) have engendered a culture of 'defensive medicine' in Israel. This also is not unique to Israel. However, ethical issues used to be integral of the round-table deliberations of 'a case'; further exposure of physicians to liability in Israel has actually had the effect of 'expulsing' ethical discussion from these deliberations. Ethical dilemmas (when and if these are perceived) are now discussed in the obscurity of hospital corridors (personal communication). Worryingly, the patient's rights legislation in Israel, which undoubtedly has the best of intentions, to protect patients from (potential) arm/abuse and/or negligence in the hospital setting, has the side effect of hindering ethical reflection, and/or open deliberation on ethical issues; which are key tools for decision making; and, for learning medical ethics.

Health Risk Management

Contrasting sharply with PRECs, Health Risk Management committees (HRMCs) have thrived in Israeli hospitals. ('risk management' of health risks issues is one of three components of 'health risk'; the others being 'risk assessment' and 'risk communication'). Again, the development of HRMCs, is not unique to Israel. Yet in Israel both PRECs and HRMCs have in common that they are the result of the Patients' Rights Act. But there are substantial differences between HRMCs and PRECs. The most obvious difference is that PRECs do care for the patient, while the core preoccupation of the HRMC is with the hospital. A second difference is that the legislation that made possible the existence of PRECs did not allocated a budget for their functioning. Thirdly, not all of the members of PRECs work at the hospital (including the chairman of PRECs), which means that PRECs cannot be convened ad hoc. By contrast, HRMCs have become stable bodies of the managerial practice. Ultimately, but not the least, the fact that PRECs are chaired by any person qualified to be appointed District Court Judge, means that a decision by PRECs is compulsory, which makes PRECS incompatible with HRMCs. In other words, the mere 'existence' of PRECs is considered a risk for HRMCs. Yet it could be that an 'ethical' assessment' of care (within the assessment of risk) may be better for HRMCs than just getting a 'legal' advice?

HRMCs and HECs

Risk assessment is considered "a scientifically based process"; by contrast, risk management "may be affected by other factors." This is why within the European Commission there is a functional separation between the process of 'risk assessment' and the 'risk management' of health. The EC points out that "this separation is essential in order to protect the scientific integrity of the risk assessment process and to ensure an appropriate balance of the various factors that affect risk management choices." [13] For similar reasons (thus, to protect the integrity of the ethical assessment process), there is the idea that a functional separation between HECs and HRMCs is necessary. Moreover, as McLain notes "it may be too simplistic to presume that ethics committees can perform a function for healthcare professionals [and/or hospitals] as well as patients."[6] (my adition in parenthesis).

On the other hand, Beleveld et al. [14] suggest that there are two possible main missions of hospital ethics committees: to help with the ethical concerns of clinicians and, to assuage managers' concerns, such as restoring public confidence or decreasing litigation claims from patient [14]. Meulenbergs et al. [10] observe also that "the availability of ethics consultation in hospitals may lead to optimised patient care, and, also reduce hospital costs." [10]. Surely, without (some kind of) managerial recognition/acceptance of PRECs in Israel, these bodies

will remain as redundant as they have been for the past 13 years. In this context, the concept proposed by Thurber [15] of 'organisational ethics' is key; since organisational ethics aims at enhancing the overall ethics of an organization with the goal of changing the climate and then the culture of the organization [15]. In such an ambience (thus in the 'culture' of organisational ethics), ethical assessment of care, along with (or on top of) any kind of 'legal' assessment of risk, could positively affect hospital environments; and most probably could do better not only for the patients, but also for the hospitals (in Israel and elsewhere).

Some conclusions

McLean warns HECs from becoming focused on legal matters [6]. Indeed, the effects of the often massive intervention of the legislation in Israeli PRECs suggest she is right. The setting of PRECs has discouraged ethical discussion in Israeli hospitals. Worse, doubt about a 'case', and possible error/s may remain undisclosed within the system. This may undermine the useful, and necessary, process of learning ethics.

The idea of hospital committees being legally required has been followed in Croatia. In Israel, however, PRECs remain ineffective. Therefore it is reasonable to change the law. HECs, rather than ruling PRECs, should be promoted. However, HECs should become budgeted, permanent consulting bodies; and provide advisory assistance for HRMCs. As a result, the availability of ethics consultation may lead to optimised patient care; and, work best for the management of hospitals as well. Moreover, a culture of 'organisational ethics' may effectively improve the 'management of risk' in hospitals. Restructuring Israeli legislation of PRECs to a permanent advisory bodies on ethics for HRMcs, and developing an 'ethical environment' may make ethics consultation more workable for patients and members of staff; and more effective, not only in Israeli hospitals but also in other parts of the world.

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How Should Ethics be Taught to Medical, Nursing and Other Healthcare Students?

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Abstract

In the last three decades, formal ethics education has become a common feature of medical curricula. However, ethics teaching in medical schools has faced difficulty justifying the allocation of substantial time in the busy medical curriculum. The authors' primary goal is to summarize the core approaches attempted in the health care ethics courses at our University and described in the textbook written by one of the authors.

Our educational goals are: (1) to provide historical insights; (2) to provide a methodological guide for addressing ethical issues in clinical and multidisciplinary settings; and (3) to inspire students' introspection. In our view, both the internal and external directions of moral inquiry should be pursued. In history education, the knowledge of landmark events will be indispensable, but not sufficient. Learners need to be motivated in the internal direction by not letting them separate the past and the present/future. In our experience, the internal pursuit in learning the history of health care ethics can be carried out by the student being aware of the possibility of being on "the wrong side." In methodology education, principles and the four-quadrant method are useful, but should not be presented as simply a set of action guides or checklists. Careful application of these "tools" to a particular case requires not only their external manipulation, but also some approaches to intake subjective viewpoints of each individual in the case. The narrative approach might be useful for that purpose, but needs to be grounded on basic principles not to place excessive value on consensus.

Introduction

In the last three decades, formal ethics education has gradually become a common feature of medical curricula. The trend first appeared in the United Kingdom and United States, where systematic reviews on medical ethics education were published in the 1980s. These early documents shared a core premise that ethics should be integrated into the formal curriculum throughout medical teaching. The Institute of Medical Ethics in the UK argued that medical ethics education

should recur at regular intervals throughout medical training [1]. A 1989 review article from the U.S., entitled "Medical ethics education: coming of age," pointed out that ethics education should be more clinically centered than human values education, and should be more inclusive of philosophical, social, and legal issues than interpersonal skills training [2]. In Asia, the establishment of medical ethics education apparently did not fall behind much. International surveys in 1990 showed that 89 of 100 medical schools in 14 countries (Japan, China, Hong Kong, Taiwan, Korea, Mongolia, Philippines, Thailand, Malaysia, Singapore, Indonesia, Sri Lanka, Australia, and New Zealand) offered some courses in which ethical topics were taught [3,4].

Despite ethics being frequently included in medical training, ethics education in medical schools has experienced difficulty in justifying the allocation of substantial time within the busy medical curriculum. For example, the 1990 Asian survey also showed that 87.5% of Japanese medical schools offered ethics education, but the majority taught it as a unit of other courses and allocated only a short time to ethical topics [4]. Empirical studies and theoretical arguments from around the world suggest that on the one hand, ethics education has been established as various types of courses in medical curriculum, but on the other hand it has not yet been established as an area of scholarship with definite goals, and well-grounded contents and methods relevant to it [5-9].

Teaching Goal – Internal or External?

Some philosophical concerns have been addressed regarding the development of ethics education in medical schools. One criticism is of the *ahistorical* presentation of standard bioethics textbooks that respect the Hippocratic Oath and the Nuremberg Code, but seldom engage in serious historical reflection [10]. In contrast to the role of history in medical ethics education, it has been argued that its goal should be primarily concerned with inculcating medical *professionalism*, and that it should give medical students the tools for navigating the ethically charged terrain of clinical practice [11]. However, there are competing ideas even when there is the shared goal of cultivating medical professionalism: some regard this as creating *virtuous* physicians, while others perceive it as developing the *skills* for analyzing and resolving ethical dilemmas [12].

The dichotomous argument over the goal of medical education might be reflecting the controversy regarding the direction of moral inquiry in contemporary medical ethics – *internal* vs. *external*. Today's medical ethics (or bioethics) has converged on the *external* analysis of human morality that is most evidently observed in a narrow conception of human *autonomy* [13]. While the traditional quest for autonomy addressed *internal* moral laws or self-awakening (for example, in Buddha's and Immanuel Kant's theories), bioethics focuses on an *external* account of a patient's self-determination: how a person can be judged autonomous by means of external observation (for example, with some criteria to judge that he or she is competent). This argument can be applied to the controversy over the goal of medical ethics education. If *internal* pursuit is at the core, we should help students become good physicians and expect them to develop the virtues entailed by the profession. According to Edmund Pellegrino, some of these virtues are fidelity to trust, benevolence, intellectual honesty, courage, compassion, and truthfulness [14]. He also mentions the teachability of virtue, referring to ancient Greek philosophers, and states: "He (Aristotle) said we learn by practice and that the best practice is to follow a model of the virtuous person. In medicine this means we need virtuous physicians as teachers." However, this argument might be vulnerable to attacks on the establishment of ethics courses in the busy medical curriculum, because models of the virtuous physician can be found during the clinical clerkship or in the workplace after graduation. These concerns lead us to rely more on pragmatic *external* approaches, with which teachers can consider more concrete instruction on "skills" and "tools" for analyzing ethical dilemmas.

Medical Ethics or Health Care Ethics?

Still another type of integration should be pointed out with regard to the cultivation of professionalism. Ethics in clinical settings might not be best described as "medical ethics" in its narrowest sense. In other words, the terminology needs to be questioned. In real clinical settings, ethics cannot be considered as the ethics of the "physician." Nurses and allied health professionals have their parts and therefore, ethics education in classrooms should also be planned in a multidisciplinary context. Preferably, students in medicine and various health professional programs should be given the opportunity to talk about ethics in a classroom around a table. For this reason, we used "health care ethics," rather than "medical ethics" in the title of our courses and the textbook.

All these controversies over medical ethics education might be attributed to its youth as an academic discipline. Resolving these issues will require many more years of trial and error in classrooms and clinical settings. In this essay, we summarize the core approaches attempted in health care ethics education at our University and described in the textbook written by one of the authors [15]. The first two of fifteen chapters in the textbook present a review of the history of health care ethics, followed by three chapters on methodology explicating three approaches in the field: 1) principle-based, 2) procedure-based, and 3) narrative. In the following chapters, cases in "death and dying", "sexuality and reproduction", "patient's rights and public welfare", "medical research and health care resources" are discussed combining the three approaches. Our educational goals are: (1) to provide historical insights, (2) to provide a methodological guide for addressing ethical issues in clinical and multidisciplinary settings, and (3) to inspire students' introspection.

Historical Insights

Japanese textbooks of medical ethics might be also subject to the criticisms mentioned above regarding ahistorical presentation. They tend to review bioethical concepts and history as a set of novel socio-academic movements observed in the US during the last few decades of 20th century. Theoretical arguments in

bioethics (e.g., "patient autonomy," "personhood theory," and "slippery slope argument") are often described as a set of American artifacts in the context of landmark developments in bioethics, such as the Nuremberg Code, Helsinki Declaration, Tuskegee syphilis scandal, and the American Hospital Association's Patient's Bill of Rights put an end to the long tradition of "medical paternalism" since the Hippocratic Oath. Some Japanese critics have claimed that medical students should be taught important events in which Japanese medical society played a key role [16].

A historical review of health care ethics can have a deep impact on medical students, as it inevitably includes reviewing how their predecessors failed or committed inhumane acts. In our courses, we begin by illustrating practices in ancient medicine in the East and West, and ethical norms and codes of the time. Students learn that most of the important principles such as "non-maleficence" and "beneficence," (or "benevolence" in Eastern conceptualization), already existed at very early stages of medicine not only in the West, but also in other parts of the world. In contrast, they see that one of the essential principles in contemporary medical ethics, "respect for the patient's autonomy," is *not* seen in most of the ancient medical norms and codes.

The knowledge of ancient medical ethics invites students to consider when and why the principle of patient autonomy--one of the most important topics in the history of health care ethics—was established. Students first learn the tragic history of Nazi medicine. Then they are introduced to what was done by medical professionals of Unit 731, a Japanese unit which conducted human experimentation and vivisection, primarily for the development of biological weapons, using predominantly Chinese prisoners-of-war and citizens. We also discuss how the American occupation army exonerated Unit 731 leaders from the Tokyo War Crimes Tribunal in 1946 in exchange for the data they accumulated, leaving no renewal of the rules for human experimentation. This incident is contrasted with the Nuremberg Medical Trial that sentenced seven of the defendants to death and issued the Nuremberg Code, widely regarded as the first document to set out ethical regulations for human experimentation based on informed consent. In the last part of the historical review, we discuss the history of the Japanese leprosy control policy, which started in the late 19th century and continued until 1996 [17]. Students discuss the responsibility of the medical profession for development of the control policy, which resulted in a mass human rights violation.

In the history review in our health care ethics course, we never guarantee that learners are safe from standing on "the wrong side." In other words, we do not adopt the simplified dichotomy which lets learners think that the *past* was wrong while the *present* is just, or that those in the past demonstrated bad faith or thoughtlessness to which the present students are unconnected or immune. Instead, we expect them to engage in self-reflection through the historical review and realize that the "banality of evil" coined by Hannah Arendt can become their own, if they are not prepared to think critically about the results of their actions or inaction.

Methodological Approaches

The underdevelopment of methods in health care ethics represents the poor scholarship in medical schools in Japan. Textbooks often utilize thematic descriptions of headline-grabbing contemporary issues such as organ transplantation, euthanasia, assisted reproduction, and human cloning. Theoretical foundations and grounding concepts to bridge different issues and topics are less frequently discussed. In the English literature, case-based learning has been widely recognized as one of the most effective methods in health care ethics education. Empirical studies conducted so far have reported on the method of health care ethics education - *how* it should be taught. They focused on the *material* (videos, movies, documents) [18, 19], the *mode* (lecture, small-group discussion, role-playing) [20-22], and *approach* (moral-theory, literature/humanities, practical case discussions) [23, 24]. However, the theoretical basis for case studies has received relatively little attention. We have distinguished three different approaches in health care ethics. Some of them are not necessarily proposed for educational settings, but can be applied in a classroom with either fictional or non-fictional cases.

1) Principle-based approach

The principle-based approach, which was ironically called "principlism" or the "Georgetown mantra," has dominated bioethics and attracted criticism from various points of view. For example, Clouser and Gert claim that the principles lack any systematic relationship to each other and the conflicts between them are unresolvable because they are not derived from a unified moral theory [25]. Others charge that the application of already established principles to new situations "can do more harm than good" [26], concerned that principles can be used as action guides or checklists in a shorthand manner without promoting practitioners' deliberation. Nevertheless, the advantages of a principle-based approach, including its applicability to a wide range of medico-ethical issues and its utility to people with great differences in belief and ideology, are so evident that the approach has survived criticism and been accepted across the world. However, the weakness of this approach becomes obvious in educational settings where case studies are often attempted with only a short description or "vignette" of a model case. Actually, it is difficult for many students to analyze ethical problems in clinical cases using principles. As we reported previously, students showed relatively poor performance and were often not able to recognize conflicts between two or more ethical principles [27]. This problem might be rooted in the nature of the principle-based approach: principles are abstract and do not indicate any concrete direction about how to judge and act in a given situation. They require deliberate interpretation when being applied to real cases.

2) Procedure-based approach

Another category of methods in health care ethics is what we coined as "procedure-based" approaches. This is most vividly illustrated by Albert Jonsen's *"Casuistry and Clinical Ethics"* [28]. In an attempt to bring casuistry

(which had been harshly attacked by Pascal in the 17th century) back into the limelight, Jonsen laid the foundation for the methodology on case studies in health care ethics. Jonsen and colleagues claimed that principles should be appreciated in the specific context of the actual circumstances of a case, and formulated a practical method that integrates basic principles into a healthcare provider's working procedures [29]. They developed a four-quadrant method for analyzing a case that specifies four topics ("medical indications," "patient preferences," "quality of life," and "contextual features"), with which physicians can integrate ethical issues with the other aspects of daily medical practice. Japanese philosopher Tetsuro Shimizu noted that Jonsen's method is based on the healthcare culture of the US, and proposed his version of clinical ethics that was intended to integrate ethical considerations into the Japanese context of health care [30].

Procedure-based approaches are also friendly for medical, nursing, and other healthcare students, especially for those in clinical education. Once they become familiar with factual discussions of clinical cases, the four-quadrant method is much easier than a principle-based one. However, procedure-based approaches hardly guide students to find a solution when there is a conflict between moral points of view among players in a case. Teachers can facilitate the students' clarification of the point of conflict in a case, but not illuminate how to proceed. This weakness might be attributed to the nature of the procedure-based approach, in which principles are contextualized in actual circumstances, because no single principle is privileged in these methods. This must be decided in the context of each case, which is not possible to demonstrate in a classroom.

3) Narrative approach

The narrative approach in health care ethics education was developed using linguistics/communication-based moral philosophies (e.g., narrative ethics, ethics of care, and discourse ethics) and social constructivist theory. We have applied pragmatic narrative-based approaches in health care ethics education for approximately ten years [27]. A case is defined as a complex of multiple narratives and utilizes the "Rashomon effect," the subjectivity of perception that results in individuals producing substantially different but equally plausible accounts of the same event [31]. This approach requires students to carefully analyze how the case is experienced by individuals in different positions by means of collecting narratives.

In clinical settings, these narratives are collected via interviews with each individual, focused on their history of the experience using questions like: *"What was it like when you first noticed the symptom?"* and *"How did you think about your daughter's future life if she is dependent on a ventilator?"* The answers from each individual's perspective are transcribed as "the patient's narrative," "the mother's narrative," "the family doctor's narrative," "the nurse's narrative," etc. In educational settings where such interviews are impossible, a case must be presented not in the form of vignette, but as a set of "narrative data" that includes what they have been told up until the present situation.

The review of individuals' narratives allows for, although not perfectly, a deeper understanding of the "temporal wholes" of personal experiences of the parties involved in the case. The knowledge of how the individual has been led to his or her current state of moral belief will promote participants to imagine further steps much more easily than in other approaches. Students can discuss the future scenario and its options in the case with questions such as: *"What is the possible scenario(s), if not best, that can be accepted by all parties in this case?"* and *"Who should talk to the patient's father on this topic, and let him consider the options?"*

The weakness of the narrative approach touches on the debate concerning communication-based moral philosophies in which human morality is regarded as being established by means of a communicational process. With these lines of conceptualization, the narrative approach in health care ethics and its education must overcome *relativism*, or the "anything goes" paradox, in which consensus is regarded as the ultimate goal, and no rule or principle is referred to in moral consideration. For this reason, the narrative approach requires inspection with principle-based or procedure-based approaches.

Conclusion

This essay has summarized the core approaches attempted in the health care ethics courses at our University and described in the textbook. We have pointed out that there are competing views regarding the goal of health care ethics education, which reflect the *internal* and *external* directions of moral inquiry in contemporary health care ethics. In our present view, both directions should be pursued in education. The external dimension is addressed with history education. The knowledge of past landmark events will be indispensable, but not sufficient. Learners need to be motivated in the internal direction by *not* letting them separate the past and the present/future. In our experience, the internal pursuit in learning the history of health care ethics can be carried out by the student being aware of the possibility of being on "the wrong side," as illustrated by tragic events in the history of medicine.

We have distinguished three different approaches in health care ethics applicable in a classroom. At present it is not clear whether all three approaches should be used in parallel, or whether two of them should be combined. Principles and the four-quadrant method are useful, but should not be presented as simply a handy set of action guides or checklists. Careful application of these "tools" to a particular case requires not only their external manipulation, but also some approaches to intake subjective viewpoints of each individual in the case. The narrative approach might be useful to that end, but needs to be grounded on basic principles *not* to place excessive value on consensus.

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An ethical and social examination of the death penalty as depicted in two current films made in a "pro-death penalty society"

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Abstract

In Japan, although various arguments exist regarding the appropriateness of the death penalty, nationwide public opinion polls regarding the death penalty revealed that 85.6% of respondents supported maintaining the death penalty in 2009. Under these circumstances, it is worthwhile to deliberate the ethical and social issues surrounding the death penalty as depicted in Japanese films from medical humanities perspectives. In the present paper, we discuss two recent films concerning the death penalty, *13 kaidan* directed by Masahiro Nagasawa, 2005 and *Kyuka* directed by Hajime Kadoi, 2007. The two films describe the impact of execution on the executioners, secrecy of executions, rehearsal of the execution, and voluntary participation in execution. They depict the current situation surrounding the death penalty and execution, as well as everyday life on death row, in detail. Serious concerns about current execution procedures were also described. The two films seem to try to tell the audience that there is something strange in killing people in perfect order with good will in the name of law and justice. They show the officer's instinctive aversion provoked by the execution and make us think about what it means to kill a human.

Introduction

Various arguments exist regarding the appropriateness of the death penalty. Proponents argue that we should take the murder victims' families wishes of retribution into maximum consideration, social justice requires death of the killer, and the death penalty works as a deterrent to keep murder from happening. They also argue that a life sentence without parole is more inhumane than the death penalty, and we should maintain it as a less cruel punishment for vicious criminals. On the other hand, opponents argue that it is not only the killer who should be blamed because society as a whole is responsible for the occurrence of murders, which occur in part due to factors such as poor education and severe poverty. They argue that we should stop the chain reaction of killing, cases of false accusation undoubtedly exist, and many innocent individuals have been and will be executed in the name of justice. Other opponents argue that the death penalty is an infringement of fundamental human rights, particularly the right to life. They also point out that the death penalty is wrong because those who are in charge of executions

suffer a serious psychological burden and even discrimination, and that the death penalty has no power as a deterrent. Under these circumstances, it is worthwhile to deliberate the ethical and social issues surrounding the death penalty as depicted in films from a medical humanities perspective. Through films, we can see many aspects of a country: culture, morality and religion, and views on life and death. The best films can both entertain audiences and provide viewers with opportunities to think about fundamental human problems [1, 2]. In the present paper, we discuss two recent films concerning the death penalty in modern Japanese society that were produced in midst of an atmosphere in which more and more Japanese people approve of capital punishment as a legitimate social system.

Current situation of the death penalty in Japan

In the 1950s in Japan, the average number of executions was about twenty-five per year. In the 1960s and 1970s, the numbers of both executions and death sentences began to fall, and in the 1980s, the number of executions dropped to three or less per year. No condemned criminal was executed between 1990 and 1992 [3]. In the meantime, four cases of false accusations resulting in death sentences became clear, and the convicts in these cases were all found to be not guilty and released. These four cases of false accusation had a tremendous impact on Japanese society and facilitated civil movements against the death penalty and the decrease in executions beginning in the 1980s [3, 4]. The worldwide trend of abolishing the death penalty may also have influenced the decrease in executions.

The indiscriminate assaults carried out by members of "Aum Shinrikyo" brought about a complete change in the trend toward abolition of the death penalty. Aum Shinrikyo was a religious cult established in 1984 that carried out attacks using sarin nerve gas in five Tokyo Metropolitan subway lines in 1995, which killed thirteen people and injured 6300 people. This mass murder case cast the Japanese into the nadir of confusion and terror. As of now, thirteen members directly involved in the attack have been sentenced to death. Furthermore, in 2001, a man named Mamoru Takuma broke into a primary school and indiscriminately killed eight boys and girls, shocking and terrorizing Japanese society. Families of the murdered children publicly wished for death of the murderer and the mass media broadcasted their rage and agony every day.

Non-fiction writer Tatsuya Mori wrote that Japanese society after the Aum sarin subway attack collectively developed a sharp dichotomy between right and wrong. He claims that following the attack, a murderer is perceived as a complete stranger who is absolutely evil, and their desire to chastise murderers has been enhanced along with a resulting tendency to punish criminals more severely. Fear of indiscriminate terrorism has caused social anxiety and facilitated risk management [5]. Japanese people expect the death penalty to deter murder [6].There is more interest in and sympathy with the families of murder victims than ever, and their desire for retribution resonates with Japanese society as a whole, leading to more support for condemning murderers to death [4, 5, 6]. Nationwide public opinion polls regarding the death penalty in Japan revealed that 73.8% of respondents supported maintaining the death penalty in 1994, 79.3% in 1999, 81.4% in 2004, and as high as 85.6% in 2009 [6]. Statistically, the annual number of vicious criminals sentenced to death by the courts has been consistently more than ten for the past several years [3].

In 1983, Japanese courts introduced the “Nagayama Criteria” to determine whether or not a criminal should be executed. The criteria include nine factors, all of which are used by the court in its decisions: the criminal’s motive, method and cruelty of the act, number of victims, damage to and desire for retribution of the victim’s family, impact on society, age of the criminal, his or her criminal record, and repentance shown after the case [4]. Execution is carried out by hanging.

***13 kaidan* (Thirteen steps) and *Kyuka* (Vacation): Two recent Japanese films concerning the death penalty after the Aum attack**

We performed an extensive computer search with the purpose of finding Japanese death penalty films dealing with contemporary issues of the death penalty. We focused our search on films produced after the Aum sarin subway attack in 1995 that made Japan a “pro-death penalty society.” We used the Japan Cinema Database (http://www.japanese-cinema-db.jp/), which enabled us to search Japanese films made between 1914 and 2010 by title, and other Internet sites and literature reviews [7]. Many death penalty films made in Japan after the 1950s focused on the tragedy of innocent individuals involved in false accusations caused by inhumane and authoritarian prosecutors and police officers [8]. However, our search identified two Japanese films, *13 kaidan* (directed by Masahiro Nagasawa, 2005) and *Kyuka* (directed by Hajime Kadoi, 2007) that we considered suitable for this study and were available on DVD. We will first provide synopses of the two films and then discuss problems surrounding the current system of execution in Japan.

The plot of *13 kaidan* may be summarized as follows [9]: The day of execution for a condemned criminal, Kihara, is approaching. Kihara had been sentenced to death for killing a probation officer who took care of him on parole and the officer’s wife. However, Kihara has no memory of committing the murder and there are no eyewitnesses. The death sentence was given based only on circumstantial evidence. Nango, a death row officer who believes that Kihara is innocent, begins a private investigation to clear Kihara’s name with the help of Mikami, a young man who had been charged with manslaughter and is currently on parole. Their only clue for finding new evidence that proves Kihara’s innocence and revealing the real murderer is the memory of a staircase with thirteen steps that Kihara recently remembered. This film may be categorized as a thriller and the main theme is clearing the false charge of the condemned by the day of execution. At the same time, however, the film depicts Nango’s longstanding agony that he has suffered since he participated in the execution of a condemned criminal named Terada, who had killed four people to get money. The film shows Terada’s repentance and atonement, rehearsal of the execution, Terada’s execution by hanging, and the breakdown and regeneration of Nango’s family. The film also follows the paroled convict, Mikami, showing the everlasting hatred for Mikami held by the father of a son

who Mikami accidentally killed in a fight, Mikami's confession about the fight, and his salvation.

The plot of *Kyuka* may be summarized as follows [10]: Hirai, a veteran death-row officer, is going to marry Mika, a single mother with a son. The wedding ceremony is planned, but Hirai has already used up all his paid vacation and can't find time for the honeymoon. Meanwhile, the execution of Kaneda, an inmate Hirai is in charge of, is set for two days before Hirai's wedding. Kaneda was sentenced to death because he killed an old couple to get money. At the death row facility where Hirai works, it is customary for the chief warden to give a week-long vacation to an officer who volunteers for the role of "Sasaeyaku" (supporter), who holds the hanged body of the convicted during the execution in order to stabilize it. Hirai wants to please his new wife and get to know her son by spending time together during the honeymoon and, after long consideration, he volunteers for the role of "Sasaeyaku." Volunteering to participate in the execution was very unusual, especially for "Sasaeyaku," and this incurred the ill feeling of some colleagues. The film depicts the process of Kaneda's execution and Hirai's honeymoon by turns, and contrasts the end of life with the start of a new family. The everyday lives of both the condemned criminals and prison guards on death row, communication between Hirai and Kaneda, and the establishment of a relationship between Hirai, Mika, and her son are also described.

In the following sections, we refer to similarities and differences between the two films and specifically discuss the impact of execution on the executioners, secrecy of executions, rehearsal of the execution, and voluntary participation in execution.

Impact of execution on the executioners

Both films depict the agony of death row officers who were directly involved in executions. In *13 Kaidan,* the officer Nango persistently suffered from psychological trauma caused by the execution of Terada. From Nango's perspective, he had killed a man and this made him a murderer. He felt that he had committed a crime that was never judged or punished by law. The thought constantly tortured him and led to the disruption of his marriage.

In *Kyuka*, Hirai volunteered for "Sasaeyaku" and two days after Kaneda's execution, had a wedding and went on a weeklong honeymoon. He took care of his wife and her son, and played catch with the boy. However, Hirai was not as high-spirited as he seemed. While playing catch, he had sudden nausea and vomited in a public bathroom when he vividly remembered the touch of Kaneda's body during the execution. He also lost his sexual desire, even sleeping with his new wife by his side. Hirai's colleagues who were also involved in Kaneda's execution completely lost their appetites and did not touch their beefsteaks at Hirai's wedding. In contrast, a young death row guard who was not involved in the execution had an excellent appetite. A warden at the facility where Hirai worked told his men that it was hard for them to execute a condemned criminal after a three-year interval.

What does the audience feel when they watch the deep anguish and suffering of the executioners? Do they get the impression that it is abnormal for a man to kill another man and that killing is something beyond our normal psychological and physiological range? Or, do they just doubt the qualities of the protagonists as death row officers? It is possible that what they get from the two films differs depending on each person's position on the death penalty.

If Mika, Hirai's wife, had vomited instead of Hirai, the implications of the vomiting would be completely opposite. Stereotypically, a young woman's vomiting in films is morning sickness, implying pregnancy, a cause for congratulation. While one vomits because of the touch of a dying and hanged body of a murderer, the other vomits due to the beginning of new life in her body. Hirai's vomiting as well as Nango's persistent affliction may give the audience the impression that there is something wrong with the death penalty, and this could be one of the messages the creators of the two films want to convey to Japanese society.

Secrecy of executions

In *Kyuka*, a death row warden instructed his men in charge that the date of the execution must not become known to anyone beforehand, including the condemned criminal Kaneda himself, his family, other convicts on death row, and any third parties. On the morning of the execution, Kaneda was informed that he would be hanged and from then on, he was paralyzed with fright. He had to be brought to the scaffold by several death row officers. At the beginning of *13 kaidan*, Kihara, a condemned criminal on death row, is terrified by the footsteps of guards making their rounds. A convict would be executed in about an hour if the footsteps stopped in front of his room. In the film, the criminal put in a nearby cell was brought to the scaffold. The loud voice of the criminal's resistance echoed throughout death row. At the end of *13 kaidan*, the footsteps of the death row officers approach Kihara's room again. Do they stop in front of Kihara's room? This is the most suspenseful scene in the film.

In reality, execution is conducted in absolute secrecy in Japan. No one, including the condemned criminal and the criminal's family, is informed beforehand. The convict is told approximately an hour before the execution and the family is informed only after the execution. The criminal is sometimes unable to stand up, or gets upset or violent when informed [11, 12].

Japan used to inform a condemned criminal and the family a day or two prior to the execution, and there was a chance to have a final family meeting. However, a condemned criminal committed suicide before the day of his execution in the 1970s, although the details are not known. The suicide made it impossible to execute the law as scheduled. The government concluded that the timing of disclosure of the execution was inappropriate and decided to abolish the advance notice [11, 12]. The secrecy of execution is notorious. For such prisoners, each day could be their last, since they are not informed of their date of execution until a sudden visit from a prison guard with a death warrant signals their execution within hours [13]. The two films precisely depict this aspect.

A criminal who is sentenced to death has to be executed exclusively by hanging exactly as planned. The death of the condemned criminal by sickness or fasting is unacceptable. In *13 kaidan*, the convict Terada attempted to commit suicide by fasting, but one of the death row officers told him that such an attempt was in vain because his life would be saved and sustained by

artificial nutrition and hydration. According to an ex-death row officer, the first three rules for dealing with death row convicts are "keep them in prison," "keep them alive," and "keep them sane" [12].

We speculate that there are additional reasons that Japan continues to keep executions secret. It is possible that the government wants to avoid trouble. If the date of an execution is officially announced, many reporters would arrive in front of the prison beginning early in the morning. Reporters who lack care or consideration may harass the murder victim's family or the convict's family. Death penalty proponents could clash with opponents. No one in the government would want such a situation. It is also likely that government officials and death row officers want to avoid letting the condemned criminal down, or want to make the period of despair and horror as short as possible. This consideration may be derived from good will toward the criminal, but it is also possible that the officers wish to avoid confronting the intense fear of the convict and the deep sorrow of the family. Even veteran death row officers may be at a loss when they have to cope with the heavy emotions of those involved. The current secret procedure of executions reminds us of similar secrecy in disclosing diagnoses of serious medical conditions such as cancer, dementia, and serious psychotic disorders. Japan has a long history of doctors not informing their patients of the true diagnosis or prognosis in order to avoid letting the patient down [1].

Rehearsal of the execution

The two films both depict arrangements for the execution. In *13 kaidan*, a preliminary drill of all steps involved in the execution is described in detail. Under the instructions of the chief warden, all aspects of the execution are carefully confirmed, including the condition of the floor which will fall out from under the condemned criminal, the appropriate length of the rope which will be used to hang the criminal, the positioning of officers in charge at the moment of execution, the signal to push the button controlling the floor, and tea or sweets which may be given at the final wishes. In *Kyuka*, Hirai and one of his colleagues sweep and clean the scaffold area.

The preliminary drill and preparation depicted in the two films is a rehearsal of the execution, and we feel that these scenes make the audience uncomfortable regardless of the creators' intentions. Naturally, murderers also develop a plan and make thorough preparations, and they may sometimes rehearse the homicide. However, murderers kill people with malicious intent. They commit a cruel homicide out of self-interest. They perform the ultimate evil deed with evil intentions. Although there is no room to justify their killing, understandable consistency exists in terms of the relationship between their intentions and actions. In other words, a cold-blooded person does things that are very wrong, and bad intentions lead to bad actions.

On the other hand, audiences of the two films witness a good man, who is a guardian of justice in our society, engaged in preparations and arrangements for killing in perfect order as a member of a legitimate professional group. The films show us fellow citizens calmly and quietly devoting themselves to preparing a perfect ceremony in which another man is "humanely" killed. We feel there is something bloodcurdling in such well-organized and rational actions. There is something unconvincing to us. How can someone who is right and good, rather than someone evil and wrong, cause the death of a healthy man in a deliberate manner under a strict schedule without any violent emotion? Killing is an ultimately evil deed that has to be prepared by ultimate evil or caused by uncontrollable emotion. Therefore, the scenes of the rehearsal can be as disturbing as those of the execution.

Voluntary participation in the execution

As previously mentioned, in *Kyuka*, Hirai volunteers to play the role of "Sasaeyaku," which incurs ill feelings from some colleagues. In both films, all officers designated for the execution are described as doing their painful duty, and no one looks happy or willing to be involved in the execution. It is something ill-omened and abominable. Some are superstitious that their participation in the execution will cause something unhappy to happen to them. When an old veteran officer was asked by a young officer how many times he had participated in executions, the veteran responded that it was something that should not be thought about. It seems that even among death row officers, execution is a taboo subject and something which must not be discussed. Death resulting from the execution may be perceived as impure in Japanese culture and something to be avoided because of its transmissibility. [2]

There is a custom in Japan that an officer who is expected to have happy events in his private life, such as a birth or marriage, is not nominated as an executioner [11]. Under these circumstances, Hirai's volunteering for the execution to gain vacation time for his honeymoon upset his superior, Mishima. Mishima was also angry because he thought that Hirai took advantage of Kaneda's death for a highly private and trivial reason. He blamed Hirai's motive and said, "What do you think of a human life?" Hirai replied in turn, "You too earn your bread doing this job!" Mishima was also designated as one of Kaneda's executioners. The audience has the chance to deliberate if Hirai should be blamed for his decisions, and whether or not there is a difference between Hirai's voluntary participation in the execution and Mishima's ordered participation as part of his job.

In our opinion, there is no difference between Hirai's voluntary participation and Mishima's participation by order. This is because their participation in an execution is legitimate law enforcement in Japan. The warden asked for volunteers for "Sasaeyaku," and execution is part of a death row officer's job. As Hirai mentioned, other officers including Mishima obtained their jobs voluntarily and have kept them to earn their livings. It would be hypocritical for us to say that it is acceptable to participate in the execution as an ordered job, but it is blameworthy to volunteer for it. Both Hirai and Mishima take part in killing a man with their own will and both benefit from it. Only the officer who goes against orders and refuses to be involved in the execution because of conscience or anti-death penalty activism would be qualified to blame Hirai's actions. As long as the death penalty is legal in Japan, we cannot accuse Hirai.

Conclusions

The two films depict the current situation surrounding the death penalty and execution, as well as everyday life on death row, in detail. Serious concerns about current execution procedures, complicated emotions of death row officers involved in the execution,

and physiological hatred held by executioners were also described. Interestingly, a family member of the victim killed by Terada or Kaneda never appears on screen. Crime scenes or violent characterizations of the condemned criminals are also absent. In *Kyuka*, the old couple killed by Kaneda makes an appearance in his cell for only about ten seconds, standing quietly behind Kaneda. In *13 kaidan*, one of the death row officers told the warden, who had just been informed of the date of Terada's execution, that the murder victim's family commuted Terada's death sentence to life imprisonment. Sorrow, anger, or agony of the murder victim's family would easily enable the audience to feel that the criminal deserves death, but no such expression was used in the films. It can be argued that the two films at the least do not emphasize the cruelty of the crime and criminal.

On the other hand, in *Kyuka*, Hirai's story concludes very successfully. Love of a new family healed the psychological damage that Hirai suffered from the role of "Sasaeyaku." Although the film reminds the audience of Kaneda's death by showing the empty room where he had been living, it ends by focusing on Hirai's new happy family life. In *13 kaidan*, one of the death row officers declares to Nango that murderers have a completely different brain structure and they have to be killed in any case, and Nango does not refute the officer's comment. Furthermore, despite the fact that Nango has serious psychological damage from Terada's execution, he continues to work as a death row officer for decades before he quits the job to concentrate on his investigation to clear the false accusation made against Kihara. The miserable and unhappy past of the condemned criminal, compelling reasons for his crime, and the deep grief of the convict's family were not depicted. In *Kyuka*, a younger sister comes to see Kaneda, but she says nothing to him. Both films seem to give the audience no chance to empathize with the condemned criminals, suggesting that the two films are not protesting against the death penalty.

In a society where the death penalty legally exists, more than 85% of the people approve of capital punishment as a legitimate social system, and more than ten convicts are executed annually, what significance do these two films have? It may not be the presentation of aggressive messages against the death penalty. It is possible that such objections against the execution of condemned criminals will just provoke antipathy and lead to ignorance. It seems that the creators of the films are trying to tell us there is something strange in killing people in perfect order with good will in the name of law and justice. They show the officer's instinctive aversion provoked by the execution, and make the audience think about what it means to kill a man. There may sometimes be a criminal who deserves death, but the death penalty, despite its legality, is a type of killing. The two films let us deliberate on what killing a man means in a "pro-death penalty society."

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Directed Organ Donation: Can Japan maintain fairness?

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Introduction

In light of organ donation and transplantation, there are two distinctive features between Japan and Western countries. One would be that the rate of organ donation and transplants in Japan is extremely low. In comparison with the United Kingdom which adopts the opt-in system of organ donation, for instance, the number of those who register organ donation in Japan is merely one tenth and that of transplant practices in 2009, for example, was one twentieth [1] (Japan Organ Transplant Network [2]; NHS Blood and Transplant [3]). [4] Although the reason for such distinctive numerical differences can be argued by a variety of viewpoints, this controversial topic was discussed in a previous essay (Yoshida 2004). The other two features would be that the concept of directed organ donation was uniquely legalized in the revised version of Law on Organ Transplant (Law No. 86. 2009) under which priority donations among family members was permitted from the 17 January 2010. The first case under the revised law is that of a wife of a man who had died of stomach cancer on the 21 May 2010 received one of his corneas by an hour-and-half transplant operation carried out on the last day of May 2010 (*Daily Yomiuri* [5]; *Mainichi Shinbun* [6]).

According to principles of justice and equity and to standards of the greatest medical need, organs from deceased donors have been distributed to potential recipients on a waiting list of relevant organs, although the Western countries have the differing opt-in system and opt-out one in dealing with the intention to donate organs. Therefore the equal and impartial allocation of organs engages prohibiting discrimination, unrelated to medical concern of life or death, on the basis of sex, age, ethnic origin, races, sexual orientation, colour of skin, religious, etc. The issue of directed organ donation has recently caused much controversy (Ankeny 2001;

Wilkinson 2003; Sherwin et al. 2004; Hirholst 2005; Pennings 2007; Cronin & Price 2008). The reason for it is chiefly that the serious scarcity of cadaveric organs urges the increase the supply of organ donations and has an efficient strategy for justifying the directed organ donation by the relation with the practice of living organ donations such as kidney. This justification challenges the egalitarian principle of justice so that it is inevitably in the heat of discussion.

Firstly, in this paper, I want to sort out general issues on directed organ donation. In the UK a case where the kidney donation happened between a daughter (donor) and her mother (recipient) (BBC News [7]), and in the USA, a problematic donation based on racial discrimination [8] were under fire due to breaking the principle of the impartial and equal allocation of organs. Secondly, based upon the *status quo* I will interpret how the directed organ donation was legalized in the revised Law on Organ Transplantation enacted on July 2009. According to a survey carried out by the Japan Organ Transplant Network, among new 695 donors who online-registered organ donation for ten days between 15 January and 24 January 2010, the number of donors who preferred the choice of directed organ donation was 168 (Ministry of Health, Labour and Welfare [9]). The number seems to be larger than expected. Thirdly, I will explore how directed organ donation has been justified in the process of legalization and why the specified donation practice enjoys great popularity among donors after the enactment of the new Law on Organ Transplantation.

Discussion on Directed Organ Donation

A serious shortage of organs for transplantation has been continuing in most countries. The scarcity and value of organs, as useful resources, unbalanced between demand and supply, seem to have produced an idea of directed organ donation, which challenges the principle of organ allocation, based on anonymity and impartiality to promote the number of donated organs. The directed organ donation refers to an example of the dilemma which occurs when a donor of organs expresses the willingness to donate his/her organs to a specified person who has an intimate relationship with him/her. This dilemma lies in discussion on the respect for individual's autonomy, the maintenance of the fairness of the organ allocation system, the value of the goods based on altruism, preference and discrimination, and historical development of ethics.

Attention to two well-known British cases which provoke such ethically complicated controversies should be drawn. [7] [10] The current public policy started from the result of an inquiry into an incident in Sheffield where a racist condition was added to a cadaveric organ donation. Under the condition of transplants to white people, the family of the deceased consented to donate his organ(s). The British government condemned the acceptance of the racist offer and the panel rejected all conditional offers of donation. The principle adopted is that of altruism and meeting the greater need. It would not be difficult to find out some reasons for prohibiting the racist offers of donation, but what about the condition that an organ goes to a relative? The second case [7] took place in Bradford in 2008. A 21-year-old woman, who died after an asthma attack, expressed her willingness to donate one of her kidneys to her mother who has end-stage renal failure, but the Human Tissue Authority (HTA) denied the wish. As a result the two kidneys and liver were donated to anonymous unrelated recipients. To the HTA, the central principle of matching and allocating organ from the deceased is dogmatically that the organs are "allocated to the person on the UK Transplant waiting list who is most in need and who is the best match with the donor" (BBC News [ibid.]). But the decision of the HTA raises a number of interesting ethical questions over the family priority donation. The discussion developed by recently published essays is briefly reviewed below.

Various perspectives

(1) E. W. Kluge (1989) thinks organ donation as not only a personal action but also a social act. He writes: *"Without active social involvement and intervention, it is merely the giving of a piece of human flesh. To become a gift in the sense that both we as members of society as well as the donor and the recipient understand, the donation must take place in a heavily institutionalized context consisting not only of the medical transplant team but of a whole array of support services without which transplantation itself would not be possible"* (ibid.11).

In this aspect, underlying the social involvement with organs, it would be argued *"society itself becomes a participant giver, and the organ, which as tissue was merely a private good, becomes a social good when it is an organ-as-donated"* (ibid.). So procedurally it follows that *"if there are formal constraints that govern social acts per se, then these will also apply to organ donation"* (ibid.). The constraints in this case derive from *"the principles of equality, justice, and respect for persons and which govern all social interactions in a fundamental way"* (ibid.). However, he takes as ranking criteria two kinds, namely *condition-specific* and *person-specific*. The latter benefits those who are selected and therefore violates the principle of equality. He argues that designated organ donation is *person-specific*, and thereby abandons the general ethical framework (ibid.).

(2) Acknowledging Kluge's argument that an organ becomes a social good when it is donated, R. A. Ankeny (2001) states *"Although it is clear that organ donation has a social character and there is a symbolic change of meaning that occurs when mere flesh becomes donated organ, this argument fails to capture some of the salient facets of the situation"* (ibid.: 389), and suggests some weak points related with the discussion: *"[M]any undertakings are social … but do not necessarily result in the creation of social resources. An example is the bequest of material possessions after death via a socially recognized and enforced document such as a will. Directed blood donation is currently permitted (and encouraged) in many places"* (ibid.).

(3) Wondering if it is really so bad to attach a condition to an organ condition except the racial ones, unlike Kluge, T. M. Wilkinson (2003) criticizes the opposition against the conditional donation. He notes that *"we are considering the moral assessment of the donor's behavior and not the decision by the transplant services to accept or reject the offer"* (ibid. 163). According to him, the panel overlooked this vital distinction. The government and the panel have a decisive authority, but if the details of the case are reviewed it is not clear,

despite apparent opposition of the panel, that wanting organs to go to a child is a violation of altruism more than donation to a children's charity is. It is not obvious, he also argues, that even racial condition violates the altruistic principle to which that organ donation should be subject. Moreover, he mentions *"it is unclear that why people would be obliged, if they choose to donate, to donate according to the greatest need"* (ibid.). What he emphasizes is that "[there is a crucial distinction between *attaching* a condition to an offer and *accepting* it" (ibid.), and shows his plausibility in the point by taking the following example: *"If I offer money to Oxfam in order to spite my wife, it would be preposterous for Oxfam to be morally required to turn down money that would save lives on the grounds that I should have given the money unconditionally and my offer was a morally bad one. But although the general principle its unsound, perhaps we can draw something relevant from the panel's claim that would morally forbid accepting conditional offers in the specific context of transplantation"* (ibid.163).

Wilkinson's ethical perspective from the drastic audit of the relevant cases is less dogmatic than that of the panel which forces their own principle and gives little satisfactory explanation. For instance, think about a case of the family priority donation where a relative almost perfectly meets with the greatest need. In that case the panel's argument is supposed to reject the conditional donation. So the organ would not go to the relative who matches the clinical criteria but to someone who matches less. Conversely, the principle of the greatest need which enables the panel to justify their decline of the conditional donation, would enable to the justification of that conditional donation. *"Even if the principle is sound, it does not support the unconditional rejection of conditional donation, because it does not justify rejecting conditional offers that would lead to the organs going to those in greatest need anyway"* (ibid. 164).

Since this justification has a high plausibility, the panel should rethink it. Although Wilkinson counter-argues at the same level of the panel's reject, we note that the panel disregards the family intimacy which is a great value as a community. The reason why this point is needed for discussion would be that the donor's decision for donating organs is mostly based on his/her feelings or emotions such as empathy and sympathy to those who suffer from organ failures.

(4) In an essay titled 'Is directed donation misguided?' (Sherwin et al. 2004), six experts present brief reviews over the directed organ donation. But they spend much time in the discussion of the racist case in 1998 rather than that of the family priority donation, so that the conclusion necessarily leads to the opposition against the directed donation between relatives. That might be why the experts understand that the discrimination, such as racism, is based upon the priority donation to relatives. Among them Armitage explains the difference between the great need such as a clinical one and the family priority in this way: *"Donated tissues and organs are frequently directed to particular recipients using objective, evidence-based, clinical criteria (such as tissue type, age, or size) that are intended to maximize the efficacy of the transplant and thus the benefit to the recipient. This is entirely different from the imposition of arbitrary, subjective conditions by a donor family that denies treatment to patients who may be the most suitable recipients, the most in need, or simply next on the waiting list"* (ibid. 8). Taking the UK racist case as an example, Armitage suggests that condoning the directed donation may imply tacit acceptance of the underlying discrimination likely to be based on racism (ibid.). However, his argument is not sufficient in analyzing or identifying the family priority donation, and would not only overlook the discussion on motivating donors through directed donation but also my aspect which criticizes Wilkinson. (5) G. Pennings (2007) grasps directed donations of organs as tactics for increasing the supply of organ donations, and considers four possible justifications for the directed donations: the utilitarian benefit, egalitarian principle of justice, the maximine principle of justice and the autonomy principle. As a result he concludes that none of these principles justifies the acceptance of designated donations. First of all, Pennings states *"[at first sight, the evaluation of directed donation by Utilitarians is fairly simple: the increase of organs due to the acceptance of directed donation maximizes the aggregate net benefit" (*ibid.: 42). However, even if the kind of donation is accepted this would not automatically result in an increase in the total amount of utility, because those who want to donate in the present system do not want to be in a system they think unjust. Also as a matter of fact, in the USA some research confirms that *"[women, members of minorities and people with low income do not receive a proportional member of organs"* (ibid: 43). Justifying by the utilitarian perspective would not stand well.

The second possible justification, i.e. the egalitarian principle of justice, would not enable the application of the current system to lead to the expected proportional distribution of the organs. There is a study that black people remain twice as long on the waiting list than white people (ibid.). In the third justification, Pennings reviews Robert Veatch's argument that the 'difference principle' of Rawls could justify directed donation of organs (ibid. 44). He states "the difference principle implies that deviations from the purely equal distribution are acceptable if they benefit those who are worst-off. This maximin system tries to maximize the minimum" (ibid.). Comparing with the situation that would exist if the rule that the first person on the waiting list comes first for the allocation of organs is respected, the persons higher up on the list are harmed by the direct donation. Also he suggests *"the persons behind the recipient of the directed donation on the list enjoy a benefit by moving up one place compared to the situation when no donation would take place"* (ibid.: 45). Then what about the worst off? He explains in this way: *"With unconditional donation everyone on the list would benefit. The problem with this benefit for the worst off is that it undermines itself. If directed donation is accepted as a rule, moving up on the list serves little purpose. Moving up is only advantageous if the list is respected and this is exactly what directed donations fail to do"* (ibid.). In the criticism of the autonomy principles, Pennings argues that *"The autonomy principle implies that a person has the right to make important decisions about his or her own life"* (ibid.). Therefore, the decision for donation can be seen as a part of the person's

autonomy. His argument will lead to the justification by the relationships between the society and the recipients as follows: *"We allow people to decide what to do with their time and money but we do not allow people to decide who will live and who will die. That decision is, like decisions regarding the spending of health care resources, a choice that has to be negotiated within society. The recipient is the society (in the form of the transplant centers), which in turn distributes the organs according to the procedures …"* (ibid. 46). So it should be noted that *"this society defends equality of all people by prohibiting discrimination on the basis of sex, ethnic origin, sexual orientation, religion etc."* (Ibid.). (6) In a recent paper A. J. Cronin & D. Price (2008) consider, from the perspective of donor ownership of body parts, the implication that conceiving human body parts as property have for both directed and conditional donation. They state *"gifts are not valid where the donor has no 'disposing power'. One cannot give what one does not have"* (ibid. 129). But it is right that *"one can quite properly and coherently own something that one may nevertheless not trade"* (Ibid.). Furthermore, despite the acceptance of the notion of body ownership, one can through the notion of consent endorse the donor's right to control the use of his/her body parts while either alive or dead (ibid.). To them, this would be a power of autonomy over one's body. In the discussion on autonomy they argue as follows: *"If we are to persist with a framework of consent as the basis upon which donor organs become available for transplantation then it is imperative that we make clear why, having consented, a person should have greater autonomy over the use of their organs when alive than when dead"* (ibid.: 130). If this autonomy is emphasized, the reason why the family priority donation is possible while alive but not while dead may depend on the strength or effects of autonomy, although, of course, even the power of autonomy cannot justify the directed organ donation based on racism.

Legalizing Directed Organ Donation In Japan

The law on Organ Transplant (Law No. 104) enacted in 1997 assumed that when three years passed after coming into effect, the situation of the enforcement is taken into consideration and if there is a need for taking measures, the law should be revised (Supplement 2). However, the reason why the law was not revised for twelve years is not only a political reluctance but also weak practical interests in organ transplants among the general public. According to an opinion poll on organ transplantation in 2002, 91% of respondents did not hold a donor card and 63.8% [11] were unfamiliar with how to gain a donor card. In the period before and after the revision the mass media covered stories and comparisons on the rival four bills submitted to the parliament every day. It also covered the discourse by patients on the waiting list and their families; the reaction of donors' families, etc.

The general public's main interest focused upon the definition of death in that the revised law authorized brain death as human death, rather than discussion on organ donation and transplantation. The significant issue on whether brain death is a human one has not been developed because an essential issue on the assumption 'what is human?' has been disregarded. The revised Law on Organ Transplant (Law No. 83) was established on the 13th July 2009 (Yoshida 2010). The ideal aim taken over from the previous law, as Article 2 prescribes, is the respect for the intention to donate organs, the autonomy, and the justice and impartiality for the opportunity to have an operation for transplantation. There are three significant points in the revised law: (1) person's intention; (2) organ removal from children under 15; and (3) priority donation to relatives of donors. In the previous law organ removal from a dead person is authorized if that person expressed in writing the intention to donate, and his/her relatives, who were informed about the will, do not object to his/her body being donated (Art. 6). In the revised law, however, organ removal from a dead person is authorized even if the person's intention to donate is unknown and only if the relatives give their consent to the donation. In other words the opt-in system was changed into a version of the opt-out system. With relation to organ donations by children under 15, the acceptance of brain death and organ removal are authorized by their parents. This amendment assumed a case where it is more difficult for Japanese patients under 15 to require a private transplant abroad than at the present time.

In this paper we will focus on the third issue 'donation priority to relatives'. It is an ethically tough task to justify priority donation to relatives as a form of directed donation. Legally, the priority donation to relatives is against the tenet of respect for the intention to donate organs, autonomy, and fairness of the opportunity for organ transplants which are explicitly prescribed in article 2 of the new law. Therefore readers will be interested in how Japan overcame the difficulty of justifying the priority donation to relatives and how it was able to practice and legalize the idea. The priority organ donation to relatives directs to a specified person, and regard as secondary importance, the medical standard for organ allocation. This is a different point from the allocation determined by the principle of autonomy, equality and fairness. The rule of determining the recipient under the 1997 law was based on the point system of medical requirements. But the prescription of the family priority donation in the 2009 Law on Organ Transplant is that emotional factors are taken into account to the rules of scientific allocation of organs for transplants.

The issue on priority donation among family members in Japan can be traced back to the fifteenth case of organ donation by a brain dead patient in 2005. The patient ante mortem expressed his/her intention to donate his organs for to one of his/her relatives. Consulting with the Welfare and Labour Ministry, the Organ Transplant Network accepted the donor's willingness to donate and carry out the donation to the two relatives. The frame of the story was the same as the Leak case, but the outcome was different. In the Japanese case the directed donation was treated as an exception, but in the British case the authority rejected the donation to the donor's mother. The Japanese case was thought to be that, because of lacking the establishment of any rules for the directed organ donation and of the required emergency, there was no

alternative except to accept the donor's and his/her relatives' intention. It would have been an avoidable circumstance.

Pros and Cons on the Family Priority Donation

The debate on family priority donation was split into pro and con just before and after the amendment of the Bill. The cadaveric organ donation has been practiced for non-related recipients under the principle of equality and fairness, but the donor's emotions to the relatives produced an anxiety of a difficult issue arising. Discussion took place in the following way.

Worry about damaging the fairness

There is the possibility that the notion of the family priority donation is opposed to the principle of the fairness to opportunities prescribed in Article 2 of the Law on Organ Transplant (1997). Nudejima, senior researcher of the Tokyo Foundation, argued that the family priority enhances the preference of donation between the family members and resultantly not only confines the medical services for organ transplantation to the narrow scope of intimate personal relationships but also hinders the diffusion of brain-death organ transplants [12]. This sort of unfairness may imply some possible risks of a tendency taking place to claim that first of all a patient should persuade his/her relatives to register as a donor [Ibid.]. Although we cannot deny the unfairness, however, the priority donation may have an impact of increase in the numbers of donation. At a committee of the Welfare and Labour Ministry held on 27 May 2009, Tarō Kōno, member of the House of Representatives, who proposed the priority donation from his personal practice that he donated his part of liver to his father, recognized the risk of damaging impartiality and equality and provided an emotional statement "whenever I find cases where only in the light of fairness, organs are allocated among the anonymous patients on the waiting list for transplants, I think that if you sympathize patients to them, the fairness is too bitter to justify a ban" [13]. Kōno also stated to the mass media *"the probability is extremely low that parents, children or spouses who registered as a donor happens to become brain-dead. Perhaps only one case would take place per ten year. Such extremely low probability would not prevent the principle of fairness for the allocation"* [ibid.].

Natural feelings

As Kōno's emotional statements suggest, a donor's wish to save his/her relatives rather than non-related persons is caused by the natural feelings as a human. In particular those who appreciate the feelings and emotions among family members and support the system of family priority donation are emergency medical doctors, who practically communicate face-to-face with donors and their families. In a media interview with a doctor at an emergency hospital, he mentioned that though there is some concern that the priority donation to relatives may lead to suicide or organ trading, he as a doctor who has to rescue a patient's life, cannot find any reason for rejecting such a system of donation and that he would like to grant the wish, as a final will of the patient, for saving his/her family member [12]. In an emergent practice where human feelings are given priority, the drastic principle such as that of impartiality is likely not only to be thought as a cool-blooded rule by possible donors and but also to result in decreasing the rate of the number of donor card holders. On the ground for the sharing emotions people hold the justification for the family priority donation to relatives would gain the plausibility.

An open road to trading organs

Michikata Ōkubo, representative of the Group Association of Transplant Patients, commented that if a donor can opt for a patient who is donated, it generates concern leading to the organ transaction [ibid.]. The possible concern would result in restricting the scope of relatives to whom priority is given, namely parents, children and spouses, because the more extension of relatives may generate a high possibility for monetary relationship between donor and recipient. If organ donation is involved in the closer relationship than that of non-related and anonymous donation, the transaction of organs inside the family is so private that revealing its secret may be difficult. [14]

The risk in expanding the scope of relatives

In terms of the intimate relationships between parents and children, although the blood one can be admitted, can the legal one be authorized? The new Law admitted only the case of special adoption (*Tokubetsu-yōshi-engumi*) where an adopted child makes an end of the relationship with his/her biological parents and their relatives. It is argued that the expiry may reduce opportunities for organ trading. Similarly common-law marriage raises issues. That kind of marriage in Japan, as well as the legal one, is becoming recognized more legally, but it is extremely difficult in some emergent occasions of organ transplantation to confirm whether or not the case in question is common-law marriage.

Additionally in the situation of the priority donation to relatives, *"despite there being no relative's willingness to accept brain death, the seemingly good opportunity for organ transplantation may influence the relative's autonomy toward brain death, e.g., enhancing a probability of accepting brain death"* (public comments [15]). Also another criticism is: *"Since the determination for donation is very likely to be influenced by emotions between parent and child, there is a possibility that the parent commits suicide to donate his/her organ for his/her child"* (public comments [ibid.]). The criticism to the latter case is*: "It would be inconsistent that in spite of admitting organ donation done by general suicides, the judgement of brain death and the removal of organs per se are rejected only in the case of the priority donation to family members"* (Minutes of the 29th Committee on Organ Transplantation [ibid.]). There rises another problem if siblings are added to the scope of admitted relatives, because a case where siblings have their spouses may cause mutual conflicts of relationship. There are still the family members in Japan who are not necessarily emancipated from the Japanese cultural influence and the conventional *Ie* (household) system. And even the relationships between spouses would be to some extent involved in the conventionality. Therefore it

would be argued that there can arise some problems that someone of the prominent family members may persuade a female spouse to donate her organs or that the system of the priority donation to relatives *per se* may urge a relative's seemingly willingness to donate.

The Possible Failure of Proceedings

In order to realize the family priority donation, the ante-mortem confirmation between a donor and his/her directed family member should be required at the time of writing down the donor's intention in a document or a donor card. Due to the neglect of the confirmation a risky situation may happen that even at the stage of an actual donation the relative is unable to be received the organ. Also the proceedings related to the determination of brain death may not be legitimate in the family context.

Conclusions

At the 29th committee debates on the priority donation [ibid.], the following discussion on proceedings came up: in a case where the possible recipient's name is registered and his/her donor dies, can the donor card held by the donor be sufficient proof for determining the legitimacy? Mr Shirakura, a committee member, mentioned *"A donor card or anything can be acceptable … whether or not the card exists is confirmed I do not think that large confusion happens. Even if the card is forged … the forged one is okay, I supposed, only if that is done by a relative involved".* [Ibid.] Needless to say, forgery is an illegal action which damages the donor's autonomy. However, this statement suggests that a committee member at least admits that as far as the forgery is done within the scope of the relatives involved, it can be acceptable.

The rate of organ donation is extremely low in Japan. In the discourse where the trauma of brain death has not faded away, discussion is unlikely to expand its potential from the concentrated controversy on brain death to the international level on organ transplantation. As a matter of fact, although the government invited public opinions for 30 days just before the prescription of the priority donation to relatives was enacted on 17 June 2010, only 21 comments arrived [Ibid.] This number of the comments for a population of 125 million people would illustrate that the general public are less interested not only in the specific topic of the family priority donation but also in the general topic on organ donation. It should be noted that, for instance, the real situation is that there is merely about one brain-death-stated heart transplant each month nationwide. Thus, in comparison with the Western discourse on the priority donation to family members, many detailed and diverse problems have been left unsolved in the Japanese controversy. It seems that the government has been advancing toward its political aim by force. As a result of emphasizing on the family members' blood bond and closeness, the priority donation gained some grounds for justifying such a priority, but the consistency with the rule of fairness or impartiality highly respected in Western countries is somewhat lacking.

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Notes

[1] See http://www.jotnw.or.jp/datafile/offer/2009.html; http://www.organdonation.nhs.uk/ukt/i/g/statistics/yearly09/full_size/all_tx_type.gif
[2] See http://www.jotnw.or.jp/english/index.html
[3] See http://www.organdonation.nhs.uk/ukt/default.jsp
[4] Japan Organ Transplant Network required possible donors by the way of scattering donor cards, but it failed to count the exact number of donors holding the card. Only way of counting would be a sampling survey. Recently, the network has introduced the register system available on-line, but it should be said to be a too late introduction. On the other hand, visiting the Web site of NHS Blood and Transplant, you will be able to find the numerical data you want to know.
[5]See http://www.yomiuri.co.jp/dy/national/T100522001969.htm
[6]See http://mainichi.jp/select/science/news/20100601dde041040055000c.html (in Japanese)
[7] See *Mother denied daughter's organs*, http://news.bbc.co.uk/1/hi/england/bradford/7344205.stm
[8] See St. Petersburg Times 9 January 1994
[9] See http://sankei.jp.msn.com/life/body/100125/bdy1001251909004-n1.htm (in Japanese)
[10] See *Dobson: 'No health apartheid'*, http://news.bbc.co.uk/1/hi/health/387817.stm
[11] See http://www8.cao.go.jp/survey/h14/h14-zouki/index.html (in Japanese)
[12] See *Sankei On-line 24* January 2010, http://www.iza.ne.jp/news/newsarticle/living/health/349621/ (in Japanese)
[13] See http://www.shugiin.go.jp/itdb_kaigiroku.nsf/html/kaigiroku/009717120090527015.htm (in Japanese)
[14] See http://www-bm.mhlw.go.jp/shingi/2010/02/txt/s0202-10.txt (in Japanese)
[15] See http://www.mhlw.go.jp/shingi/2009/12/txt/s1218-20.txt (in Japanese)

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