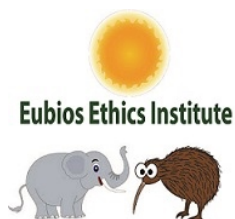


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Editorial: What is Dignity?

This issue includes 8 papers that could be grouped as commentaries on different aspects of promotion of dignity, as an essence of bioethics. As the first article by Isabel and myself explores there are many embedded meanings in the term "dignity" which is widely used in international law and ethics. Promotion of a good-life (Eubios) for all beings will necessitate protection of their dignity.

There are several applications of this term in the papers on patient-physician relationships, the paper on hand-washing by food industry workers, and the paper on linkages between violence and terrorism. In all these cases abuses of dignity are clear to see upon analysis, but often bad habits and group mentality leads to people forgetting the dignity of others.

Two papers on bioethics education in Pakistan explore how students can be taught about bioethics, and how to protect dignity of patients. The abuse of dignity also reduces the dignity of the abuser. The final two papers look at medical experimentation and stem cell research, and the abuses that often have occurred in developing countries.

EJAIB announces that the September 2016 issue will be a special issue with contributions submitted for the first World Bioethics Day, which will be celebrated on 19 October 2016. Please submit articles accordingly.

The Asian Bioethics Association (ABA) and local hosts, UGM in Jogjakarta, Indonesia, have released the Call for Papers for **ABC17 to be held 14-17 November 2016.** Readers are also invited to see the forthcoming conferences page to find satellite meetings in Malaysia, 9-11 Nov, and in Kumamoto, Japan, 19-21 Nov 2016. AUSN and Eubios Ethics Institute are also co-organizing with others a number of Bioethics Conferences trainings in 2016 all around the world, so please join.

- Darryl Macer

Cross Cultural Perspectives on Dignity, Bioethics, and Human Rights

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Abstract: The concept of dignity is the foundation of fundamental rights expressed in international declarations on human rights and bioethics. Sometimes there are collisions of rights, which must be weighed. However, more often dignity is invoked in order to argue for or against the same issue. Is it possible that a concept can be so broad that it becomes meaningless? What do we mean when we argue for moral decisions based on dignity? This paper aims at understanding dignity as a construct, in an analytical and evolutionary cross-cultural approach, from a Western and Eastern view, and then considers its impact on the teaching of human rights and biolaw.

Key words: Dignity, Bioethics, Human Rights, Biolaw, Self-Determination, Freedom

Introduction

This paper aims at positioning the idea of dignity in the context of human rights and bioethics from an intercultural perspective. Both discourse in the fields of human rights and bioethics have invoked the word dignity as an argument in reflections involving the defense of personal welfare, of community identity, and humankind in general.

Dignity is a construct, a spiritual imperative to shape a vague sense of the uniqueness of the human being. It is often used to argue for a universality of cultures in a multicultural, interconnected and global society. The expression that some action is an affront to dignity is often agreed between persons from various cultures, with some clear examples defined in international law such as genocide. Some other issues however see arguments between persons, and Peoples, on what is a dignified approach, such as in discussions of death with dignity and the end of life.

The paradox is that the very origin of the word indicates that there may be different levels of discursive use. Thus, "Dignitas" in the sense of a special qualification for "power" or "authority", is not comparable to "inherent dignity" as a feature of humanness. Only after the Enlightenment did it come to be considered as a quality of all human beings.

Recognizing the core of the fundamental dignity in rationality in Kant, Pico della Mirandola, Dworkin, McIntyre, Gewirth, Nino and others assigned value to human beings by virtue of their rationality. However, the foundation of dignity in reason could not be an adequate explanation to maintain the life a person in a vegetative state for 41 years, or to understand the disability or special abilities in the sense currently accepted by the doctrine of human rights.

Background of the idea of Western dignity

The evolution of the concept of dignity moves from the ancient Greek and Roman conceptions, different from what we understand today, through the revolutionary conception of Christianity up to the secular Kantian idea of dignity. Those have been influential in our Western legal systems. In Greece the concept of dignity is different from what we think today. The closest idea to dignity in Greek culture is the idea of honor (time) (Chuaqui, 2008). From an etymological point of view the word is akin to the concepts derived from Axios (worthy), and more closer to dignitas are: Axia and axiom in the sense of dignity, value, prestige, although they are not comparable to dignitas in content, brightness and frequency. In relation to the prestige enjoyed by prominent politicians, axiom appears regularly on Thucydides. Plato thinks that axiom means value, prestige, and thus it appears in the Republic. Also Demosthenes referred to the city and the Greeks. In Greek philosophy the term axiom is used to refer to the place of the man in the cosmos and the range of his spirit or soul. In the Stoics it comes to mean value (Chuaqui & Rodríguez, 2002). Before Christianity, Gentiles, slaves, patricians and plebeians had not only a different legal status, but not all were considered humans. The slaves had the legal status of a thing, so that its owner could exercise over them all the attributes of ownership (Cornejo & Escorza, 2014).

Dignitas in Rome was related rather to the political sphere, providing rights and power to the owner. Dignitas also had gradations, and would increase, decrease or be lost, having clear aristocratic features. Cicero separated moral from political dignity. For Cicero every man, to be recognized as such, will have something divine, godlike and dignity. The idea of divine creation of man was in the mind of Cicero and Ovid, but it may be considered only a hint that did not develop into doctrine. However, Cicero advanced some elements of the modern concept of dignity. In Christian culture dignity is given by the relationship of the human creature with God and the idea of divine image and nature.

This idea of equality among humankind, is central to the Christian doctrine. Men and women are worthy of God's love, because their nature makes them worthy of his precious protective mantle. Men are equal between them. Just God, is the example and perfect guide. This idea is absolutely new, revolutionary, not seen in the Hellenic world.

There was the figure of the apatheia in Greece, in which a disciple hired a teacher, seeking release of

pathos, the passions that take over and enslave the soul. The subordination to a guide is seen as the vehicle to move from a state of disorientation to another state, and become master of one's own life. Such direction was paid and temporary. But God, the pastor, directs permanently. Such a conception continued to develop during the Middle Ages. Renaissance humanism, through Pico della Mirandola, begins to link dignity to free will, freedom of choice and rationality.

The revolution of Christianity, according to Foucault, was founded on the idea of will. First, the will of God, vertically seeks salvation of the souls of the faithful, through obedience to reach those who should give eternal life to himself. This waiver concerns the passions of human nature that is expressed as sin in the Catholic doctrine (Foucault, 2006). Christianity in Western culture crystallized its perennial influence in all areas of knowledge, as the Hellenic culture in antiquity; Christianity did it in the Middle Ages and the Renaissance. Despite the skepticism related to Catholic dogmas and their abuse in the name of faith, the idea of equality had already settled in such a way that even in the process of secularization ideas of equality were incorporated in the Age of Enlightenment.

Rationalism, free market, prosperity of nations and the end of the feudal order, were a cause and effect of the Enlightenment, a process that spanned most of the eighteenth century. Its principles shaped the modern constitutional state. The ideas of the French Revolution and the Constitution of United States constituted sources of inspiration and guidance for constitutions and legal bodies in Latin America and influenced legislations worldwide.

Dignity needs a context

Leaving aside the Platonic essentialism, and understanding language as a convention, it may be futile from an analytical point of view to search for an univocal concept of dignity. Trying to throw light on the concept we can create a pseudo-problem if its' meaning does not consider the context of its usage. As Taylor notes, *"the demand for individual rights presupposes belonging to a specific community defined by specific traditions"* (Taylor, 1985). Thus, instead of asking what dignity means, we should ask what it is dignity for, who or who applies the notion, who protects, what or why it is invoked, etc. ... Hobbes says: *"The names of things that affect us, namely that we like and dislike are of variable significance in the constant speeches of men ... "* *"therefore, the reason a man should ponder the words; which, next to the meaning we imagine by their nature, they also have their own meaning of nature, willingness and interest of the speaker"* (Hobbes, 1978).

The dignity and distinction, existence and degree requirements

Carlos Nino observed that the central nervous system appears as condition *sine qua non* not to know who the subjects of rights are, but to know who can enjoy the benefits they provide (Nino, 1984). MacIntyre

says that morality consists of rules that any rational person can accept under ideal conditions (MacIntyre, 1984). The Kantian proposal has been radical in content to give dignity to the autonomy of man, when he expresses: *"the rational beings are called persons because their nature distinguishes them as ends in themselves, that is, as something that cannot be used as medium and therefore limited real treat in that sense"* (Kant, 1988). *"Identifying the human capacity for moral choice with the existence of free will"* (Mosterin, 2006).

In one of his last books, Justice for Hedgehogs, Ronald Dworkin pointed out that respect for human dignity involved: respect yourself, take care of the consequences of decisions made in serious and authentic ways, that is, identify personal responsibility for finding what is considered successful for life. These two principles, respect yourself and authenticity, should serve as a personal ethics in pursuit of the good life (Dworkin, 2011). For Ruth Macklin, the issue of dignity is subjective, difficult to live up to the powerful moral claims that are assigned an ambiguous notion. In 2003 she said: *"Bioethics has struggled really well with the principle of personal autonomy in the idea that all human beings have the same minimum capacity to suffer, prosper, reason and choose. No human being has the right to interfere in life, body, or freedom of others ... once admitted the principle of autonomy-argument Macklin, "dignity" not care"* (Pinker, 2008).

For some authors human dignity and dignity in general should be distinguished. Herbert Spiegelberg says: *"dignity in general ... is a term with many meanings. It applies to humans and nonhumans, and mainly indicates certain distinctive qualities that give more than others who have certain qualities range. Indeed, dignity in general is a matter of degrees. This is reflected in a picture of reality in the traditional "Great Chain of Being", with upper and lower dignities. Such honors are subject to change, can be acquired and lost, increase and decrease. This expression is found in those dignities granted to certain people called dignitaries, by their titles or honors, and can be expressed in worthy or unworthy behavior. Human dignity is a very different matter. It implies a real negation of grades or orders of dignities. It refers to a minimum of dignity for all humans as a species"* (Spiegelberg, 1970).

Spiegelberg considered inherent dignity as a subjective right of individuals. This word is used with such connotation for the first time in the Enlightenment by John Locke. The Constitution of the United States began contextualizing dignity as a range or signal recognized in certain people within certain social hierarchies. But later thinkers understood dignity as a broader concept applied mainly to human beings.

Pacific concepts of dignity

The concept of dignity is also seen in many Pacific Island cultures. The New Zealand Health Research Council *Guidelines on Pacific Health Research* (HRC, 2004), include the term "dignity" in a few sections. For example in article 7.4 *"Participants must be able to*

withdraw at any stage of the research process with dignity, and respect, and without embedded disadvantage." The context of the term implies that in an ordinary sense they possess dignity, in a honorable sense of the term. Interestingly however, unlike many International Instruments, the term "dignity" is not listed among the core values, which are: *"They are centred on relationships as the overarching principle that binds each of the following ethical research principles: Respect, Cultural Competency, Meaningful Engagement, Reciprocity, Utility, Rights, Balance and Protection. These have been identified as the guiding principles for conducting ethical relationships for research. These values are a summary of many of the values found around the Pacific, and further examples of values will be discussed when reviewing specific cases."* (HRC, 2004).

Love would be considered as more basic than dignity (Macer, 1998). The term love is usually omitted from international law, whereas the concept of human dignity is often cited. Human dignity is arguably even more difficult to define than love. For example, Article 11 of the *Universal Declaration on the Human Genome and Human Rights*, states, "Practices which are contrary to human dignity, such as reproductive cloning of human beings, shall not be permitted" (UNESCO, 1997). Why cloning is always against human dignity is not clear. For example, if it was the only way a family could have a genetically related child why is that against human dignity? Especially when using donated sperm and eggs or a surrogate mother is permitted in many countries, even for commercial contracts. If we are assisting in the formation of a family through assisted technology, this does not appear to be against dignity. Part of the concept of dignity is linked to self-determination, so access to technologies to reproduce, which is a human right, could seem critical for the preservation of dignity. Yet, at the time following the cloning of Dolly the sheep by nuclear transfer in February 1997, it became a popular call for many government leaders to say cloning was against human dignity because of some idea that the new technology was "unnatural" or going too far. Here we see an example of how dignity can be used to support both sides of an argument.

Across the world we can find many common expressions of dignity from many sources (Macer, 2011). It is clear to see the abuse of dignity when people are actually harmed physically, such as in murders, wars, racial and sexual discrimination, and prohibitions of migration. The dignity of a community is enhanced when all members are well-treated and in ethical relationships. Sometimes it can appear that a community welfare takes precedence over an individual, but the dignity of a community is maximised when every member also has dignity in their existence and relationships.

Kant and inherent human dignity

It is important to emphasize that intrinsic human dignity is a Western construct. Traditionally, Western

philosophy considers it to be objective and seen as inherent feature of the human person. This aspect of objective dignity, in Eastern cultures is supplemented by a subjective dimension in the sense that human beings try to create their own world of life, in what might be called acquired dignity. This view of acquired subjective dignity can be observed in Japanese culture. From an hermeneutical perspective, the person strives to acquire dignity through moral behavior, actions or practices. In other words, human dignity is manifested in an inter-relationships with others, rather than an inherent condition that people have for the sake of existing.

The distinction between hierarchical thinking about dignity and its character as intrinsic human value is attributable to Kant. The whole theory of human rights can be anchored on a deep understanding of the idea of dignity. The categorical moral imperative of Kant is *"act only according to that maxim whereby you can at the same time will that it should become a universal law"* (Kant, 1981). This will, commanded by *"pure reason is practical and gives only his (the man) a universal law that we call moral law"* (Kant, 2006). In addition, the categorical imperative regards man as an end in itself, never as a means. It considers dignity not as cause but as a result of that imperative.

The Kantian view does not contradict, indeed it complements, the Christian maxim *"Do not do to others what you do not want done to yourself,"* present in all cultures and religions with different nuances. In the center we find the idea of equality contained in the moral principle of treating others the same way I want to be treated and the Kantian aspiration that the act of each can be elevated to the rank of a universal law.

We may suggest that *"dignity is a mirror of the human intrinsic condition"* (Cornejo, 2014), that which does not mutate or is modified by sociological considerations or impaired consciousness, or awards, claims or any other circumstances. For Kant, which does not mutate, the permanent is given by the soul, given as immaterial substance, incorruptible, spiritual and immortal. Kant, in his Third Paralogism of Personality, said that *"what is aware of the numerical identity of himself at different times is a person."* Now, *"the soul ... then the soul is a person"* (Kant, 2006). And the identity of the person must be unfailingly in my own consciousness.

If I contemplate myself from the point of view of the other, the outsider begins by considering in time, because the apperception of time has only been shown in me. Kant and Mirandola felt that dignity is manifested in the autonomy, rational human capacity to discern. Apparently, the progress of science challenged the thinking of these humanists, who had no chance to consider what happens in a person in a persistent vegetative state or in advanced Alzheimer's in which the cerebral cortex is so damaged that they have no awareness of themselves or their environment.

If we apply the criteria of rationality underlying dignity, according to Kant, these people could not be considered rational beings and therefore worthy. To

overcome this problem, according to some authors, the Kantian use of the word "dignity", *"belongs to the world of meta-ethics, merely serve as a record that explains, on the one hand, human origin of morality and can reject the aristocratic conceptions of morality, to show that this capacity for morality is connected with humanity itself and not having special characteristics"* (García-Manriquez, 2009).

Carlos Nino points out that decision on the rights of citizens based on a convention called dignity must be justified on the basis of principles whose basis or validity does not depend on the convention. In other words, the ideal morality is above the positive morality. Then, the ideal morality must be based on principles and neither the principle of the inviolability of the person nor the principle of autonomy is sufficient to deny the principle of dignity. These three principles form part of the basis of the principles of liberal constitutionalism and the set of fundamental rights that are associated with this concept (Nino, 1997).

Human rights and dignity

The meaning of the word dignity is certainly complex; however, this term has been the essential basis of numerous declarations, constitutions, covenants and legal documents of global relevance. The Preamble to the Universal Declaration on Human Rights of 1948 states that *"freedom, justice and peace in the world are based on recognition of the dignity (...)"*, and the Declaration on the Protection of All Persons from Torture and other Cruel, Inhuman or Degrading (1984) states that human rights *"derive from the inherent dignity of the human person"*.

Most Latin American Political Constitutions reiterate these ideas. However the rank and hierarchy accorded this notion of dignity, as stated above, there seems to be little clarity or consensus when it comes to the definitions and details about their content and meaning. Indeed, dictionaries and the most famous encyclopedias do not include the voice "dignity".

The conclusion is already tacit contained in the above reasoning, the concept of "dignity" is ambiguous, vague, ethereal, undefined. Lawyers have great difficulty in arriving at an acceptable definition (Figuerola, 2009). However, on that concept all human rights are based, from those who were already recognized in the Constitution or in the Bill of Rights, to those that have lately taken up the Universal Declaration on Bioethics and Human Rights (UNESCO, 2005). As we can see in the above example of reproductive cloning, dignity can be used on both sides of the argument.

Dignity and enhancement

Human dignity will be promoted through the empowerment of all to make well considered moral decisions. The International Bioethics Survey conducted in 1993 in ten countries in Asia and the Pacific (Macer, 1994a) found positive views towards genetic enhancement in China, India and Thailand, with less approval in the Philippines, Singapore, and a

majority rejection of this in Japan, Australia and New Zealand. Eugenic ideas found both positive support in some countries, for example for improving genes by genetic screening; with less negative reaction, for example a few people cited social eugenics programs, or many being against gene therapy for enhancement. The questions regarding genetic screening and gene therapy suggest positive support for eugenics among a significant portion of the population, especially in China (Lo et al., 1994), as well as India and Thailand (Macer, 1994b). Subsequent research has also supported this conclusion that there is significant support for enhancement in the most populous countries in the world, China and India.

Access to cosmetics is not usually considered counter to dignity. Whitening creams are widely used in East and South East Asia, and it is difficult to find cosmetics that do not contain whitening agents. Even the dowry prices for ladies to marry is lower for fairer skins in India, and conversely fairer skin tones in Thailand can raise a higher price for the ladies (where men pay the dowry). There have been studies of attitudes to dental orthodontics which suggest Asian patients are more willing to tolerate discomfort and pain from realignment of teeth than Caucasian patients (Lew, 1993). Improvement in dento-facial aesthetics following orthodontic treatment enhances the self-confidence and self-esteem of a majority of patients – can we say it enhances some sense of dignity. The same could be said for hair styling and fashion accessories.

There are some associations between particular psychological states and tendencies to undergo cosmetic surgery (Swami et al., 2009), such as greater psychological investment in physical appearance and greater internalisation of mass media images of physical beauty (Sarwer et al., 2005). Swami et al. (2009) found that less open and more emotionally stable individuals had a greater likelihood of accepting cosmetic surgery in order to maximise its self-oriented benefits. Such emotionally closed individuals may maintain more negative evaluations of their appearance, which leads to a greater acceptance of cosmetic surgery if it is able to enhance their appearance. While we could argue that beauty is not linked to dignity, but the freedom to enhance one's perceived beauty through cosmetics is something we can see in every indigenous culture, and inhibitions on the freedom of individuals when told that they cannot enhance themselves seem to be counter to dignity itself.

Conclusions

We have observed that the construct dignity is part of Western history, although its content has evolved and requires nuances in interpretation. Perhaps the same ambiguity and polysemy seen in the use of this word are guarantees of permanence and widespread use. Dignity is also something guaranteed by self-determination, and can be diminished when choices are limited by invasive laws and governments.

We should ask whether it is the foundation of human rights and is also regarded as a principle and foundation in Western bioethics. This conception is adopted by the doctrine of human rights. However, other interpretations relate the concept of dignity to his corollaries, autonomy and inviolability of the person, establishing the bases of modern deliberative democracy, which involves participating citizens, whose arguments no matter how diverse they might be. The notion is that society can lay the groundwork for a participatory democracy and therefore more legitimate and solid.

Much of the arguments to protect the disabled are based on ontological dignity, perhaps because dignity implies a higher cortical development, allowing discerning and choosing, which is the general rule, but there are exceptions and the principles should be wide enough to provide solutions to these exceptions. The meaning of dignity in its intrinsic ontological conception is still needed. This interpretation serves to protect vulnerable people who otherwise would be not considered human.

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Developing a Context-Sensitive Patient-Physician Relationship Model for Health Care in Bangladesh

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Abstract

Bangladesh has a complex scenario of patient-physician relationships and there is no single established model. Several points have indicated that it is necessary to develop a new model. A framework of ideal patient-physician relationships for Bangladesh which is context-sensitive has been explored in this paper. It argues that an ideal model should not just be based on some moral jargon but rather it should also consider the context seriously. A balance between ideal and reality is vital. So, illiteracy, scarcity and cultural differences are *morally* relevant and *not* only practically relevant. The paper concludes that care ethics will provide the moral basis of the proposed ideal patient-physician relationship model since people in Bangladesh, who are embedded with emotions, perceive autonomy as relational rather than individual.

Keywords: Autonomy, beneficence, communication, context-sensitive, ethics, paternalism, values

1. Introduction

I have discussed elsewhere different patient-physician relationship models in the Bangladesh context (Talukder 2011). I have argued that there are considerable reasons to build a new patient-physician model for the country. Some of these reasons are: first, no model pays enough attention on the role of the family in making medical decisions which is vital for the Bangladesh context. The family could be taken as a main entity of care; individuals depend on the family members when they are ill, in social life, individuals are sometimes identified by their family, family members stay in the hospital with patients, share and take care when somebody becomes ill. So, the family members seem to hold a right to help the patient to decide and in this way the family's role is morally relevant. Secondly, the consequences of strong paternalism in the country are immoral. Thirdly, some physicians devalue moral values and are desperate for money. Finally, many patients are not satisfied with the current patient-physician relationship. Therefore, we need a new type of relationship which is effective to solve current problems and to be compatible to the context.

In this paper, I will explore what type of patient-physician relationship suits as an ideal in the Bangladesh context when we want to account for the facts of illiteracy, scarcity and cultural differences. We will try to find out the answer whether and why illiteracy, scarcity and cultural differences are ethically relevant concepts. In addition, how these three conceptions may influence to outline a context-sensitive ideal will be analyzed. It is necessary to mention that some key aspects of the patient-physician relationship seem crucial to build a context-sensitive ideal. In our previous discussion on the models we point out that Emanuel and Emanuel have emphasized four key conceptions and Veatch also analyzed some conceptions as vital. From my point of view six conceptions - trust and beneficence, the patient-physician communication, decision-making authority, the role of the physician, the patient's autonomy and resolving the conflicting values need to be stressed in analyzing an ideal relationship for current Bangladesh context. We order six aspects on the necessity and importance for the current Bangladesh patient-physician relationship. This analysis collectively presents an idea of realistic as well as ideal relationships. The status of context-sensitive relationship is pragmatic and possible to achieve in Bangladesh context. These aspects incorporate the minimum requirements so that it makes a balance between ideal and reality.

Finally, for the moral foundation of this ideal relationship we will discuss the relevant ethical theories.

2. Aspects of a context-sensitive ideal patient-physician relationship in current Bangladesh

a. Trust and beneficence: Trust and beneficence are two valuable elements of an ideal patient-physician relationship in Bangladesh. Achieving the patient's trust should be one goal of a physician. Trust will be achieved only when all criteria of effective communication are satisfied. That is, the patient will trust the physician when she is careful, does not harm, maximizes the patient's benefits, is sympathetic, selfless, skillful, benevolent, respects the patient's rights and autonomy, is communicative and so on. In an illiterate society trust could be the basis of an ideal relationship since the disadvantaged people easily trust their physician. They consider their disadvantage as a serious lack and trust the physician to do what is in their best interest. The patient-physician relationship is ultimately a bond of trust. As Beauchamp and Childress write, "...relationships between health care professionals and their patients...ultimately depend on trust, and...rules of veracity is essential to foster trust" (Beauchamp and Childress 2001, p. 284).

Beneficence is the other major foundation for the ideal relationship. Pellegrino and Thomasma hold beneficence as the "guiding principle" of the patient-physician relationship. Indeed, they propose a new term namely "beneficence-in-trust" which incorporates other moral principles. What does "beneficence-in-trust" mean? Pellegrino and Thomasma write, "By

beneficence-in-trust we mean that physicians and patients hold "in trust"...the goal of acting in the best interests of one another in the relationship" (Pellegrino and Thomasma 1988, p.54).

b. The patient-physician communication:

Communication gaps or miscommunication is a serious issue for Bangladesh. Ideally for the correct understanding of the patient's problem, clarifying and collecting necessary information, discussing about the disease and possible treatment require a considerable amount of time. Indeed, we have stated in the introduction that Bangladesh has a large population; and scarcity is a major problem there. So, the physician may not be able to allocate too much time for a patient. An effective patient-physician communication makes a significant relationship. Effective communication eventually results in patient's satisfaction. Sometimes effective communication is as important as medicine. Travaline et al. (2005) write, "*In fact, research has shown that effective patient-physician communication can improve a patient's health as quantifiably as many drugs...*" (p.13).

So, effective communication is a skill and an ideal patient-physician relationship should include this skill. Now, what are the conditions or criteria of effective communication? According to the Accreditation Council for Graduate Medical Education, effective communication skills have five elements: "1. *listening effectively* 2. *eliciting information using effective questioning skills*; 3. *providing information using effective explanatory skills*; 4. *counseling and educating patients*; and 5. *making informed decisions based on patient information and preference*" (Travaline et al. 2005, p.15).

The Bangladeshi patients often cannot reach the physician on time because of the scarcity of transport and medical resources. Illiteracy is another barrier for effective communication. We cannot set the ideal that the physician will spent a set time, e.g. an hour for a patient and communicate with the patient in a technical language which is sometimes essential. However, considering the context an ideal communication could be providing true information in an easy language which the patient wants to know. This would create an environment where the patient feels free to disclose confidential information about the disease. As a whole, the patient will be fully satisfied after communication.

c. Decision-making authority: Medical decision-making is a complex issue. We are uncertain about the future risk and have to depend on the present available information. Our knowledge, wisdom and experience helps us make the most prudent decision for us. However, when there is a question of life and death, taking risk for future benefit; the decision is crucial. Who should decide in the patient-physician relationship? As we know most of the patients in Bangladesh are illiterate and poor. Are the illiterate and poor people capable of making their health care decision? Are they competent enough when they have not received any formal education? Is the family's participation in

decision-making process morally acceptable? These questions need to be answered.

A common and immediate argument could be that uneducated, illiterate people are unable to understand, communicate and use information, therefore, the physician should decide for them. Paternalism is appropriate for this class of patient. Yet, Luna has rejected this argument as unsound and shows that illiterate people are not incompetent to make medical decision. She analyses three possible meanings of this argument. Firstly, communication with illiterate people is "impossible" hence they are incompetent. Secondly, as the illiterate people are unable to use the information they are unable to understand. Thirdly, even if illiterate people are competent they might have some additional "difficulties" such as fears, psychological and mental blockings to understand and communicate properly. According to Luna, the first interpretation is unfair and too strong as it denies that illiterate people possess basic human values. The second interpretation is mistaken by confusing information and understanding. That illiterate people cannot read and write does not imply that they don't have "cognitive faculties" to understand. The third interpretation is plausible but it might also be applicable to the literate people. Therefore, Luna concludes that if the physician interprets health problems in an easy language by giving some additional "time and effort", the illiterate people can make their own decision (Luna, 1995, pp.286-289).

Luna's conclusion is not fully acceptable. It is difficult to agree with her that there is no difference between the educated patient and the uneducated patient to make medical decision. That is illiteracy does not matter in making medical decision. An educated patient may be able to decide by using information, risk-benefit analysis and so forth. But it might not be easy for an illiterate patient. An illiterate patient could choose among the options, but their choice may not be rationally justified. Ideally, the patient should have the authority as he or she is the owner of his or her body and possess the right to decide. Nevertheless, when illiteracy prevails the patient may not be able to decide alone without any discussion. As Clarke et al. write, "Our experience indicates that many patients do not want to decide alone, however; they prefer family or friends to be involved and they want advice from a spouse, son or daughter before they make the final decision" (Clarke et al., 2004, p.16). So, it may not be pragmatic to say that the illiterate patient has the absolute authority to decide. We have to consider their reasoning limitation, low cognitive ability and so forth. There is nothing wrong if the physician or the family helps them to decide.

Another feature needs to be considered is cultural circumstances. In a Bangladeshi culture, the patient's family members or relatives attending him or her have an influence to make the final decision. Generally, the physician informs the patient's condition, risks and benefits to the family members if he or she being asked. Although the patient may not participate in this

discussion the family conveys the information. So, the role of the family is crucial. In an ideal relationship, the patient will directly participate into the physician's interpretation, explanation or suggestion and may seek family members' or intimates' advice before preferring the final decision.

d. The role of the physician: Different ethicists propose different roles as ideals for physicians. We have seen Emanuel and Emanuel propose the ideal role of a physician as a moral deliberator while Veatch proposes as a contractor. But we cannot apply their ideals in Bangladesh context as most of the patients are illiterate, poor and they want family involvement in medical decision-making. The illiterate and poor patient has a chance to be treated paternalistically and sometimes the physician could abuse them for their poverty and ignorance. In considering this practical situation, in our ideal model the physician's role may not be confined. Giving proper treatment, providing correct and true information, building a trustful and cordial relationship, counseling health care values, interpreting and discussing patient's condition with passion, sympathy, and respecting patient's rights are the basic role of a physician. Although in a disadvantaged society the physician's role is defended as, "...when important decisions are to be made the doctor feels justified in overriding the patient's wishes. The doctor may subscribe to the view that patients do not have sufficient knowledge to make good decisions..." (Mckinstry 1992, p.341).

This traditional attitude should be changed. As Hui argues for interpretive model instead of traditional paternalistic model in Chinese tradition by saying that, "A Chinese PPR [Patient-Physician Relationship]...fits well in the "Priestly"/ "Paternalistic" models that are incompatible with modern medical codes...educating and enabling their patients to properly exercise their right of autonomy so that...outcomes can be achieved through the ideal "interpretive"/ "collegial" PPR model." (Hui 2005, p.223)

So, we could suggest that instead of taking the easy way out, the physician should make an effort to build a caring relationship with their patients and explain, advise health care rights and values.

e. The patient's autonomy: The concept "autonomy" originates from the Greek words "autos" means "self" and "nomos" means "rule". So, the literary meaning of the word "autonomy" is "self-rule". While applying to the individual level autonomy refers right to choose, right to liberty, right to privacy and so on (Beauchamp and Childress, 2001, pp.57-58). Autonomy is a fundamental requirement for an ethical patient-physician relationship. Acknowledging a patient's autonomy implies that the patient is capable of making his or her own decision, able to choose or refuse any treatment, conscious about the health care values and so forth. According to Childress, autonomy has two important features: "acting freely" and "deliberating rationally". Acting freely refers to acting without others coercion or influence. An autonomous act is free and voluntary. On the other hand,

deliberating rationally means the deliberation of “imaginative” rational action. (Childress 1982, p.62). Now the questions are: who is an autonomous person? Can the poor and illiterate patients fulfill the criteria of autonomous personhood? Is autonomy ideal or relational?

According to Beauchamp and Childress, an autonomous person is able to act freely, he or she has a “self-chosen plan” while a person lacks autonomy when he or she is unable to act according to his or her self-chosen plan and “controlled” by someone. They hold that “autonomous choice” is the basic criterion to be treated as autonomous (Beauchamp and Childress 2001, p.58). The poor and illiterate patients may not have self-governing capacity in a standard sense, i.e. draw conclusion by a sound reasoning process, analyze and use health care information and values and so on. Still, they are able to make a choice for them. They have the capability of choosing the most suitable option and in this sense they are autonomous persons.

Autonomy might not be the goal of the patient-physician relationship rather a condition for a satisfactory relationship. As the poor and illiterate patients lack some criteria of autonomy such as rational self-governance their autonomy is not individualistic but rather relational.

f. Resolving the conflicting values: The patient’s and the physician’s values may conflict in their relationship. The causes of conflict could be inequalities in health care knowledge, social status, religion, moral belief and so on. Illiterate people might have dogmatic attitude, false belief or misperception of religion. As a result, their values may conflict with the values of the physician. Indeed, the same holds for the physician. Their attitude toward medical science, hierarchical social status and different moral values may conflict with the patient’s values.

Different authors have proposed different ways to resolve this conflict. According to Childress, these conflicts may not be reducible to a single moral principle. We need better understanding and interpretation to resolve the conflict. A plurality of principles, collective justification may help to make a harmony between conflicting parties (Childress 1982, p.72).

Veatch says that there are three ways to resolve conflict. First, we could choose a single general principle. Second, we may rank the conflicting principles by lexical ordering, and third, we may seek the balancing principles that possess equal status. However, Veatch rejects all of these alternatives and possesses an alternative of exploring (Veatch 1981, pp.295-305).

Pellegrino and Thomasma have suggested “rational organizing” of the conflicting principles on the basis of “beneficence-in-trust” criterion. Their proposal has two schemes: “procedural” and “metaethical”. According to him, the procedural scheme includes: patient’s directives, patient’s negotiated values, proxy judgments, ethics committee, legal system while

metaethical scheme includes: the last good, patient’s good, particular good and the biomedical good (Pellegrino and Thomasma 1988, pp.84-91).

As the patients are illiterate they might have a blind belief or conservative idea about the health care values as I just mentioned. So, we cannot set out our ideal that the physician and the patient will rationally resolve their conflicting values rather they could resolve these conflicts in a customary way. That is, dialogue or counseling could be appropriate for resolving conflicting values. By counseling the patient may rectify their values which will help them in the long run as well as the physician has an opportunity to review his or her particular values. By dialogue both parties will understand each other more clearly and able to find out a common ground between them.

To conclude this section, we have shown that it is difficult to set up a high standard ideal for the Bangladesh context. Since such type of ideal will be unreachable or utopian. We cannot ignore the three contexts particularly illiteracy, scarcity and cultural differences to have an ideal relationship. The proposed context-sensitive ideal is possible to fit for Bangladesh. These factors matter morally. Further, for the moral basis of this relationship we need ethical theories. An ethical theory will guide the physician as well as the patient to act morally. Theories could be exercised and used to overcome the current problematic situation. Therefore, in the next section we will concentrate on the related ethical theories.

3. A brief discussion on related ethical theories

An ideal patient-physician relationship must be supported on moral grounds. What should be the basis of an ideal relationship: utility, rule or care? Two prominent approaches to evaluate the moral permissibility of an action are: utilitarianism and deontology. The moral standard of utilitarianism is ‘utility’ while for deontology it is ‘moral law’. We may reach two different conclusions by following utilitarianism and deontology in the same case (e.g. truth telling or lying). So, we cannot solve many moral dilemmas in the patient-physician relationship by these two principles. To overcome this problem a new moral approach has developed, namely, care ethics. Care ethicists claim that some moral problems are better solvable by taking ‘care’ as a moral standard. We will discuss these principles in this section.

I. Utilitarianism: Utilitarianism is a widely applicable ethical theory in biomedical ethics. Utilitarianism asks us to calculate utility and make decisions by maximizing utility. The chief characteristics of utilitarianism is stated as, “...there is one and only one basic principle in ethics, the principle of utility. This principle asserts that, in all circumstances, we ought to produce the greatest possible balance of value over disvalue for all persons affected” (Beauchamp and Childress 1983, p.20).

From the above definition, we may say that firstly, the fundamental principle of utilitarianism is utility i.e. the morality of any action is justified by the utility. Secondly, we should maximize the value of the good

consequences over bad consequences. Thirdly, we will calculate the value in consideration to a utility calculus. Jeremy Bentham and John Stuart Mill are the most prominent philosophers in utilitarian tradition.

Now, we may clarify: what is utility? And whose utility should be maximized? Utility is something which we want for itself and not for its consequences. That is, utility is intrinsically valuable and all other things are extrinsically valuable. But ethicists have different opinions about the intrinsic value. Some ethicists (e.g. Mill and Bentham) hold that "happiness" or "pleasure" is intrinsically valuable while others (e.g. G. E. Moore) hold that "knowledge" or "beauty" could be intrinsically valuable. The former approach is known as "hedonism" while the later is "pluralism". The solution is that the individual will decide which value is greater to him or her (Beauchamp and Childress 1983, pp.24-25).

Should the individual consider any particular 'act' or 'rule' to justify an action? There are two answers to these questions. Act utilitarians hold that "particular circumstances" are important to determine the rightness or wrongness of any action while rule utilitarians hold that "justified rules" are valuable to determine the rightness or wrongness of any action (Beauchamp and Childress 2001, pp.342-344). While act and rule utilitarianism differ about the means of the justification, both of these theories agreed that we should maximize good consequences over bad consequences. The consequence of an action is the determinant of its moral permissibility. Utilitarianism is thus a consequentialist theory.

How does utilitarianism reply against illiteracy, scarcity and cultural differences and the patient-physician relationship? As the consequences of an act are the main considerations of utilitarianism, utilitarians will argue for the maximum benefit of scarce resources. For this reason they may support paternalism. For an illiterate society paternalism is justified from a utilitarian perspective by considering time, the patient-physician ratio, insufficient medical infrastructure. However, we have seen that paternalism is no more acceptable as an ideal model and in addition the consequences of paternalism in Bangladesh are terrible. Utilitarianism may not consider individual patient's welfare. Since the greatest happiness of the maximum number of people is the ultimate goal of utilitarianism. Utilitarianism may not consider relationships rather the equal distribution of health care services is desirable. As a result this ethical theory may not contribute to the illiterate poor patients.

II. Deontology: Deontological theory rejects utilitarian standards of morality and claims for a reason and obligation-based moral principle. Immanuel Kant formulated the core principles of a deontological theory which he calls the "categorical imperative". All ethical rules derive from the conception of the categorical imperative. Kant's first formulation of the categorical imperative is, "*Act only on that maxim through which you can at the same time will that it should become a universal law.*" (Mappes and DeGrazia 1996, p. 17). The second formulation says, "*One must act to treat*

every person as an end and never as a means only" (Beauchamp and Childress 2001, pp.350-1).

These two principles have large influence on biomedical issues. Apparently, it seems that when we use human beings as an organ donor or research subject we violate Kant's second principle but Beauchamp and Childress argue that in those cases we do not use human beings as "merely", and Kant allows using persons who have given consent (Beauchamp and Childress 2001, p.351).

Kant's 'principle of autonomy' protects respect for persons and imposes three duties on us to others: "*1. the duty not to kill an innocent person 2. the duty not to lie and 3. the duty to keep promises*" (Mappes and DeGrazia 1996, p.18). Now, we may consider these principles in the patient-physician relationship. Should the physician ignore patient's autonomy? Is lying morally acceptable? If we follow Kantian principle the answer of these questions are 'No'. In any situation the physician should not lie to the patient and the patient's autonomy must be protected.

How will deontology respond to illiteracy, scarcity and cultural differences? Deontology offers us such an ideal conception that in any situation whether literate or illiterate the patient's autonomy should be treated as universal. Deontology emphasizes rationality and reason and argues that moral rules are always absolute. According to Kant, "The principle of autonomy'...is "the sole principle of morals", and autonomy alone gives people respect, value and proper motivation" (Beauchamp and Childress 2001, p.351).

But practically it is difficult to accept that the illiterate, poor people could realize or able to apply her autonomy in a Kantian standard. Moreover, the cultural differences of Bangladesh do not permit that the patient will decide autonomously ignoring family's association. It does not imply that the family undermining the patient's autonomy rather the patient is embedded in the family and as a result the family members have a right to decide for the patient. So, deontology will not consider the reality of illiteracy, scarcity, and cultural differences and strict to apply the universal moral law in all situations.

III. Care ethics: The care ethics values 'care' as the prime criterion of morality and rejects the notion of 'impartiality' in moral thinking. Care ethicists highlight some human qualities such as care, empathy, sympathy, relations, which are more acquainted with the feminine gender and are morally relevant. According to van den Hoven, "*Care ethicists hold that care should be accepted as a central moral notion, because care is what moves people, what stimulates them to act, and from which our legitimate expectations to others derive and are negotiated*" (van den Hoven 2006, p.93).

The care ethics originates from the feminist approach of morality. Carol Gilligan's work *In a different voice* (1982) contributes remarkably to develop "the voice of care" (Manning 2001, p.99). Why is 'voice of care' morally significant? van den Hoven interprets this

question very clearly. She points out that Gilligan's works give us a "positive interpretation" by reconstructing traditional negative interpretation of care associated with women and concedes care as a morally valuable notion. She states Gilligan's view is that women are more caring to maintain relationship whereas men are concern about "moral rules and justice". So, women possess a different approach than men to articulate a moral judgment. (van den Hoven 2006, p.93).

According to van den Hoven, an ethics of care provides special emphasis on persons. As she writes, "To conceive of care as a primary moral notion implies that we have to acknowledge that morality and moral deliberation take place within dynamic practices in which the concrete attention to persons is of utmost importance" (van den Hoven, 2006, p.94).

Another vital characteristic of care ethics is that it is context-sensitive and denies "universality" as well as "impartiality" as preconditions of moral deliberation. However, a care ethicist does not refuse wholly these two notions rather argues against their necessity as a "starting-point" for "moral deliberation" (van den Hoven 2006, p.95).

Joan Tronto indicates that care ethics is not only helpful to make a balanced, interconnected ethical decision but also to eliminate all oppression against women. By forwarding a step further Susan Sherwin claims that we can apply care ethics to solve bioethical problems (Dodds 2000, p.222). The main theses of care ethics are valuing relationships and interconnectedness. This theory discourages isolation and tries to solve the debates that arise by following isolated autonomy-based bioethics. Dodds mentions, "The care focus gives us an awareness of the relationships between people and the ways these relationships are affected by health care" (Dodds 2000, p.222).

How can care ethics contribute to our ideal patient-physician relationship? Care ethics emphasizes on caring as a moral phenomenon and in the patient-physician relationship a mutual understanding is expected. The basic structure of this relationship could be contractual, deliberative or one of the others discussed earlier. Indeed, the care could provide an extra advantage and resolve contradiction arises by self-interest in a single principle. As van den Hoven (2006) writes, "The fact that care is our central moral notion implies that being attentive to the needs of others is a moral quality of agents and failure to see and meet the needs of others will be morally reproachful." (p.97).

The conflict of interest might sometimes be much more difficult to resolve. Only care attitude could make a reasonable and acceptable solution of these problems. As Purdy (1992) says, "Should doctors lie to cover up negligence? Should they suggest unnecessary surgery to make an extra buck? Should we invest in strategic defense initiatives when AIDS patients languish without care? Everybody knows the

answers: the question is whether we care enough about others to do the right thing" (p.10).

The illiterate, poor patients highly expect a caring relationship with the physician. They may not have the ability to analyze information, value of informed consent, standard competency and sense of autonomy but they surely feel how much a physician is caring to them. We may claim that many ethical dilemmas, negligence and medical malpractice will be reduced greatly if this humane principle is included in Bangladesh health care practice.

4. Conclusion

To summarize, in this paper I have tried to build up a framework of ideal patient-physician relationships for Bangladesh which is context-sensitive. Our hypothesis was to offer an ideal model where context matters. We have made a balance between ideal and reality by incorporating the minimum requirements. So, illiteracy, scarcity and cultural differences are possibly morally relevant and not only practically relevant. The care ethics will provide the moral basis of our ideal patient-physician relationship. Since the poor, illiterate, embedded people perceive autonomy as relational and evaluate their relationship by sympathy, empathy and care.

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Violence and terrorism in the Middle East

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Abstract

Recently, there has been a lot of debate on whether Islam is similar or different from other religions regarding the potential to incite violence/terrorism. Some researchers claim that Islam as a religion may not incite violence and/or terrorism any more than other mainstream religions, and refer to the fact that the majority of Muslims are peaceful. Others suggest that the majority of recent terrorist attacks are committed by certain groups of Islamic fundamentalists known as *Salafi Jihadists* and violent aggression including terrorist attacks is more common in parts of the world where *Salafi* Muslims live, such as in the Middle East. A third group explains that many areas in the Middle East have been impacted by sociopolitical conflict, war and failed states thus making them vulnerable for terrorism; therefore the association with Islamic fundamentalism is only secondary to geopolitical issues. This article examines some of the common beliefs among Islamic fundamentalists in order to demonstrate if and how aggression may be incited and aggressive violence including terrorism be justified in this worldview. It is demonstrated how a strict emphasis on pure monotheism (*tawheed*), sovereignty of God (*hakimiyyat*), a belief in God's omniscience (*ilm*) and predestination (*qadar*), emphasis on right 'intentions' (*niyyah*) rather than right actions, and unequal treatment of humans based on religious beliefs are 'risk factors' that may incline some *salafi* (fundamentalist) Muslims towards *jihadism*. The article concludes by suggesting awareness programs to help reform the philosophical worldview of *Salafi* communities by focusing on the value of life and Islamic humanism.

Keywords: Islamic fundamentalism, monotheism, Muslims, omniscience, predestination, *salafi jihadism*, terrorism.

Introduction

The increasing number of terror attacks by Islamic fundamentalists who claim to have followed on their Islamic teaching has caused a controversy both in the public and among academicians on whether Islam is a peaceful religion or it incites violence per se. Some academics argue that many other religions have teachings that could be misused for rationalizing violence, and that the recent increase in the number of terror attacks is related to geopolitical changes including the invasion and occupation of Afghanistan by the Soviet Union in 1980s and the invasion of Iraq by the US forces in 2003. Others hold that not all terrorist attacks may be attributed to such geopolitical issues and many attacks have been committed even in conflict free places by radical Muslims who were barely affected by the mentioned calamities.

Some researchers (Henslin, 2009) have asserted that none of the religious terrorists, whether Muslim, Christian, Jew, or Hindu, etc. represent the mainstream of their religion. There are usually well known elements that appear to incite some religious people towards terrorism; first, they believe that they are under attack by a rival religious group (for example by Christian troops in Iraq, communist Russians in Afghanistan, etc.). Second, they are convinced that God wants their rivals destroyed. Third, they have concluded that violence is the only solution to the problem. Fourth, they believe that God has chosen them for this task, and fifth, the community they belong to nurtures such points of view. Under these circumstances their morality changes into a form that justifies killing for the right cause.

Karen Armstrong (2001, 2007 and 2014) is a well-known author on the history of religions in general, and on the history of Christianity and Islam in particular. She has also authored a book about the relationship between religions and violence throughout history. She explains (Armstrong, 2014) that violence is usually covered by a religious cloak, while the real reasons for violence have often been in the political context. In other words, political conflict has often framed religion as the source of violence. In the case of Islam, she describes how the early Muslims preferred peace and would only turn to fighting in defense. However, after a large Islamic empire formed and needed a tool to establish political order, violence became a more common issue in Islam; the same thing had happened with Christian empires before. Even so, Muslim leaders usually had the "people of the book" including Jews and Christians under protection.

Reading Armstrong's book, one may conclude that religion throughout history has influenced the form of political governance because people have commonly believed that religion would bring significance to any social movement. However, the source of violence has almost always been the state which colored its politics with religion. Armstrong recommends against blaming religion for violence and reminds us that nationalism has far more often been used to incite violence. Therefore, one may conclude that the association

between violence and any religion including Islam is not a causal relationship but is just a correlation.

Frazer (2011), Jones (2014) and Turner (2010, 2014) explain in detail the role of *Salafism* and the *Salafi* movement in the formation and organization of terrorism based on a religious ideology. It is worth noting that even among the Salafi, most are purists or quietists, while a small percentage estimated at 10% may become politically active, with a much smaller number of the latter choosing to support or join *Salafi jihadism*. However, the existence of this chain points to the possibility that there may be 'risk factors' in the *salafi* worldview that increases the chances of committing acts of terror and violence under the name of religion. Therefore, this paper attempts to explore if there are 'philosophical' beliefs influencing the worldview of Islamic fundamentalists, and reflected in common beliefs shared by most Muslims, which explain why a radical *salafi* Muslim may be more prone to the use of violence in a conflict.

Methodology

This research is partly based on a review of the literature about Islamic fundamentalism and *salafi* principles and a few academic papers and books published on this subject, and partly on qualitative research using focus group discussions with a small group of radical Muslims believing in or familiar with *salafi* views, from Afghanistan and Pakistan. The findings of literature review were put forward for 'discussion' by the members of the group, while notes were taken from the discussion for more detailed analysis.

Members of the group discussion were all serious, strict Muslim men who were made assure of anonymity and in exchange were asked to honestly reflect on their solemn opinions regarding Islamic fundamentalism and violence. None of the group members were *salafi jihadists* nor did they support the violence committed by the associated groups, though they provided their view of what the ideology behind the violent actions of these groups was. The group members did not support violence committed by the group called *Taliban* though some were sympathetic to the reasons (such as governmental corruption) why such actions were committed. However, they were quite familiar with the worldview of members of *Taliban* and their teachings. An ethical explanation on the use of the information was provided and oral consent was taken for the use of the shared information only for research purposes. The discussion started by asking a series of questions that are listed in Table 1. Notes were taken and screened for concepts that were both related to the topic of this research and also were held in common with other members of the study group. The ensuing debate was analyzed.

Table 1: The main questions used in the focus group discussion to invoke a critical debate

<p>B- What is the scope of God's knowledge? How does it affect human freedom and fate?</p> <p>C- What duties does a man have towards God and to other people? How are these duties different?</p> <p>D- Among acts, intentions, and consequences of acts, which one is the basis of morality?</p> <p>E- Is there any difference in the value of humans, and if so, what is it based on?</p> <p>F- How do you explain the violence that exists among Muslims living in the Middle East?</p> <p>G- How can one help reduce violence among Muslims living in the Middle East?</p>

Findings

I shall first summarize the findings of literature review about the topics that were put into qualitative research discussion through the questions outlined in Table 1. The ensuing group discussion and debate helped with a better 'tuning' of the information while participants confirmed some parts and added explanation to others along *salafi* (fundamentalist) Islamic views. Thus, following the findings of the literature review, these points will be discussed.

Monotheism (tawheed): The first question that any belief system based on one almighty God should answer is related to the presence of evil in the world (Abel, 2004). Basically, if there is an almighty and powerful God as the source of all creation, how can evil exist? An almighty God would not create evil, nor could it be forced by other forces to allow evil to exist. However, evil exists in this world and is not limited to human misdeed. There are many natural causes of disease such as pathogenic bacteria and parasites, harmful chemical and physical agents of disease, as well as natural disasters including earthquakes and fires, etc. which cause a lot of suffering for all living things including humans. In fact, one of the questions that the first group of Muslims asked Prophet Muhammad was why there was so much suffering for Muslims.

If one believes in the existence of another major power to support evil, such as the devil or Satan in Christianity, evil can be ascribed to the devil and goodness can be ascribed to God. However, the prophet of Islam firmly believed in only one God; the devil is not such a powerful entity in Islam and may only tempt humans to do wrong and lacks the power to influence the world by itself. Therefore, the Prophet explained that suffering was coming from God just as his mercy, for a number of reasons:

First, humans do not have the wisdom of God to know that suffering was really evil. For example, nature includes many forces that humans do not know well, and though they may consider them to be evil, it is because of their incomplete understanding. Only God has full knowledge of everything and therefore God's perspective of what is evil and what is not would matter, not the incomplete perspective of humans.

Second, suffering of the Muslims in this world could be a test of their true faith, and may reduce from their suffering in the afterlife and also lead to rewards that

<p>A- Why is there suffering in the world? What is the Islam's answer to the question of human suffering?</p>

are promised for the faithful. Therefore, Muslims have been encouraged to change their view of what is usually considered as evil; death, suffering, and destruction come from God, with his knowledge and will, just as life, pleasure and growth also come by God's will. Therefore humans should generally learn to 'accept' pain, suffering and death as the will of God, and 'surrender' themselves to the will of God. In other words, in Islam no one suffers without God's will.

Omniscience (ilm) and predestination (qadar): In Islamic theology, God is the all-powerful and all-knowing creator. Quran describes God as being fully aware of everything that happens in the universe, including private thoughts and feelings, and asserts that one cannot hide anything from God:

Quran 3- 29. Say (O Muhammad): "Whether you hide what is in your breasts or reveal it, Allah knows it, and He knows what is in the heavens and what is in the earth. And Allah is able to do all things."

Quran 10: 61 "And you are not engaged in any matter or recite any of the Quran and you do not do any deed except that we are witness over you when you are involved in it. And not absent from your Lord is any part of an atom's weight within the earth or within the heaven or anything smaller than that or greater but that it is in a clear register."

Quran 49:16: "Say, would you acquaint Allah with your religion while Allah knows whatever is in the heavens and whatever is on the earth, and Allah knows of all things?"

Knowing all things includes knowing what all humans will do in the future. Some Muslims believe that there is no way to change what has already been destined to happen, known as predestination (*qadar*). However, fortunately most Muslims respond by saying that this rule applies only to nature but not to humans who have been given a free will and responsibility to make the right choices and decisions they freely make. Therefore most Muslims agree that humans have been given free will by God and only evil humans would commit evil. But how does a Muslim know if what he is doing is right or wrong?

As discussed in the previous case, both life and death come from God and only God knows what is right and what is not. So how can one know what one is doing is right, when the true knowledge of right and wrong is with God? This question brings us to the next two concepts.

Emphasis on right 'intentions' (niyyah): In general, any deed can be broken down into three components: intention, action and consequence. Islamic fundamentalists, including *salafi jihadists* in Afghanistan and Pakistan appear to believe that the component that matters the most is the 'intention' to follow the God's will (that may be worded to them by a reputable Islamic clergy as the leader), as well as the 'consequence' (victory for Islam and Muslims, defeat for invading infidels who are forced to leave) rather than the 'action' itself. Therefore a *salafi jihadi* may "intend" to follow the will of God "in order to" bring victory to Islam, and he thus may have to commit actions of

violence that "under normal circumstances are not permissible", such as killing a human.

Prophet said: "*Deeds are [a result] only of the intentions [of the actor], and an individual is [rewarded] only according to that which he intends.*"

This *hadith* clearly suggests that actions are judged according to intentions.

Prima facie duties: Ethics in Islam is not purely deontological. In Islam, actions are not simply divided into right and wrong; each person at any moment may have a number of obligations some of which are more important than others. A Muslim decides to conduct a series of actions as "duties", and to refrain from other actions that are to be avoided, based on a proper ranking of them. Basically, humans are always held responsible for duties they have towards God, such as in worshipping him only. These actions need to be followed with almost no exception. This does not mean that duties to other humans especially fellow Muslims can be forsaken, but emphasizes on the priority; if commitment to one duty is incompatible with the other one, duties to God are the ones with priority.

Also, in general there are many ranks of necessity for the various actions by a Muslim, as to how necessary it is to do or 'not' to do (to refrain from doing) certain deeds. Generally speaking, from a religious/ethical standpoint all actions are classified into five broad ranks as the following:

1- *Wajeb* ("fariza") refers to obligatory actions which must be done, when possible.

2- *Mostahab* refers to actions that had better be done, but mostly are not obligatory.

3- *Mobah* refers to neutral actions with a neutral ethical status meaning that there may be no obligation or duty to do or to refrain from doing those actions.

4- *Makruh* refers to actions that had better be avoided but are not fully prohibited.

5- *Haram* refers to prohibited actions which must be avoided, if possible.

This classification is a general guideline for overall decision-making. Interestingly, actions considered '*mostahab*' are right actions which one may still choose not to do and actions considered '*makruh*' are relatively wrong actions which one may still choose to do. The category of '*mobah*' actions is not such an inert one either; commonly it signifies that the judgment to do or not to do an action is left to the person because no moral obligations are attached to the act. An example would be the looseness of the obligation to tell the truth to a non-believer.

Moreover, under given circumstances, some actions that belong to one certain category may move to another category. For instance, eating pork in Islam is generally well recognized as forbidden ('*haram*') but in a case that the life of a Muslim depends on eating pork, for example when no other food is available and he may starve to death, it may be acceptable ('*mobah*') or even obligatory ('*wajeb*') to eat pork at an amount needed to sustain life.

At any given time, a Muslim may be under more than one obligation and sometimes these obligations

are in conflict. There may also be instances when 'wajeb' obligations are in conflict with one another. For example, a Muslim must obey parents and must obey the religious directions too; what if they are opposite to one another? The following verses in Quran support this view:

Quran 9:3: "Allah and his messenger dissolve obligations."

Quran 66:2: "Allah has already sanctioned for you the dissolution of your vows."

That is why in difficult situations, a Muslim may ask for a 'decree' to resolve such conflicts. What a Muslim should do depends on the relative importance of various obligations on him. Other than duties towards God which are absolute, most other moral duties are not absolute, as opposed to the Kantian and deontological ethics, in general.

The right order of duties as well as any 'exceptions' can be learned by referring to one's pure intention (*niyyah*) or asked from the religious leader. It should not be forgotten, however, that Quran also strongly values human life as the following verse shows; though this may be interpreted by fundamentalist Muslims as applying only to fellow Muslims:

Quran 5:32: "...We ordained for the children of Israel that if any one slew a person - unless it be for murder or for spreading mischief in the land - it would be as if he slew the whole people. And if anyone saved a life, it would be as if he saved the life of the whole people..."

Inequality of humans in their prescribed treatment by Muslims: The other significant issue is a controversy over belief in universal human dignity versus a higher status for Muslims over non-Muslims. Quran regards monotheist religions including 'true' Christianity and Judaism highly and refers to their texts with a lot of respect. However, the following verse may be interpreted differently:

Quran 3:85: "If anyone desires a religion other than Islam, never will it be accepted of him and in the Hereafter he will be in the ranks of those who are losers."

Quran 3- 110: "You [Muslims] are the best of peoples ever raised up for mankind; you enjoin Al-Ma'ruf and forbid Al-Munkar, and you believe in Allah. And had the people of the Scripture (Jews and Christians) believed, it would have been better for them; among them are some who have faith, but most of them are Fasiqun (disobedient to Allah - and rebellious against Allah's Command)."

Obligations that a Muslim has towards other Muslims, such as not to lie to them, may not hold as strongly to non-Muslims, particularly non-monotheists. It is therefore not easy to make a general statement on the standpoint of Islam on universal human dignity and human rights. To explain this better, it is helpful to note that a person's 'rights' may be translated into "duties" or "obligations" of others to treat that person in a certain way. Accordingly, human rights may be looked upon in the perspective of "duties" of an individual Muslim (or the Islamic state) towards other individuals, and not the 'rights' of the people, as in current mainstream schools

of ethics. Thus, Muslims may not be obliged by the same duties towards non-Muslims, as they are towards fellow Muslims. An action that is forbidden (*haram*) towards a Muslim may only be "not recommended" (*makruh*) or may sometimes be acceptable (*mobah*) towards a non-Muslim, and an action that is obligatory (*wajeb*) towards a Muslim may be just "recommended" (*mustahab*) or sometimes "optional" (*mobah*) towards a non-Muslim.

Fundamentalist Islamic ideologies

Based on the belief that Prophet Muhammad and his earliest followers were implementing true Islam, and any later innovations (*bid'a*) are wrong, *salafism* is commonly associated with a strict literal interpretation of Islam. They ascribe this belief to a *hadith* from Prophet Muhammad, which says: "*The people of my own generation are the best, then those who come after them, and then those of the next generation*".

A *salafi* can be from any of the four main schools of Sunni Islam. They usually condemn certain practices of other Muslims, especially the *shi'a*, as polytheism (*shirk*). Still, most *salafis* would only preach "purist" Islam and stay away from political activity. Some *salafis* have become politically active, and among this latter group, a small number have chosen to follow Islamic *Jihadism*. They particularly became apparent in 1990s and are currently fewer than 10 million in number, worldwide. In Pakistan and Afghanistan, *salafi* schools (*madrasa*) were financed by Saudi sponsors who supported the powerful group known as Taliban. Therefore, even though Afghans and Saudis come from different schools of *Sunni* Islam (*Hanafi* and *Hanbali*, respectively), they shared this purist fundamentalist interpretation of Islam. As a movement, *salafis* have been growing very fast even into European countries. What distinguishes *salafi jihadism* from others is their commitment to *jihad* with enemies of Islam, particularly the USA.

Quran 2- 190: "And fight in the Way of Allah those who fight you, but transgress not the limits. Truly, Allah likes not the transgressors."

2- 191: "And kill them wherever you find them, and turn them out from where they have turned you out. And Fitnah is worse than killing. And fight not with them at Masjid-al-Haram (the sanctuary at Mecca), unless they (first) fight you there. But if they attack you, then kill them. Such is the recompense of the disbelievers."

2- 192: "But if they cease, then Allah is Oft-Forgiving, Most Merciful."

2- 193: "And fight them until there is no more Fitnah and (all and every kind of) worship is for Allah (alone). But if they cease, let there be no transgression except against oppressors".

Bruce Livesey estimates that *Salafi jihadists* constitute less than 0.5 percent of the world's 1.9 billion population of Muslims (i.e., less than 10 million). Even so, this is still a large number of potential supporters of terrorism, under the current geopolitical situation in the Middle East.

Discussion

During the literature review, five major risk factors were identified that could be a reason why a strict Muslim would be at higher risk of resorting to violence or accepting it as a possible solution in a conflict situation. These included the issue of suffering and its source, a belief in predestination (*qadar*), an emphasis on intentions rather than actions for morality, prioritizing obligations to God compared with duties to other people and the use of *prima facie* order to loosen some of the latter duties, and a belief in unequal treatment of humans based on religious beliefs. These five major issues were put into debate with our small group of Muslim men with fundamentalist (*salafi*) views, and discussed to find out if they were pertinent to the issue of violence observed in their experience. Interestingly, some points were not apparent in the beginning but later turned out to be acknowledged and/or accepted by the discussants as a possible risk factor. This implied that the issues were not superficial but lied at the base of an individual's worldview. The group agreed that a Muslim may be deceived /brainwashed into actions of violence because of strong feelings of loss, injustice and anger, affliction with poverty, and encouragement by other trusted Muslims who have similar beliefs as described in the part of findings. Therefore, the group believes that these beliefs work as risk factors in specific backgrounds. Unfortunately, for those believing in Islamic fundamentalism (*salafi*), level of education may not be such a protective factor as they tend to focus on Islamic tradition near the time of its origin, rather than more contemporary reforms.

Almost all discussants in our small group offered both 'theoretical' and 'practical' advice on how not to be deceived into the 'wrong' conclusions. For example, they said that "*God would want us to avoid suffering*", and "*Islam was not about austerity but leading a moderate life*". Also, they believed in the "*free will of humans*" and therefore they would condemn an "*immature belief in predestination*". They mentioned how their experience of the turmoil in their people showed them the very high value of protecting human life, especially of innocent children and civilians. They also said that "*people cannot be judged*" by other people for their beliefs as "*only God knows the truth*" of what they believe in, and hasty judgements are commonly false. However, they could understand how some other Muslims could be coerced by emotional others into the cycle of violence especially if they had been exposed to violence; they talked about the cycle of violence, of avenging for the deaths, and of getting used to witnessing violence in their communities.

The author of this paper thus together with the discussants came to the conclusion that the above mentioned ideas could be used as "excuses" to justify violence among a specific but large number of naïve people who had suffered or had experienced violence in their own life and thus were ready to make such "incorrect" interpretations of Islamic concepts. We all agreed that the majority of Muslims in the Middle East even in conflict ridden regions were tired of violence

and would like it to stop. The discussants suggested that the misguided teachings to the Taliban and similar groups were to blame for such wrong interpretations of Islam. Having said that, we could also identify what concepts could be misused to justify violence to a Muslim who has fallen into the trap and has given himself as a tool to the wrongful leaders of violent and/or terrorist organizations.

The next step was to examine what ideas were especially prone to misuse; here I shall mention them as risk factors. The most significant risk factor for inciting violence appears to be how evil may be attributed to God because of strong emphasis on monotheism (*tawheed*). ISIS which is currently the most violent Islamic group active in Syria and Iraq takes its ideology from Wahhabism which has been described by its followers as an Islamic "reform movement" to restore "pure monotheistic worship" (*tawheed*); they prefer to be called *mowahhidun*, which is an emphasis on pure monotheism.

Apparently, by omitting a role for the 'evil' and attributing all that happens to God, the approach of a radical believer to world problems is fundamentally changed. Essentially, a radical Muslim may only see himself responsible towards God and not to the people, other than fellow Muslims, anymore. This can be seen in their black and white flag where the phrase "Muhammad Messenger of God" is written upside down so that the word God (*allah*) is placed at the top and Muhammad is placed at the bottom. This particular positioning of the words in that phrase implies that God has a unique position and humans, even the prophet, are only below him.

The next significant risk factor is reliance on the right 'intention' (*niyyah*) rather than the right 'action'. This causes a radical Muslim not to think critically of actions he is committing but mainly of the intentions (towards only God and in the hope of approving God's authority over all else). So he may harm or kill a person if his intention is only to follow God and his decrees.

Next, the *prima facie* order of duties causes a number of flaws to appear in the morality because it allows for committing "more important" duties and a loosening of "less important" or less "strategic" ones especially in times of war and conflict.

The remaining risk factors also play some roles though it is hard to say if any of them outweighs others. A lack of belief in universal human dignity and rights makes this situation worse. Among radical Muslims, the blood of non-Muslims may be considered as '*mubah*', implying that their lives are at peril and their properties and lives can be taken as a Muslim wishes, without moral sanctions. Among Islamic *jihadists*, this view of inequality of humans may be extended to as far as other Muslims who do not show complete loyalty to the group and to the religious leader. Meanwhile, whatever happens is not critically reviewed for learning a lesson because it happened with the knowledge of God and thus with God's omnipotence it would be inevitable to happen, anyway.

The discussions, however, pointed to another factor that has influenced the relatively larger role of Muslims in “political” violence. With the establishment of a theocratic constitution in the Islamic Republic of Iran in December 1979, for the first time in modern era the political foundation of a large and strategic country in the Middle East was tied to religion and political affairs came under control. Although Iran was a *shia* country and furthermore its model of government did not lead to much success, it created a lot of interest among Muslim groups that had claimed a principal role in governance. The success of the fundamentalist Muslim group of Taliban in Afghanistan in defeating the opponents and forming a government in 1996 (till December 2001), was another example of the merging of religion with politics in the Middle East. The result has been a larger intrusion into politics by a minority of Islamic fundamentalists who then use terror tactics to intimidate the politically secular majority.

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Hospital food Manipulator’s Moral Judgment Evaluation of Hand Wash Technique Training

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Abstract

Objective: Evaluate moral judgment of hospital food manipulators, in training of the hygienic hand wash. Variables: previous and later moral and social developments, age, gender, scholarship, and seniority.

Methodology: An observational, longitudinal, comparative and prospective, non-probabilistic survey, was executed upon 17, third level attention hospital food manipulators in Monterrey, N. L. Including women, aged 18 to 60, attending a three session course with bioethical contents, with an emphasis in hygienic hand wash process, with a total of six hours (required attendance: ≥ 2 sessions).

Background: Moral judgment (Kohlberg), allows human beings to discern between good and bad, and also organize life in an intended way, because with his thoughts foretells and impacts not only the decision making in the working area, but also other aspects in life. Moral dilemmas, dialogue, and reflection can develop Moral Judgment.

Legal and moral standards are linked as a constitutional value that promotes the proxy and recovery of health in people. Health institutions, as ethical entities, are responsible for broadening the ethical professional conscience of their personnel when promoting courses with a bioethical sense. A course was chosen for this purpose, oriented to kitchen area professionals, reminding them about responsibility in hygienic hand washing, the awareness over food preparation, storage, and service to prevent food-borne infections, as a principle of justice for hospitalized patients. Justice and responsibility, considered as the most important biomedical principles of Beauchamp and Childress, and care ethics (Gilligan), are expressed in hygienic hand washing procedures.

Keywords: Moral judgment, hand washing techniques, hospital food manipulators

1. Introduction

In these days of intensive technological development in a globalized world, where the economic competitiveness has displaced the traditional ethical values, and where it seems that dehumanization is a

constant factor, it is necessary to make a pause on the way to realize how the individual reacts in order to take action on the real nature of the human being: care taking (Torralba-Roselló, 2000). This care is conceived as the most basic sense of every living being: self-protection and the protection of more vulnerable "others", observation that is realized from the optics of the Ethics of the Care (Alvarado García, 2004).

Moral development, mainly in educational systems and the society, also affects decision-making or moral specific behaviors of the working field, and all other aspects of life. Decision-making originates from conscience, and this is a sign of authentic human dignity (Vargas Vargas, 2007). According to Kohlberg's explanation, moral judgment is made before the action is taken, and is the reasoning of the individual, which determines his conduct when he faces dilemmas that put the acquired values to a test, on having to choose between a correct or incorrect action (Zerpa, 2007).

It is significant to know that in the last 40 years, Adela Cortina has warned about the need to extend the ethical professional conscience, limited till then only to doctors, nurses and researchers, to all personnel that works in the sanitary world, as an individual, organization or health institution, for the effect of fulfilling the tasks that the society has entrusted them. It is also worth highlighting the fact that the companies are now necessarily ethical for being immersed in an environment of morality, and these, in turn, can be driven in a morally correct or incorrect manner (Cortina 2002).

In accordance with previous information, the juridical procedures are constituted in an element of indispensable and obligatory entail with the norms of moral character that allow us to observe and certify how moral social pluralism is assumed, not only as a fact, but it raises, in these terms, as a constitutional value that promotes the procurement and recovery of the health of the persons, which is supported in aspects of moral character that are happening in the society and support a point of convergence for the resolution of the conflicts that have genesis in this area (Albarellos, 2007).

A hospital, institution or health organization, of undeniable form, is a company that chases a purpose, for what it establishes limits that facilitate the obtaining of its objectives, nevertheless, in the same manner, it is warned that there are procedure requirements that they regulate actions before an individual especially and the society. Under this observation, the food manipulators of the hospital area must remain included in the need to broaden their ethical, judicial and professional conscience, in agreement with what has been established by Adela Cortina (Cortina, 2002).

Professionals that work in the health area, with or without direct contact with the patient, turn into moral agents who are obliged to provide a briefing of their actions and be responsible for the consequences derived from them, even of the generation of preventable adverse effects.

In a particular manner, the limits established by Norma Oficial Mexicana NOM-251-SSA1-2009, "Hygiene practices for the processing of foods, drinks or food supplements", (Secretaría de Salud-2009), paragraph 5.14, titled "Training", regulate that the whole personnel that operates in the areas of production or food preparation must be instructed in a constant and permanent way at least once a year, in the good practices of hygiene. This includes, among others, personal hygiene, correct use of the apparel of work attire (uniform) and washing of hands (5.14.2).

Therefore the present investigation tries to approach evaluation of the moral judgment of the hospital food manipulators, in the training of hand washing in a health institution of the third level of attention in the north of Mexico. Using the point of view of the Ethics of Care, by means of the conscience and the compassion towards their kind, from the perspective of the Principlism, where the food manipulator takes responsibility for all the decisions and moral actions of professional order that he/she executes, and seeks to act fairly and responsibly, sticking to the institutional values.

2. Approach of the Investigation

According to the results of diverse microbiological studies performed on live surfaces (hands) of the food manipulators, and the observed numerical values, one concludes in general that, most kitchen personnel of the third level attention hospital, do not know the hygienic hand washing techniques or lack the discipline to fulfill it in the critical moments, or probably, is not even conscious of the transcendence of the practice and of the impact in the prevention of the food borne illness ("food borne infection", or "food borne disease") for the goals of public health, and social-economic progress. The previous agrees with the results obtained in the recent work of Corrêa and Nunes, who advise on the lack of this habit, in the personnel of health, to become attached to the suggested recommendations about the hand washing techniques (Corrêa and Nunes, 2011).

It is necessary to favor the moral judgment development, with a wide and substantial background in principlism (beneficence, non maleficence, respect for autonomy, and justice) between the professional of the nutrition area in regards to the good practices of food production and the practice of the hygienic hand wash, adducing that must be the very same institution the one who offers the educational program.

With this activity, the hospital, as macro example of the action of the "benefactor", and immersed in the ethical-juridical frame, stimulates the development of the moral judgment among the Nutrition area personnel, to regenerate the conscience centered in the procurement of justice in doing good and prevention of avoiding any harm to the peers, "perfect" duties of any qualified institution with social responsibility.

3. Situational Frame

Any individual, has the human and inalienable right to be provided with innocuous food (FAO/RLC, 2010). The procedure of major risk that favors food contamination and the surfaces where these are prepared, is malpractice during the hygienic hand washing, as well as the insufficient follow-up or scanning supervision of this action, in order for it to be executed in a suitable manner (Caballero-Torres and Lengomín-Fernández, 1998).

The context of food safety requires defining some concepts of competence in this item. Each and every single manual procedures that are carried out for the preparation of the food (manipulation), must be performed on having to follow the indications and taking the necessary cautions they should, assuring to avoid or to provoke damage in the patient's health (practices of hygiene and innocuousness). Foods that are served in fixed or mobile locations go through a mechanical process, which goes from the selection, the wash and the disinfection, when it is necessary, the chopping and mixing, up to its cooking with boiling and humid heat, or dry heat (baked), or fried, and the cooling or freezing to be finally eaten, which is then considered to be a prepared meal (Secretaría de Salud, NOM-51-SSA1-2009).

The food prepared or ready to eat, can bear strange material, harmful substances for the health or microorganisms that exceed the maximum allowed values (contamination) (Secretaría de Salud, 2009), which regulates the Official Mexican Norm NOM-251-SSA1-2009, "Hygienic practices for the processing of food, drinks or food supplements", and that is expressed in the technical criterion of Paragraph 1 of the microbiological sanitary specifications in food, of the Informative Appendix B of the Official Mexican Norm NOM-093-SSA1-1994, "Goods and services. Practices of hygiene and health in food preparation that are offered in fixed establishments" (Secretaría de Salud, 1994).

Food borne infection can surely originate in any stage of the manipulation of the food, in one particular procedure, or even, to come from some different product, to this type of contamination is known as "crossed" (Secretaria de Salud NOM-251-SSA1-2009). Finally, the product that generates this kind of contamination can be also an inert or inanimate surface (tables, cutting boards, knives, another food, etc.) or live surface (any body surface, mainly hands) (Secretaria de Salud NOM-093-SSA1-1994).

Diverse governing international organizations agree on indicating that the most energetic measures and with major impact in the prevention of Food Born Transmitted Diseases, FBTD's in forward, are sanitary education programs that promote the information and the knowledge, to establish healthy habits that influence the conduct (moral judgment) of the participant, in his/her own healthy benefit and that of the community, furthermore if it is a question of a vulnerable population, as the case of the hospitalized patients would be.

Federal regulations within the Mexican territory laws, promote among other things, the actions of physical or moral persons in search of justice for all. In the particular case of the present research, the law: Norma Oficial Mexicana NOM-251-SSA1-2009 is most relevant. Hygienic practices for the processing of food, drinks or food supplements, approach the hygienic procedures for the preparation of food, drinks or food supplements that are manufactured, served or sold in fixed establishments, such as the case of a third level attention hospital and go over aspects as wide as those that are elicited in the general regulations: facilities and areas, equipment and tools, services, storage, control of operations, control of raw materials, control of packaging, control of the water that comes in contact with the food, maintenance and cleanliness, control of plagues, managing residue, health and hygiene of the personnel, transport and training.

Within the general regulations, the NOM-251-SSA1-2009 previously specified, a special indication is made in Paragraph 5.14 defined as "Training" where directives are urged to give the instruction to the whole personnel that works in the production and elaboration areas, with at least an annual frequency, and that it should include, among other topics, the personal hygiene, the use of proper gown or uniform for work and the practice of hand washing.

The fact that the health institution adopts a sanitary education program for food manipulators, is to respect a juridical federal obligation, but shall aim to go beyond the elementary mission of satisfying a requirement only for "the duty for abidance". The hospital, in its position of ethical entity as an organization or health attorney, can promote among the personnel the performance of their work, more than for just mere abidance, for absolute conviction, where the search for the necessary tools to favor the development of the moral conscience of the participants is performed.

The kitchen personnel of the hospital in study, complies with a performance of 52,800 meals a year, distributed in three shifts. By considering that every meal represents a possibility or risk of acquiring a FBTD, the moral responsibility this represents, for the Nutrition Service and for the institution, takes them to understand the importance of having properly updated and trained personnel in procedures of correct food manipulation and rigorous practice of proper hand wash.

This act becomes more relevant, when the diffusion of knowledge goes hand-in-hand with the "construction" of the reasoning of moral judgment in the food manipulator, which will allow him/her to act for the highest well-being (beneficence), with the necessary diligence to avoid damaging (non-maleficence) in the vulnerable subject, but especially, because they have full conscience of the sense of justice that every human being rightfully demands, especially the hospitalized patient, for whom all the efforts are directed.

4. Referential Frame

4.1 Ethics of care

Humans, just like other living beings, have a primitive attitude that has been useful to them for survive: self-protection and care for their more fragile. This attitude triggers in humans a series of responsibilities, and its highest purpose is to achieve care for their peers, or even their own self (Alvarado García, 2004). The basic elements to execute the action of "caring", are clung on a structure moved by compassion, competition, confidentiality, trust and conscience, are so, the roots of the ethics of care (Torralba-Roselló, 2000).

The elementary virtues that constitute the ethics of the care are explained further where, though both of them are important and necessary, its harmonic and thorough amalgam is required to obtain the best results. A) To perceive the vulnerability of an individual, and to be sensitized in a conscious way before the suffering of another, is what gives origin to the virtue of pity or compassion. B) The development of the professional activity, across knowledge, the techniques, the skills and the procedures, lead to the domain and suitable application of them, which is considered as competence in an individual. c) Confidentiality is explained as the capacity that an individual possesses to be a silent depository of the secrets and intimate life of another subject. D) The certainty in something or in someone generates the confidence and provokes the tranquility to what the person is recognized by moral or professional authority, as well as in the actions that are executed. E) An internal resource of the human being that is basic for the good professional practice is the virtue of conscience, which leads the individual to own knowledge and its prudential use, by deduction of the consequences that are obtained in means of the practice of reflection (Torralba-Roselló, 2000).

With the passing of the years, the amazing technological and scientific advances, as well as the globalization, have generated a transformation in the culture of the human beings, leaving aside the human traditional values, being substituted or replaced for "having", with a repercussion in the individual and social conduct (Franco and Velazquez, 2007). This new state of mind has brought as a consequence the dehumanization: the people already do not look for the common well-being, but only the individual or own. The society and organizations have become egocentric. It is here where ethics of care rises on a counter-flow, by trying to understand the world in which it is immersed and in which the human being operates, to be able to understand and rescue the most basic attitude which is the commitment and responsibility towards "the other", and where this link is expected to translate into actions of aid and help towards others.

The concept of ethics of care differs from the model of principlism in ethics developed by Beauchamp, T. L. and J. F. Childress (1979), which is based in four universal principles of bioethics: autonomy, beneficence, non-maleficence and justice.

4.2 Principlism

During the 1980s, the book *Principles of Biomedical Ethics* published, from the authors Tom L. Beauchamp and James F. Childress, proposed a new conception in ethics, which serves as a moral archetype for the workers of the health sector, with the purpose of clarifying their doing upon concrete and particular situations; these are four principles that serve as support to this new philosophic current: autonomy, beneficence, non-maleficence, and justice. These principles, according to what was mentioned by the authors, constitute the universal norms of common morale and are present in all individuals (Beauchamp and Childress, 2009).

These principles lack a hierarchic value per se, so that, in conflicts or complicated dilemmas, specifically medical bioethics, favors the convergence in a solution, suitably among the different parts involved, even if the participants or contenders, differ in their ethical theories. It is sure that the resolution would not be simple because the moral acts possess the same value and the reasons will never be conclusive.

The principles of this philosophical current are compatible with different theories and are explained or defined as follows: a) The inherent dignity of every subject allows every individual to have advantage to make more suitable decisions according to their values, criteria or preferences, in such a way that the persons with their right to their **autonomy**, decide on their own; but also establishes that an individual with diminished autonomy, has a right for protection. This value is intimately related to the so-called informed assent. The person or to the patient is recognized as the main character, which brought a radical change in the, till then, paternalistic existing ethics, since it suggests a moral limit in the intervention of the doctor. b) Doing always the good upon someone defines the principle of **beneficence**, and this has been by excellence the regulatory engine of the relation doctor - patient. The inconvenience arises in the precise moment in which an interpretive arrangement of what is understood as "good" has to be reached. c) Priority principle, *primum non nocere*, is an obligation of all individuals not to cause meaningful harm or damage to any other person, this is how **non-maleficence** is defined. This principle belongs to the oldest tradition of medical ethics and it is mentioned in the Hippocratic Oath; it relies on the actions of the doctor. d) The principle of **justice** not only includes the patient and the doctor, but it includes the participation of the society as well. Suppose a regulation to the distribution of health resources. Each individual has a right to be respected and treated fairly and equally, without distinctions. Similar as the inalienable right to live, we have the right to receive sanitary attention. For this particular case, the distribution of goods also includes organizations, hospitals, or research centers whose work is related to health (Institut Borja de Biotica, 2011; Lacalle, 2014).

4.3 Moral judgment theory development

An outstanding topic within behavioral science is moral development, mainly within educational systems and society, though it is undeniable that it also affects the decisions making or moral specific behaviors of the work area, and in any other aspect of life.

Lawrence Kohlberg is probably the most quoted exponent in Psychology and Education, with the topic of the theory of the development of the moral judgment, which explains actions of the individual in life, especially when they put dilemmas about acquired values to a test by having to choose between a correct or incorrect action. For Kohlberg it is in this precise moment when the moral judgment is given form. The dilemma arises because of the cognitive imbalance that supposes the confrontation of two values before an experience, but once the problem is confronted, and the solution is constructed, by observing the values, the thought restores its balance (Zerpa, 2007). It is moral judgment that allows the human being to organize his/her life in an intentional way, because with the thought foresees his/her real motives to act and has the ability to construct strategies of action.

In order for an individual to make moral judgments, he/she must transit through a stratified progression of their own sense of justice, along with the type of reasoning that is used; in agreement with this, Kohlberg suggests a "cognitive - evolutionary" theory of the development of moral judgment, where the person, in addition to internalizing the social rules, builds new forms of thought that allow him/her to be mobilized by freedom in his/her environment. The logical reasoning always will be prior to the moral reasoning; an individual could be placed in a high level of logical reasoning, even higher to the level of the moral reasoning, but this could not happen the other way around (Monsoon, Monsoon, Ariasgago and Rauch, 2006).

The moral judgment of the human being evolves from the primitive egocentric stage, up to a condition evolved with a social holistic vision and has to the justice as maximum value, which allows to the individual to discern between (among) the good thing or the just of a fact. Kohlberg makes clear that the moral development happens during the whole life of the individual, as it is the case. The conduct of an individual is governed by his (her, your) thought or the reasoning that it (he, she) realizes (Suárez and Rocks, 2006).

Kohlberg's theory raises the existence of three constant levels of development of reasoning or moral conscience, each conformed, by two steps or stages: pre-conventional, conventional and post-conventional. Every step and every stage represents a hierarchic integration, they are considered as epigenetic, they have a unique way of interpreting and understanding the social / moral order, where the post-conventional level is the highest (Narvéez, 2003). In addition, stages have the characteristic of being cognitive, formal and universal.

Recently, Zerpa and Ramirez published the work "Morality, empathy, emotional intelligence and

transformational leadership: a model of routes in students of MBA programs in a Venezuelan university", where they use and make reference to the theoretical model of the development of Kohlberg's moral judgment (1969, 1992), that is outlined as follows (Zerpa and Ramirez, 2013):

a. Pre-conventional level

The individual neither understands nor defines the rules. And has an individual perspective. This responds to the cultural patterns and the example. The "right" and the "wrong" is recognized as a result for obtaining a reward, punishment or exchange of favors.

Stage I: Punishment and obedience, it orientates the obedience to avoid the punishment.

Stage II: Instrumental exchange, where the rules are respected by convenience.

b. Conventional level

The individual surrenders to the rules, expectations, or the authority. Conscience is held over what society demands and what judges as right or wrong. In this level, it is important to be sought as "good" by others.

Stage III: Interpersonal (tribal) conformity. Individual acts to gain approval of others.

Stage IV: Social system and conscience moral. Respect for fixed rules, law and constituted authority. Responsibility toward the welfare of others in society.

c. Post-conventional level

The rights, values, or principles approved by the members of society, pave the way to moral decisions. Resolution to social-interest based conflicts are sought, not the individual interest.

Stage V: Prior rights and social contracts. Justice distributed proportionate to circumstances and need. "Situation ethics".

Stage VI: Universal ethical principles. Recognition of the moral universal principles with sustenance in ethics and justice, yet over social laws.

Therefore, Kohlberg's steps or stages, describe how the individuals construct their moral judgments, and are strongly related with the social development and moral reasoning that they have achieved.

4.4 Food manipulators

Every person who executes manual operations during any of the processes of food preparation is considered to be a manipulator in agreement with the Secretary of Health in Mexico (NOM-251-SSA1-2009). Being the hands of the manipulator the principal source of contamination, (Generalitat Valenciana, Conselleria de Sanitat, 2001), (FAO, 2009) and the most important work tool that the one who elaborates the food possesses, since with hands one selects, prepares and mixes ingredients to achieve an agreeable dish to sight and exquisite to the palate, although pathogenic germs can also be transmitted with them (coming from intestine or wounds, and from the manipulation of raw meats or other food), through direct or indirect contact

with surfaces, causers of the so called food borne transmitted diseases (Pantoja, 2010).

When the kitchen worker evolves in an environment where the interior analysis of the principlism in bioethics is promoted, under the observance of the ethics of care, the worker observes, thinks and acts in consequence; to rescue the basic virtues of taking care of the vulnerable subject. It is through cognitive and moral reasoning that they allow themselves to build new structures, coming from their interaction with the environment. It is through their cognitive - moral reasoning what allows them to construct new structures from their interaction with the environment and to anticipate action with will and conviction, and manages to establish a soldiery commitment to help, which can be called a "*social responsibility*".

5. Methodology

The current prospective study of observational character, longitudinal and comparative, was performed in March 2015 in a third level attention health institution in Monterrey, Mexico. Where 17 female food manipulators, who willingly accepted in agreement with the consent format suggested by the General Health Law (Ley General de Salud). The development of moral judgment was evaluated using a "Defining Issues Test", where 6 dilemmas were included, with a Chronbach's alpha of 0.71, which was applied before and after a 3 session course with bioethical contents for food manipulators, with an emphasis in hygienic hand wash. Such a course is completed in a total of six hours of training, and also included aspects related with personal hygiene, proper use of work attire (uniform), and hand wash, real dilemmas or moral hypothetical discussions were used, as well as dialogue and understanding, activities suggested by Kohlberg's theory. The variables were registered for post analysis using SPSS program.

6. Results

The population of this study was conformed by female participants. With an average age of 46.4 years, with a data variation of 10.95 years of age with regard to the average opposing value. The youngest was 21 and the oldest was 59 years old. The time this population had been working in this institution reported an average of 8.5 years with a data variation with regard to the average opposing value of 8.34 years of stay. The shortest time reported was a 0.6 years of stay and the maximum of 34 years in this position.

Regarding their academic level, 58.8% have attended or completed secondary or junior high school, 17.6% received accredited training as a technician in this field, and 5.9 % show evidence of high school studies. The population without any professional studies are a total of 82.4%, where 11.8% have accreditation of nurse licensing and 5.9% in gastronomy. Currently 94% declared that they are not studying at the moment of this training course, where as only 6% are formally registered in an educational

institution, taking a course in the marketing area. They were also questioned about having an additional job, and 94% answered they had no other work, while 6% have another type of work activity. In regards to their religious practice, 71% stated they do not follow any cult or religion, where 29% do, and from these, 82% claimed to be Protestants and only 17% are Catholic.

In relation with the development Levels of Moral Judgment that prevail in the pre and post intervention, we find that those who prevail in level 4, which relates to the relations, expectations, mutual interpretations and interpersonal conformity. On having pre interventions value of 4.593 ± 1.114 and post intervention of 5.801 ± 1.407 ; that in addition turned out to be statistically significant difference when comparing them shows 95% reliability (value of P 0.043). It was not quite this way in other levels. With reference to the P index that details the morality of principles, this does not show significant difference in its measurement values.

7. Discussion and Conclusions

The results obtained in the present research correspond to a study that intended to determine if a course about food manipulators, with bioethical contents, could achieve a change in the development of the moral judgment in personnel of a third level attention health institution. The course was carried out with the intention of influencing the development of the moral judgment, which is given thanks to the transformations of the cognitive organization, by which it is assumed that the claimed change is a process in ascending order, destined to obtain levels of major balance, which is not possible to foretell only by the learning, but through the education of the moral development of the participants, where human character decisions are truly made (Aguirre Dávila, 2009).

The resulting significant changes in the participants of this research correspond to the conventional grade in level 4, which has an orientation toward keeping social order. Nevertheless, having found a significant difference, these results did not conclude any change regarding moral development level. However, we can infer that among the participants, hospital food manipulators, their biggest concern lies among the constitution of a good employee in the health area, who from within a wider referential frame, could project him/herself over the social relationships possessed, where the priority is to comply or fulfill the regulatory aspects of their assigned chores with the purpose of maintaining an order and a good working environment.

In this respect, the supreme reason is to make a socio-labor conscience prevail, which demands people fulfill their work obligations with society, and only in extreme situations they would not follow a regulatory indication, and if this were to happen, they would always be in the condition in which another social duty with higher relevance is fulfilled. This situation reveals a moral sensibility with an orientation of inner-lying

character that is reflected upon the attitude of the participants in this investigation, since with this the cooperation among the members of a society, of a group or of an institution, is manifested (Vargas Vargas, 2008). Particularly, the situational context of the present research is to contribute to the health rehabilitation of the persons who receive their services, in order to fulfill the inscribed goals of justice and responsibility in implementing bioethics principles as well as in the ethics of the care.

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Student Perceptions and Attitude towards Bioethics Teaching to Undergraduate Medical Students

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Abstract

Bioethics is being taught nowadays all over the world to improve student's understanding of ethical issues in contemporary medicine. Undergraduate as well as postgraduate students are being trained in biomedical ethics to recognize and identify ethical dilemmas and then resolve them and also to face the situations where there is need of ethical analysis. This study was conducted at a medical university to assess the attitude and perception of undergraduate medical students regarding their bioethics curriculum, course contents and understanding of ethical issues. A total of 280 students responded to the questionnaire to assess their attitudes. This study was conducted in April 2015 and it reflected that students are aware about ethical issues in their field and they have reasonable understanding of their curriculum and course contents.

Keywords: Attitude, Perception, Bioethics, Teaching

Introduction

Bioethics has evolved over the last four decades, predominantly in the western world and then spreading its domain worldwide. It is being taught to enhance the understanding of different ethical issues in

contemporary medicine¹. In Pakistan, it was started at Agha Khan University (AKU) in 1997² and now it is being taught all over the country. It was started at our university Liaquat University of Medical and Health Sciences (LUMHS) in 2007 and it primarily involved undergraduate MBBS students. Unlike previously, nowadays graduating doctors of many medical institutes of Pakistan are familiar with terminologies like confidentiality, informed consent and conflict of interest. Regular seminars, symposiums and workshops are being conducted all over the country about the awareness of bioethics. Publications from Pakistan on ethical problems are often seen on both national as well as international forums. Ethical review committees are now an important part of teaching hospitals and are mandatory requirement for any substantial accreditation. Funding agencies are aware of the necessity of ethics and require that the ethical issues must be properly addressed for all research work including clinical or laboratory research work, prior to commencement³. Medical educators have focused on the necessity of including bioethics in medical school curriculum. They suggest that biomedical ethics education can contribute significantly to the development of "physicians' values, interpersonal skills and social perspectives for the practice of medicine⁴. Knowledge of biomedical ethics and moral reasoning are essential to good patient care and is same just as biomedical knowledge and technology are to diagnosis and the management of disease. All over the world, the teaching of medical ethics in health sciences have been subjected to clinical and scientific teaching. In 1999, World Medical Association has "strongly recommended" to medical institutes all over the world that the teaching of medical ethics and also the human rights should be made compulsory in their curricula⁵. In our university Liaquat University of Medical and Health Sciences (LUMHS) bioethics is being taught in all undergraduate programs and all essential topics are covered in the curriculum. This article reports the experience of evaluating the undergraduate bioethics curriculum in relation to students' attitude and perception of teaching of biomedical ethics and understanding of ethical issues.

Material and Methods: To assess the perception and attitude of undergraduate medical students at LUMHS Jamshoro regarding bioethics curriculum and ethical issues, a self report structured questionnaire was designed. The study population included the 3rd year MBBS students. A total of 280 students participated in this study and 27 students didn't returned the questionnaire and 46 students were absent. There are 353 students enrolled in this batch. The questionnaire was distributed among the students at the end of their biochemistry practical classes. It took six working days to complete this study. It was conducted in April 2015. The students took 15 to 20 minutes to fill the questionnaire. All the students willingly consented and participated in this study. The questionnaire used in this

paper consisted of total 32 questions and it was structured according to the course contents.

Results

A total number of 280 Undergraduate MBBS Students participated in this study. There were 127 males and 153 females. Table 1 shows the responses of the students to the questionnaire.

Table: 1 Attitude and perception of undergraduate students on bioethics curriculum and ethical issues

Statement Responses	
Do You Know?	Yes (%)
1. Why we need bioethics?	221 (79%)
2. What are fundamental principles of bioethics?	230 (82%)
3. What are components of medical ethics?	193 (69%)
4. What are different types of physician-patient relationships?	207 (74%)
5. What are the issues of organ donation?	191 (68%)
6. What is euthanasia?	202 (72%)
7. What are different types of euthanasia?	201 (72%)
8. What is privacy?	196 (70%)
9. What are different types of privacy?	188 (67%)
10. What is veracity?	187 (67%)
11. What is fidelity?	185 (66%)
12. What is an ethical dilemma?	198 (71%)
13. What are the steps required to resolve an ethical dilemma?	190 (68%)
14. Why medical representatives of pharmaceuticals companies offer promotional gifts to physicians/doctors?	224 (80%)
15. It is unethical for physicians/doctors to accept promotional gifts and perks from pharmaceutical companies?	232 (83%)
16. What is medical error?	235 (84%)
17. How to avoid medical error?	232 (83%)
18. What are types of errors?	229 (82%)
19. What is professional ethics?	218 (78%)
20. What is the dual role of doctor as physician and investigator?	210 (75%)
21. What are the points of Nuremberg code?	185 (66%)
22. What are different ethical theories?	202 (72%)
23. What is informed consent?	244 (87%)
24. What are the components of informed consent?	241 (86%)
25. What is difference between verbal and written consent?	244 (87%)
26. What is confidentiality?	207 (74%)
27. What are the exceptions to the requirement of confidentiality?	201 (72%)
28. What is the importance of confidentiality in medical research?	185 (66%)
29. What are the circumstances in which confidentiality can be breached?	201 (72%)
30. What is bad news?	199 (71%)

31. What is ABCDE mnemonic for breaking bad news?	191 (68%)
32. What are the things to be avoided while breaking bad news to the patient or his/her family?	188 (67%)

Discussion

This study was conducted to assess the perception of undergraduate medical students regarding their bioethics curriculum, course contents and different ethical issues and dilemmas which they will face in their future practices. The curriculum at our university is very diverse and it covers all major areas related to medical ethics and it is reflected in the questionnaire also. It covers informed consent along with its components, fundamental principles of bioethics and their application, privacy, veracity, fidelity and confidentiality in detail. It also covers areas like organ donation and ethical issues related to it, euthanasia and its types, medical error and ways of preventing it, professional ethics, Nuremberg code, ethical dilemma and steps to resolve dilemmas. The course contents also include relationship between doctor and patient, between doctor and representatives of drug companies, breaking bad news and things to be avoided while breaking bad news. Theories of bioethics are also covered in it with pros and cons of Utilitarianism, Kantianism, Liberal individualism and Communitarianism. Bioethics teaches us what ought to be done at difficult situations and sometimes the theories and principles nullify each other, but we have to take good things from each theory and also from fundamental principles.

The present study was conducted on 3rd year medical (MBBS) students due to the fact that bioethics is being taught in the initial two years of their course and from third year onwards the students have clinical and ward rotations. The students are fully aware of this situation and they can relate bioethics in ward postings and it starts from history taking and general physical examination of the patients in third year MBBS. A good doctor is not only ethically well behaved but is technically sound also. Medical practice is an intrinsically ethical enterprise because of the reason that patients are vulnerable and medical treatments are not only technical, they often invade the bodies of patients and often engage their consciences⁶. The results of present study indicate that majority of students do have awareness about bioethics and they can understand the ethical issues. The questionnaire was designed while keeping in mind the course contents. The response of the students shows that 66 to 87 % students agreed to the statements and said yes in different questions. When asked about the need of bioethics and fundamental principles, 79% and 82% students said yes to both questions respectively. This shows that they know why we need bioethics and how we can apply and learn fundamental principles. Bioethics is taught at our university in lecture format and it is included in the final semester exams and the marks are included in final assessment and the attendance also counts. The students were asked

about euthanasia and its types, and in reply 72% of the students agreed with yes. The questions related to ethical dilemma were also asked and the students replied with yes 71 and 68% and it implied that they do know what is ethical dilemma and what are the steps involved in resolving them. In majority of questions students replied with yes and with approximately 70% positive responses. When asked about medical error, its avoidance and types, 82 to 84% students replied with yes. The results also indicate that students are aware of secondary principles and rules of bioethics like confidentiality, fidelity, privacy and veracity. They are aware of promotional gifts given by medical representatives and the motive behind them. The students were also asked about professional ethics and dual role of physician and investigator and they replied with yes with percentages of 78 and 75% respectively. The students also know the process, definition and mnemonic of breaking bad news and also the things to be avoided while breaking bad news to the patient. They replied with 67 to 71% respectively. The most important topic of bioethics is informed consent and when the students were asked about informed consent, its components and difference between verbal and written consent, the students replied with 86 to 87% yes. The present study shows that students are aware about their bioethics course and they are now able to identify and resolve ethical conflicts and dilemmas.

Conclusion

This survey was done to assess the understanding of undergraduate medical students regarding ethical issues in contemporary medicine and also their bioethics curriculum. The bioethics curriculum is recognized and designed by both Higher Education Commission (HEC) Pakistan and Pakistan Medical and Dental Council (PMDC). This study will help us in the future to fill the gaps in bioethics teaching, curriculum design and in improving student learning of ethical issues.

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Perception of Nursing Ethics among Undergraduate Nursing Students at a Nursing Institute of Pakistan

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Abstract

Objective: To evaluate the perception of nursing ethics among undergraduate nursing students and to explore their understanding of nursing curriculum and ethical issues in the field of nursing.

Materials and Methods: The final year nursing students at nursing school LUMHS were given the pre designed self report questionnaire and they were requested to take part in this study.

Results: Forty present students took part in this study and 8 students were absent. The students accepted that learning nursing ethics is very essential to understand their responsibilities which they have towards their patients and to understand ethical decision making. The students were satisfied and found their curriculum comprehensive and good for learning.

Conclusion: The students' evaluation of nursing ethics shows that the undergraduate nursing students do have knowledge about ethical issues in the field of nursing and they are able to identify and resolve those issues. They have also good knowledge about their nursing curriculum and they found their curriculum ideal and comprehensive.

Introduction

As a result of advances and modernization in science and the technology, more ethical issues and dilemmas occurring in health care have been identified. General public, health care professionals and policy makers are more aware of these dilemmas now. In the past years, nurses were always expected to be obedient and learn without question and also did not participate in the ethical decision making. Because of this view towards nursing, ethics was regarded as the science of conduct and ethics content of nursing curriculum focused on the obligations and duties of nurses. However, the increasing complexity of the health care delivery system requires increasing responsibility for the ethical decision making in the nursing care. In clinical practice nurses can be confronted with the issues related to initiating resuscitation and discontinuing life saving treatment or patients refusing treatment (1). Clinical experience has always been an essential part of nursing education. It prepares nurses to be able of "doing" and "knowing" the clinical principles in nursing practice. The clinical practice encourages students to

use their abilities and critical thinking skills for the problem solving (2). Nursing as a practical field, requires students to develop those clinical skills that are very essential in caring. The process of clinical instruction occurs in different variety of social and cultural contexts and behavior of clinical instructors plays very important role in learning process of the students. Clinical teachers have the opportunity to influence the students' learning and these students eventually graduate and shape their nursing practice (3). Bioethics is being taught at our university Liaquat University of medical and health sciences (LUMHS) in all fields and nursing is not the exception. Nursing ethics is taught in final year of undergraduate nursing and the students have clinical rotations through out their undergraduate period. The curriculum is recognized by Higher Education Commission (HEC) Pakistan and Pakistan Nursing Council (PNC). In this paper I will determine the perception of students regarding their curriculum and also their understanding of the ethical issues and dilemmas in the field of nursing.

Material & Methods

To determine the perception of undergraduate nursing students at nursing institute LUMHS Jamshoro regarding nursing ethics, a self report questionnaire was designed. The study population included final year nursing students (BS Nursing 4th Year). A total of 40 present students took part in this study and 8 students were absent. There were 48 enrolled undergraduate students in this batch. The questionnaire was distributed among the students on last day of their final year classes. The data for this paper was collected on 20th February 2015. The students took 15 minutes in completing the questionnaire. The students consented and willingly participated in this study. The questionnaire used in this paper consisted of a total of 12 questions. The knowledge of students was tested and 5 point Likert scale was used in the questionnaire. The responses were 1 to 5 as 1 very low; 2 low; 3 moderate; 4 high; 5 very high.

Results

A total number of 40 undergraduate nursing students participated in the study. The content of nursing course is shown in Table 1. Table 3 shows the responses of undergraduate students regarding the questionnaire. There were 4 male and 36 female students.

Table 1: Contents of Nursing Ethics Curriculum

- Introduction to nursing ethics
- Value Set
- Ethical principles and theories
- Confidentiality and informed consent
- Bills of rights
- Code of ethics
- Nursing practice
- Professional autonomy and ethics
- International health organizations and nursing organizations

Table 2: Perceptions of nursing students regarding nursing ethics

Likert Scale: 1 very low; 2 low; 3 moderate; 4 high; 5 very high.

Statement:	How do you rate your knowledge about:-				
Response:	1	2	3	4	5
1. Main Ethical Theories and Principles	(1) 0	(2) 0	(3) 2	(4) 26	(5) 12
2. Key concepts of nursing ethics	(1) 0	(2) 0	(3) 4	(4) 25	(5) 11
3. Identify ethical issues and relate it to nursing practice	(1) 0	(2) 0	(3) 6	(4) 20	(5) 14
4. Conflict arising in nursing due to different value and cultural systems	(1) 0	(2) 0	(3) 5	(4) 21	(5) 14
5. Complete understanding of nursing ethics curriculum and course contents	(1) 0	(2) 0	(3) 3	(4) 27	(5) 10
6. How to apply case based reasoning in resolving ethical problems	(1) 0	(2) 0	(3) 4	(4) 24	(5) 12
7. Ethical issues arising due to organ donation	(1) 0	(2) 1	(3) 6	(4) 24	(5) 9
8. Informed consent and its meaning in healthcare	(1) 0	(2) 0	(3) 1	(4) 22	(5) 17
9. Advance directives when patients are terminally ill	(1) 0	(2) 4	(3) 4	(4) 27	(5) 05
10. Brain death diagnosis in the patients	(1) 1	(2) 2	(3) 7	(4) 21	(5) 09
11. Understanding Code of Pakistan Nursing Council	(1) 0	(2) 0	(3) 4	(4) 21	(5) 15
12. The moral and ethical issues arising from withholding and withdrawing of life sustaining treatments	(1) 0	(2) 2	(3) 4	(4) 21	(5) 13

DISCUSSION

The challenges faced by nurses in rapidly changing health care environments have highlighted the need for graduating nursing students to feel both competent and also prepared for practice. This importance and necessity has highlighted the increasing significance of the quality and nature of student clinical learning experiences (4). Ethics curriculum which is being taught at the Nursing Institute of LUMHS is very comprehensive and covers almost all the areas of clinical practice. The basic concepts of ethics, its theory, principles and norms are covered. The course content comprises of units and divided into various components.

The first unit which includes introduction to nursing covers definitions of ethics, bioethics, nursing ethics, moral attitude and ethical dilemma. It also includes importance of ethics in nursing, review criteria of a profession and how to develop characteristics of a professional nurse. The second unit includes value set which comprises of identification of personal, societal, organizational, professional and moral values. It further

focuses on recognition of value conflicts and implication to nursing practice, how to develop professional values and implication of nursing care ethics in society. The third unit includes ethical theories and principles and includes ethical principles in health care in the light of ethical theories. It further discusses ethical dilemmas faced by nurses and clients. How to resolve ethical dilemmas in daily nursing practice and list of steps of ethical decision making are elaborated. The fourth unit comprises of confidentiality and informed consent and includes definitions of both, importance of both and discusses nurse's roles and responsibilities in nursing ethics.

The fifth unit comprises of bills of rights and includes definition of rights and bills of rights. It also focuses on types of rights and role of nurse in relation to bills of right. It also explains patients' bills of rights in a tertiary health facility. The sixth unit covers code of ethics and includes definition of code and code of ethics. It also focuses on function and elements of ethical code, application of code of ethics in clinical settings, comparison of code of ethics between International council of nursing (ICN) and Pakistan nursing council (PNC). This unit ends on explanations of both ICN and PNC code of ethics. The seventh unit covers professional autonomy and ethics and includes definitions of profession and professional autonomy. It discusses the characteristics of professional nurse and also discusses professional autonomy and ethics. How to relate nursing ethics to standards of nursing practice is also covered. The eighth unit covers ethical dilemma in professional practice. It defines dilemma and professional obligation, how to identify common areas of negligence and nurses liability in these areas. Discussion of nurse's advocacy in various scenarios and clinical cases related to life support equipment, risk management and occupational hazards are included. It includes documentation of nursing care, employment issues and medical malpractice lawsuit.

The last ninth unit covers international health organizations and nursing organizations. It focuses on identification of nursing organizations all over the world, functions of international council of nursing and role of world health organization (WHO). It concludes on elaborating the functions of Pakistan nursing association, federation and council.

The results of this study show that undergraduate nursing students have good knowledge about nursing ethics. The questionnaire of this study comprises of 12 questions and Likert scale is used to calculate the responses of participants. In the response to first question about main ethical principles and theories 26 students (65%) were of the view that they have high knowledge about ethical theories and principle, 12 students (30%) said that they have very high knowledge and 2 students (5%) have moderate knowledge. The second question asked the students about key concepts of nursing ethics, in reply to this 25 students (62.5%) students said high and 11 students (27.5%) replied that they have very high knowledge of the key concepts of nursing ethics and 4 students

(10%) replied that they have moderate knowledge. In the third question students were asked that if they can identify ethical issues and relate it to nursing practice, 20 students (50%) replied with high and 14 students (35%) replied that they have very high knowledge and they can identify ethical issues and can relate those issues to their clinical nursing practice, 6 students (15%) were of the view that they have moderate knowledge. When asked about the conflict arising in nursing due to different value and culture systems, 21 students (52.5%) said high and 14 students (35%) said that they have very high knowledge and only 5 students (12.5%) replied that they have moderate knowledge.

The fifth question focuses on nursing ethics curriculum and its contents and 27 students (68%) replied with high and 10 students (25%) replied that they have very high knowledge of nursing ethics curriculum and contents of course, 3 students (7.5%) replied with moderate knowledge. In reply to sixth question about their application of case based reasoning in resolving ethical problems, 24 (60%) students replied with high and 12 students (30%) replied that they have very high knowledge and they can apply case based reasoning while resolving ethical problems, 4 students (10%) replied with moderate knowledge.

The seventh question was asked about the ethical issues arising due to organ donation and in reply to this 24 students (60%) have high knowledge and 9 students (22.5%) have very high knowledge and only 6 students (15%) said that they have moderate knowledge about ethical issues arising due to organ donation, 1 student (2.5%) replied that she has low knowledge about the issue.

The eighth question highlighted the most important issue and asked about informed consent and its meaning in health care and in reply to this 22 students (55%) replied with high and 17 students (43%) replied that they have very high knowledge about the concept of informed consent and its meaning in health care, while only 1 student (2.5%) replied with moderate knowledge option. The ninth question asked about the advance directives when the patients are terminally ill, 27 students (67.5%) replied with high and 5 students (12.5%) replied with very high knowledge, 4 students (4+4 (20%) each replied with moderate and low knowledge about the concept of advance directives in terminally ill patients. In reply to the tenth question regarding brain death diagnosis in the patients, 21 students (53%) replied with high knowledge and 9 students (23%) replied with very high knowledge, 7 students (18%) replied with moderate, 2 students (5%) with low and one student (2.5%) replied with very low knowledge.

In the 11th question it was asked if they understand the code of Pakistan nursing council, 21 students (52.5%) replied with high and 15 students (38%) replied that they have very high knowledge and they can understand code of Pakistan nursing council, 4 students (10%) replied with moderate knowledge. In the reply to the last question about the moral and ethical issues arising due to withholding and with

drawing life sustaining treatments, 21 students (53%) replied with high and 13 students (33%) replied that they have very high knowledge about the ethical issues arising from withholding and with drawing life sustaining treatments, while 2 students (5%) replied with low knowledge. The results of this article show the perception of undergraduate nursing students regarding nursing ethics at Nursing Institute LUMHS Jamshoro.

Conclusion

The students' evaluation of nursing ethics shows that the undergraduate nursing students do have sound knowledge about ethical issues in nursing field and they are able to identify and resolve those ethical issues and dilemmas. In addition to this it is shown that they also have good knowledge about modern medical/nursing care like organ donation issues, withholding and with drawing life support equipment, brain death and diagnosis issues, informed consent process and advance directives in terminally ill patients. They students were fully aware of their nursing ethics curriculum and course contents and they found their curriculum comprehensive. This study will further help to identify the gaps in knowledge of clinical care among nurses and also in further improvement of the nursing curriculum and undergraduate teaching.

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Prospects and Problems of Stem Cell Research in Bangladesh: Can Equity and Justice be Maintained in the Context of Public Health Demand?

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Abstract

Background: The aim of this paper is to justify whether and to what extent access to expensive, technically demanding stem cell research or therapy could be possible for the poor population in terms of equity and

social justice in Bangladesh. **Methods:** A total number of 51 articles were scrutinized based on specific themes, following searches in PubMed, Hinari, Web of science, Web of Knowledge and Google Scholar databases, between September 2011 and May 2012. Moreover, different guidelines were taken into consideration. **Results:** Stem cell research is in its primary experimentation level and the results are still to achieve. Religious barriers and moral judgments, economic constraint and social justice are key issues in stem cell research in Bangladesh. Bangladesh lacks minimal health care service, pure water supply and sanitation for its population with a struggling health budget and the agendum of stem cell research is absent there. Based on equity and justice, it is still questionable whether to go for stem cell research/therapy, where its impact in public health setting is very low let alone allocate public funding or even to allow private investment/collaborative research on stem cell. **Conclusion:** For a resource poor health care setting in Bangladesh, involvement of public funding in stem cell research should be made in research support when this research is only reasonably related to the promotion and protection of public health. Besides, a concrete guideline needs to be formulated to monitor and prevent commercialization and exploitation, addressing religious and cultural values.

Key words: Stem cell research, Stem cell therapy, Public health, Equity and justice in health care.

Introduction

Stem cells are primitive cells having the capacity to divide and give rise to more identical stem cells or to specialize and form specific cells of somatic tissues (Lo and Parham, 2009; Chapman, Frankel and Garfinkel, 1999). Two types of stem cell can be distinguished: embryonic stem cells which can only be derived from pre-implantation embryos and have a proven ability to form cells of all tissues of the adult organism (pluripotent), and adult somatic stem cells, which are found in a variety of tissues in the fetus and after birth and are, under normal conditions, more specialized (multipotent) with an important function in tissue replacement and repair (de Wert and Mummery, 2003; Keller and Snodgrass, 1999). These cells are unique cells that are undifferentiated and have the ability to self-replicate indefinitely (Holland, Lebacqz and Zoloth, 2001). They offer great promise for understanding basic mechanisms of human development and differentiation, as well as the hope for new treatments for diseases such as diabetes, spinal cord injury, stroke, Parkinson's disease, and myocardial infarction (Lo and Parham, 2009; Committee on the Biological and Biomedical Applications of Stem Cell Research, 2002). In spite of great advantages, stem cell therapy has potential complications and disadvantages that consist mainly of tumour formation, genetic abnormalities, infection, tissue rejection, immunological complications, failure rate and high cost (Larijani and Zahedi, 2008; Chapman, Frankel and Garfinkel, 1999).

Stem cell research has been accompanied with numerous ethical, economic, and organizational problems related to the issue of equity, social justice and policy making. As stem cell technology progresses to the clinical setting, health care systems, especially publicly funded health care systems concerned with access, fairness, and cost control, will probably be challenged to derive, expand, and distribute cells and tissues routinely and on a massive scale (Moazam, 2006; Kneopffler, 2004). One of the key ethical issues in the stem cell policy is proportionality. It needs to weigh up the potential therapeutic benefits of the procedure of stem cell research against its potential harms and disadvantages (Larijani and Zahedi, 2008). On account of the fact that stem cell research could be an unrivalled approach to save many lives, it is difficult to argue that research into human embryonic stem cell is disproportional. On the other hand, the obligation to pursue the best medical treatment is a prime duty; therefore, it is not professionally acceptable for physicians to let millions of people die or continue to suffer from chronic and life-threatening diseases. Beyond that, we need to weigh out the costs against the benefits. Despite their promise, stem cell based therapies are likely to remain, at least for many years, both expensive and technologically demanding (Corrigan et al., 2006). Distributive justice (to allocate justly the medical resources, costs and benefits, among the community) is, therefore, an important concern. Just distribution of potential benefits from stem cell research needs coherent well-structured planning. Equity, fairness and equality are the main factors in this issue. Justice, as the primary ethical consideration in health care resource allocation, should be considered at the national level (Mitton and Donaldson, 2004).

Bangladesh is a poor, developing country in South Asia (World Bank 2009). Poverty reduction, improvement of health, especially of the poor, and minimizing socioeconomic inequities have been the major focus of development strategies in the developing nations during recent years. Poverty and ill health are interrelated in a bi-directional way, meaning that poverty results in ill health and ill health leads to poverty (ICDDR,B, 2010). The health and poverty situation in Bangladesh is typical of the other poor nations. Nearly half of the Bangladesh population lives below the poverty line. The life expectancy at birth is around 60 years characterized by high infant and childhood mortality. The maternal mortality ratio is around 380 per 100,000 live births (BBS, 2009). Under-nutrition, malnutrition, diarrhoeal disease, endemic diseases like malaria, kala-azar, dengue, and high incidence of tuberculosis remain to be the major problems. Despite improvement in health outcomes in the recent past, socioeconomic, gender, and geographical differences in health and in utilization of health care services still persists implying that health of the disadvantaged segment of the population is yet worse than the better offs and this trend is likely to continue (ICDDR,B, 2010). Moreover, sanitation problems are acute in many communities, particularly in

urban slum areas (World Bank, 2009). Providing a basic health care facility for the people with equity and social justice is still a great problem in this country.

Bangladesh is still lagging behind in the field of human stem cell research in the region. Neighbouring countries like India and Pakistan have made much progress in stem cell research and tissue banking both in public and private sectors (Moazam, 2006). Even no national guideline has been set for 'stem cell research' yet in the country (BMRC, 2011) to pave the way for wide-ranging researches, where as the researchers have an obligation to observe some moral values. However, few researches are going on there through private sector sponsorship and in collaboration with foreign countries. 'Tissue Banking and Biomaterial Research Unit' of Bangladesh Atomic Energy Commission (BAEC) regularly providing radiation sterilized amnion membrane and bone allografts to different hospitals and clinics throughout the country. At present, 109 hospitals and clinics and more than 300 surgeons and physicians are involved with this unit through utilization of radiation sterilized tissue allografts (Zahid et al., 2010). Even some of the private tissue banks are working on commercial basis by exporting tissues abroad. Some organizational policies do not address commercialization, while others fail to consider confidentiality and quality of research (Zahid et al., 2010). However, even in those instances where one of the four factors is recognized by all policies (commercialization, confidentiality, informed consent, and quality of research); there is often a lack of uniformity in its meaning, scope, and ethical significance. Until uniform ethical guidelines regulating the storage, distribution, and use of human tissues for research are established, the international transfer of human tissues and multinational research involving industry will not only remain cumbersome, but, in many instances, ethically problematic (Zahid et al., 2010). Moreover, there is no preparation for the government to go for stem cell research or allocate public funding for this in annual health budget. Besides, government health departments i.e. Ministry of Health and Family Welfare of the People's Republic of Bangladesh or Bangladesh Medical Research Council, the highest ethical body of the country, are yet to implement a policy or guideline for stem cell research (BMRC, 2011). Several proposals have already been given to the authorized bodies to make a national guideline (Zahid et al., 2010).

While the national budget is still under pressure to provide primary health care delivery to the people and achieving the Millennium Development Goal (MDG) by 2015, an endeavour like stem cell research, which is very expensive and technically demanding matter, seems a day dream to the Government of Bangladesh. Health related research in developing countries is a necessity. Bangladesh needs to investigate, understand and develop effective preventive and curative approaches to diseases that are endemic to this region. But the benefits of such research must accrue to the communities used for research (Moazam,

2006). It is known to many that the '10/90 gap' described in the 2001–2002 Report of the Global Forum for Health Research (Global Forum for Health Research, 2002) is really critical. The report highlights the fact that of the 73 billion USD USA was investing annually in health research at the turn of the 21st century, less than 10% was being devoted to health problems that account for 90% of the global disease burden and those are related to problems of the developing countries. Hence, public funding or private investment on stem cell research and therapy in a resource poor country like Bangladesh is a matter of great debate, as we are still fighting public health problems with communicable diseases e.g. diarrhoea, malaria, kala-azar, TB, and non-communicable diseases e.g. diabetes, cancer etc. where enormous funding is needed for providing health care support, life saving drugs or vaccination and health research in those fields. The national annual budget is still facing crisis to meet the basic needs of people e.g. fooding, housing, pure water supply and sanitation, minimum health care support and treating and preventing endemic diseases.

As stem cell research and therapy is very expensive and highly technical in its application, accessibility to it is still questionable in context of public health need and public funding in a developing country like Bangladesh. There is much more to reveal the facts, consider the ethical suitability, and above all, formulate regulations maintaining the equity and justice in public health care for people. The aim of this paper is to analyze the research on stem cells in relation with the goals of public health in Bangladesh and find out the answer to the question as some parts of the population have no access now, or only to basic health needs, whether and to what extent to give them access to an innovative, expensive and highly technical stem cell therapy or is it really feasible to ensure the accessibility of its hopeful results for the population in general in terms of equity and social justice.

This work was aimed to evaluate the main aspects involved in the decision-making process regarding stem cell research in a developing country perspective e.g. in Bangladesh. Mainly two aspects will be analyzed here:

Firstly, it would be tried to determine if it is really justifiable for a poor, developing country like Bangladesh to go for an expensive, technically demanding stem cell research at this present economic condition, where providing a minimal health care facilities for the people is still a burden for the government or state, based on current public health problems, goals of public health and health budget allocation.

Secondly, different guidelines for stem cell research both in developed and developing countries will be taken into consideration, and analyses will be done to find out the common approaches and directives that could be useful for all stakeholders for their better understanding and decision making regarding prospects and problems of stem cell research, public health strategy, health research strategy, public funding

and privatization of the process. The ethical aspects implied in each of these sections will be analyzed.

The potential contribution expected from this work is a better understanding of the position of different stakeholders like physicians, researchers, patients, public and private health care institutions, religious leaders, government regulatory bodies concerning the prospects and problems of stem cell research in a developing country in relation to equity and justice in health care. This knowledge could be useful for dealing with the complexity of the situation, to improve communication among all these groups of persons, and to help all those concerned in the decision-making process.

Methods

An extensive literature review was done between September 2011 and May 2012 based on searching from the following databases: PubMed, Hinari, Web of science, Web of Knowledge and Google Scholar. The key words used for searching were 'stem cell', 'stem cell research', 'developing country', 'ethical issue', 'equity and justice in health care'. Latest articles (for example, published in last 10 years) were primarily searched. Moreover, the guidelines proposed by the European and North American Medical and Bioethical Associations, and National guidelines of different neighbouring countries like India and Pakistan, and other Muslim countries in the Middle-East, resource-poor, developing countries of Africa as well as institutional directives were collected.

A total number of 239 literatures were identified. Then the literatures were scrutinized based on their contents, and according to the some specific themes like '*prospects and problems of stem cell research*', '*stem cell retrieval*', '*ethical concerns relating to developing countries regarding stem cell research*', '*current crucial problems in health care system in Bangladesh*', '*question of distributive justice and equity in public health strategy regarding stem cell research and therapy*'. After these selection criteria only 51 literatures were identified those are relevant to my proposed work.

Results

Based on specific themes or selection criteria a total number of 51 articles were identified. My proposed work was based on these literatures. Among them I have categorized as *prospects and problems of stem cell research* (37), *stem cell retrieval* (21), *ethical concerns relating to developing countries on stem cell research* (15), *current crucial problems in health care system in developing countries focusing on Bangladesh* (9), *question of distributive justice and equity in public health strategy regarding stem cell research and therapy* (6).

Reviewing the articles related to prospects and problems of stem cell research, it was found that stem cell research or therapy is a promising innovation in medical science to provide better treatment and reduce the disease burden, especially if it is based on

embryonic stem cells. However, it is in its primary experimentation level and the results are still to achieve.

Stem cell retrieval is of a great ethical debate. Religious barriers and moral judgments have risen a lot of controversies, particularly dealing with embryonic stem cell and production of human embryos for that purpose. However, those gaps can be minimized through involvement of different stakeholders and create common approach.

It was evident in different articles that current public health concerns in Bangladesh are providing minimal health care service to people of all ages, providing pure water supply and sanitation, vaccination, and prevention and reduction of maternal and child mortality rate and achieve millennium development goals (MDG). The agenda of stem cell research/therapy was absent there.

Ethical concerns in stem cell research in a developing country like Bangladesh are many. Moral values, cultural differences, religious barriers and social taboos play important roles. Besides, public health problems addressed in local settings are different and far apart from modern stem cell research/therapy.

Based on equity and distributive justice, it is still questionable to go for stem cell research/therapy where its impact in public health setting is very low let alone allocate public funding or even to allow private investment/collaborative research on stem cell.

Discussion

It has been stated that human embryonic stem cells (ES cells) derived from early embryos and embryonic germ cells (EG cells) have particular promise for a wide range of therapeutic applications because they are capable of giving rise to virtually any cell type. Research on these primordial cells will also provide a unique opportunity to study human cell biology. Adult stem cells, obtained from mature tissue, differentiate into a narrower range of cell types. As a result, many cells of medical interest cannot currently be obtained from adult-derived stem cells. It is also less feasible to develop large-scale cultures from adult stem cells.

The ultimate step is likely to be taken towards the improvement of transplantation therapy and toward lengthening a person's life. I would like to postpone discussion of life-extension, noting here the relevance to transplantation medicine. Specifically, rejuvenation through transplantation of tissue grown in a laboratory from stem cells would be of enormous value for cardiomyocytes to renew heart muscle to prevent congestive heart failure; replacement of hematopoietic stem cells for producing healthy blood in bone marrow to resist infection by the human immunodeficiency virus and to treat AIDS and possibly sickle cell anaemia; cultivating endothelial cells to reline blood vessels as treatment for atherosclerosis, angina, and stroke due to arterial insufficiency; rejuvenating islet cells in the pancreas to produce natural insulin to fight diabetes; renewal of neurons in

the brain to treat Parkinson's disease and victims of stroke; fibroblast and keratinocyte cells to heal skin in the treatment of burns; and chondrocytes or cartilage cells to treat osteoarthritis or rheumatoid arthritis. Now, the trick will be to discover just what turns which genes on and off. Once scientists have learned how to trigger gene expression, they can apply it to pluripotent stem cells and direct the growth of selected bodily tissue. Particular organs could be grown in culture. Heart tissue or entire organs such as the pancreas or liver could be grown in the laboratory. These would be healthy rejuvenating organs ready for transplantation. It is expected to bring a revolution in the world of medicine and therapy, as public health really matters. However, the results are still to achieve. The scientists and pharmaceutical companies are very much enthusiastic about the prospects of stem cell in near future.

The risks of innovative stem cell-based interventions include "tumour formation, immunological reactions, unexpected behavior of the cells, and unknown long-term health effects" (Hyun et al., 2008). Even with these safeguards, however, because of the highly innovative nature of the intervention and limited experience in humans, unanticipated serious adverse events may occur. In older clinical trials of transplantation of fetal dopaminergic neurons into persons with Parkinson's disease, transplanted cells failed to improve clinical outcomes (Freed et al., 2001; Olanow et al., 2003).

It was also evident that about 15% of subjects receiving transplantation late developed disabling dyskinesias, with some needing ablative surgery to relieve these adverse events (Freed et al., 2001; Olanow et al., 2003).

Problems with informed consent are well documented in phase I clinical trials. Similarly, Participants in phase I stem cell-based clinical trials might overestimate their benefits and underestimate the risks. The scientific rationale for human stem cell transplantation and preclinical results may seem compelling. In addition, highly optimistic press coverage might reinforce unrealistic hopes (Lo and Parham, 2009).

As stem cell technology progresses to the clinical setting, health care systems, especially publicly funded health care systems concerned with access, fairness, and cost control, will be challenged to derive, expand, and distribute cells and tissues routinely and on a massive scale (Giacomini, Baylis and Robert, 2007).

Nevertheless, because the study of human stem cells is at an early stage of development, it is difficult to predict outcomes and findings at this point in time. As more research takes place, the full developmental potential of different kinds of stem cells will become better understood. And to realize the potential health benefits of stem cell technology will require a large and sustained investment in research. The government is the only realistic source for such an infusion of funds. For those who are challenged daily by serious diseases that could in the future be relieved by therapies gained

through stem cell research, public funding holds the greatest promise for sooner rather than later research results that can be transferred from the bench to the bedside. Without the stimulus of public funding, new treatments could be substantially delayed and more costly.

Besides, the commitment of government funds also offers a basis for public review, approval, and monitoring through well established over-sight mechanisms that will promote the public's interest in ensuring that stem cell research is conducted in a way that is both scientifically rigorous and ethically proper. Additionally, public funding can contribute to sound social policy by increasing the probability that the results of stem cell research will reflect broad social priorities that are unlikely to inform research in the private sector.

Of course, there are some other favouring points for encouraging stem cell research in context of public health benefit and economy. According to Caufield (2010), also described earlier, "...policy arguments in support of stem cell research often use economic benefit as a key rationale for permissive policies and increased government funding. Economic growth, job creation, improved productivity, and a reduction in the burden of disease are all worthy goals and, as such, can be used as powerful rhetorical tools in efforts to sway voters, politicians, and funding agencies.

However, declarations of economic and commercial benefits can be found in policy reports, the scientific literature, public funding policies, and the popular press and tend to have created a great deal of expectation. Can stem cell research really deliver on the economic promise? And what are the implications of this economic ethos for the researchers who must work under its shadow?" The debates of funding and expected outcome and ethical issues are increasing day by day (Kirk, 2000). Moreover, in developed countries like USA and UK, commercial enterprises that are beginning to present research that is still in its preliminary stages as proven therapy or treatment for various diseases (Biotechnology and Biosciences Research Council, 2002). Desperate patients and misinformed or unscrupulous physicians are being approached directly by such for profit business enterprises (Caufield, 2010), although the expected results are still to achieve. And for a resource-poor country like Bangladesh, it is still a matter of great debate. The issue of neglected diseases research is obviously of central importance to people living in developing countries (Médecins Sans Frontières 2001).

The concept of globalization is embedded in the speedy development of technologies that have enhanced communication and interconnectedness, and have led to the rise of claims that the world has become a global village. Though it is often said to bring new opportunities for sharing ideas and technologies, it is uncertain how far this has been realized in terms of global health. What is presently apparent is that even though these technologies have been around for decades, their potential to transform the health of the

global community has not been harnessed. The resource constraints in developing countries do not promote the development or acquisition of these technologies.

Moreover, the viability of national regulatory systems is continually being confronted by a global market for health care that is driven by the forces of innovation and healthcare consumerism. The emergence of a global bio-economy has created the need for transnational regulation of biotechnology and medical products. While generating consensus in health care policy formulation has always been a challenge, it is particularly so against the backdrop of globalization where consensus needs to be located at both national and international levels.

Just distribution of potential benefits from stem cell research needs coherent well-structured planning equity, fairness and equality are the main factors in this issue. Justice, as the primary ethical consideration in health care resource allocation, would be considered at the national, provincial and municipal level (macroallocation), at the level of institutions (mesoallocation), or at the level of the individual patient (microallocation). At the level of meso- and microallocation, clinicians often find themselves in the role of manager, being required to set priorities, or affected by the decisions of others about priorities (Singer, 2000).

There will inevitably be opportunity costs for cash-limited healthcare systems considering making such treatments available. If healthcare services decide not to fund stem cell therapies, these therapies would be available only to individuals wealthy enough to pay for their own treatment. The issues of social justice and equity arise if the opportunity to live longer is available only to those who can afford access to an expensive treatment. It is suggested that a more rational approach would be to ensure 'commensurate work in ethics and social policy' to devise ways of coping with new challenges (Corrigan et al., 2006).

Undoubtedly, rising public and professional expectations, an expanding pool of treatable patients and costly new technology must be balanced against tightly monitored health care budgets, competing government priorities in public health issue (McKneally et al., 1997). What is required, and indeed what decision makers seem to be asked for, is a systematic, explicit approach to priority setting which is fair and, where possible, evidence based in current situation (Mitton and Donaldson, 2004).

Bangladesh is a country of about 140 million population with more than three-fourths majority of Muslims. Stem cell research is a sensitive issue here in its religious background (BBS 2009). Some Islamic scholars hold favourable views toward embryonic stem-cell research from the perspective of Sharia (Islamic law) (Dabu, 2005). In Islam the embryo, even in the first day of its existence, has the right of life and we have any right to kill it. However there is a distinction between different stages of human development in uterus (Larijani and Zahedi, 2007). Most of these

scholars believe that ensoulment of the embryo occurs on the 120th day of the pregnancy, and that is the point when it gains its moral status or rights as a legal person. Some Islamic scholars, however, say ensoulment occurs on the 40th day (Dabu 2005). It is worth noticing that notwithstanding the acceptability of human embryonic stem cell research, the industrial creation of human embryos and their destruction in great numbers would be morally challenging in many jurisdictions (deWert and Mummery; 2003), especially for Bangladesh for existing majority Muslim population. Even they are ready to ban embryonic stem cell research or therapy in any way.

The therapeutic potential of stem cells for treating and possibly curing many serious diseases constitutes a major rationale for large-scale investments of public and private resources in human stem cell research. To justify doing so, however, requires some assurance that people in need will have access to the therapies as they become available. Principles of justice are based on treating persons with fairness and equity and distributing the benefits and burdens of health care as fairly as possible in society. This would require equitable access to the benefits of stem cell research, without regard to the ability to pay.

Several factors make it unlikely, however, that there will be equitable access to the benefits of this research in this country. Even in the United States, 44.3 million people (16.3% of the United States population) lack health insurance and therefore do not have reliable access even to basic health care. Others are under-insured. Moreover, if stem cell research results in highly technological and expensive therapies, health insurers may be reluctant to fund such treatments. And in developing countries like Bangladesh, generally groups of people suffer lacking good treatment, free supply of drug and hospital care, even in low-cost government facilities. They cannot think of minimum costs for regular health check-up and treatment in need let alone stem cell therapy.

Another factor complicating the commitment to just access is the central role of the private sector in stem cell development. The private sector makes determinations about investments on the basis of potential profitability. This has several implications. The private sector will not invest resources in potential applications that they consider lacking in commercial value, but that may have considerable therapeutic promise. Commercial considerations will also affect the pricing of stem cell products. Here again, market concerns could raise prices, making stem cell therapies more expensive. Unless the federal government assumes a central role in setting priorities and investing in stem cell research, some of the most needed therapies may not be developed. These justice considerations are a further reason for encouraging federal support for stem cell research.

Problems of access and equity are even greater on a global level. Vastly unequal resources, differential standards of public health, and uneven opportunities for health care within and between countries comprise

barriers to achieving even a semblance of distributive justice. The World Health Organization has reminded member states that “justice demands equitable access to genetic services.” WHO has also stated that “Genetic services for the prevention, diagnosis and treatment of disease should be available to all, without regard to ability to pay, and should be provided first to those whose needs are greatest.” <http://www.counterbalance.org/stemcell/justice030.html> It will be difficult to achieve these norms in a global economy in which transnational corporations play a dominant role and disparities of all types are ever growing greater.

Conclusion

In the context of stem cell research, the understanding of the limits of public health situation, health research strategy and existing policy of Bangladesh appear to lead to three practical conclusions. One is the commitment to involvement of public funding should be made in research support when this research is only reasonably related to the promotion and protection of public health. The second is respect for opposing views should be maintained, especially those based on deeply held Islamic religious grounds especially concerning use of embryonic stem cells, to the extent that this is consistent with public health need and safety. And the third is to make support available to private investment or collaborative research into alternative sources and/or methods for the derivation of stem cells and into further initiatives on adult stem cells by adopting a concrete guideline addressing the equity and justice for all and prevention of commercialization and exploitation.

However, the accessibility to stem cell research is still questionable in a developing country like Bangladesh in context of need-based approach in public health. Overcoming these hurdles and assuring equitable access to the benefits of stem cell research in this country will be a politically and financially challenging task. It is, therefore, appropriate to begin considering how to do so now in advance of the development of applications. There is much more to reveal the facts, consider the ethical suitability, and above all, formulate a guideline maintaining the equity and justice in public health care for people. Therefore, the policy making part of the government e.g. Ministry of Health and Social Welfare, National Ethics Committee of Bangladesh Medical Research Council (BMRC) and local scientists as well as think tanks should consider ways to achieve equitable access to the benefits derived from stem cell research in a modern era.

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Medical Experimentation, Ethics and Regulation: Some Strands of Enquiry

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Abstract

Ethical concerns surrounding medical research in resource-poor settings, including the 'pharming' out or outsourcing or 'offshoring' of clinical trials, and how these relate to the economic, historical and political dimensions of the global scientific field, are a recurrent theme across the different social science disciplines.

Ethical Questions and Unethical Cases

With regard to questions on clinical trials taking place outside the US, the existing literature documents engaging ethical questions and debates over standards as well as divergent views articulated in course of such ethical debates. Adopting a political economy approach, Petryna (2007) and Fisher (2009) among others clearly interrogate the global and local dynamics of industry-led pharmaceutical trials, both in the US and 'off-shore' clinical sites. They focus on the commercialized clinical trials and the concept of experimentality to engage in a critique of neo-liberalism and the concept of using vulnerable populations in potentially exploitative commercial clinical experimentation.

Typically sociological and anthropological research on clinical trials has been extremely negatively oriented towards the pharmaceutical industry and the sponsors of clinical trials. However, in an interesting departure, Montgomery (2010) points out that this approach is heavily focused on the testimonies of victims versus exploiters and consequently, the process of the constitution of the participant as subject via the research process is obscured in the righteous critique of transnational global forces. She notes that writing about the trials as the process "*through which medically drugged bodies emerge*" eventually conjures an "*image of torpid zombies, devoid of agency and lacking mental faculties.*" So she cautions that in attending to the macro-level processes of clinical trials in which 'the West' is engaging in a one-sided exploitation of the marginalized 'Other' what is obscured is the micro-level strategies and tactics of power that all actors utilize in interaction with each other and the context.

A landmark case in the issue of ethics in human medical research in global settings leads us to the placebo controversy. Questions were raised over placebo use in the trial of short course AZT treatment to halt perinatal transmission of HIV in Africa (Angell, 1997; Lurie & Wolfe, 1997; Petryna, 2005 & 2007). Farrell draws attention to the fact that it is not just private pharmaceutical companies who have been

conducting trials on the populations of the developing countries; rather the US government through its organizations, the Centers for Disease Control (CDC) and the National Institutes of Health (NIH) had also been actively sponsoring and conducting such trials. These trials included some carried out on pregnant women who were HIV positive in certain African nations, the Dominican Republic as well as Thailand, between 1994 and 1997 (Farrell, 2006). The major controversy was whether the use of placebo was justified although there were other allegations of unethical conduct including lack of informed consent procedures and also use of coercion. Not all the subjects completely understood what the trial entailed, the risks they would incur and what might be the implications of receiving placebo. Consequently, although an accepted standard of care existed, a large number of cases with mother to child transmission of HIV/AIDS were reported. The debate that emerged on the placebo question related to whether it was ethically valid to give less than the best known standard of care to the subject participants in the placebo control group. The supporters of the trial asserted that since the women would in general be unlikely to receive any treatment at all, the placebo was seen as conforming to the best 'local' standard of care. Petryna (2007) has emphasized that in effect they pointed to the specificities of the local cultural variables and underdeveloped health infrastructures to argue that the best standard of care, was impractical. Hence, ethical variability, by which different contexts would determine the different ethical standards to be observed, was justified.

The notion of cultural relativism was also invoked by the supporters of the trial who argued that the concept of right to informed consent was a Western construct which could not be applied to Africa due to its unique communitarian social system. (Mason Meier, 2003) Pointing out that vaccine testing is related to the politics and economics of the drug market which has no relevance to African culture, Mason Meier has argued that the notion of cultural relativism was being used as a façade for what he has termed 'cultural rationalization', wherein the concept of cultural relativism has been invoked inappropriately by westerners to justify and validate their own economic and political ends. He also argues that there is no credibility in the assertion that most African social norms are communitarian to the extent that individuals would forsake their right to informed consent. Further arguing for the irrelevance of cultural questions in this situation, he notes that the trial designs were constructed in western settings by western researchers who had not even consulted African physicians.

Angell has also raised concerns about the ethical standards being observed with respect to clinical trials on vulnerable populations as well as the population in the third world. Drawing on the watershed case of medical ethics in human experimentation, she compares the Tuskegee study with the placebo arm of the short course AZT trial. The Tuskegee study of

untreated syphilis is one of the most publicized cases of unethical research where a group of poor African American men with syphilis were deliberately deceived and not provided with treatment in order to chart the natural progression of the disease (Angell, 1997). No informed consent was obtained and a number of the subject participants were misled to believe that they were receiving treatment. The argument advanced in support of the trial was that these poor men would probably not receive treatment and hence, it did not amount to unethical conduct. It is not too much of a stretch to say that the Tuskegee trial in fact provided the basis for the later justification of placebo use in poor participants from the developing countries.

Continuing with the problematic ethical practices followed in clinical trials on vulnerable populations especially in the developing world, the case of Pfizer's Trovan trials in Kano, Nigeria has been highlighted by Farrell (2006). In 1996, the company was developing Trovan (compound: Trovafloxacin), a potentially blockbuster antibiotic drug which would provide profits of \$1 billion per year. In the same year, Kano- a city in Nigeria had large-scale outbreaks of measles, cholera and bacterial meningitis. On being informed of the outbreak, the Pfizer medical team set up a temporary treatment centre at the Infectious Diseases Hospital. Two weeks after conducting the trials on the children, the Pfizer medical team left and did not do for any post-trial follow-ups. Legal cases were registered against Pfizer by Nigerian minors and their parents as they alleged that 11 children had died and a number of children had become paralysed, blind or deaf due to the drug. They also alleged that individual informed consent had not been taken and that the Pfizer authorities had not explained that the treatment being provided was experimental in nature and that participants could in fact refuse to participate. Further, Doctors without Borders (MSF), an international charitable organization was offering the standardized treatment adjacent to the Pfizer facility. Farrell has argued that as part of the informed consent process, the Pfizer team should have informed the participants that they could avail treatment at the charity (Farrell, 2006). Not informing them of the alternative treatment available may have left the participants mistakenly believing that the trial drug in fact, constituted treatment. The fact that it was an epidemic situation or a crisis may have also blunted their understanding of the risks involved and thereby compromised their rational decision-making.

Farrell notes that David Carr has argued that the Helsinki guidelines offer a scope for obtaining community consent in lieu of individual consent. This leave room for the researchers to argue that Pfizer had taken consent from the Nigerian government and the Hospital's ethics committee; hence, they had actually upheld the informed consent requirement. However, Farrell argues that this line of reasoning is problematic. While the international ethical guidelines should be sufficiently flexible to recognize cultural differences wherein community leaders may be allowed to consent on behalf of the population, it does not mean that

individual consent should be forsaken. Rather, individuals should also be asked for individual consent along with the community's consent.

This seems to recall Meier's concept of cultural rationalization - when such reasoning is being used to protect the position of the company and its researchers, it needs to be asserted that the point of such informed consent procedures for clinical trials is not just as a mere formality. It exists to ensure that the trial is being conducted ethically *in spirit*, and not just as a matter of course.

Pharmaceutical Industry and Regulatory Oversight

By highlighting the increasingly globalized operation of the clinical trial process, Petryna (2007) has sought to show that trials are being outsourced to the Contract Research organizations (CROs) which are private sector services based companies specializing in the conduct of clinical trials and drug development. She also points out that as trials are being shifted to low and middle income countries, the public health care system and quality of care available in these countries become significantly contingent on them. Specifically focusing on Eastern European (mainly Poland) and Latin American (mainly Brazil) countries, she locates the uncertainties of the clinical trial process with what she refers to as 'the paradigm of expected failure'- essentially, the failure to anticipate and thereby change the potentially unsafe outcomes that may result. It implies that the risks emerge after the drug has already passed through the clinical trials, and as a result is a source of potential risk for the consumers or patients. She also points to the context specific strategies of evidence-making like engineering subject participant choice so that results can be planned to a certain extent which helps to increase the potential for success of the drug's trial.

The question of lack of human protection in the realm of drugs necessitates enquiry into the organizations responsible for regulation. Much of the literature relates to the US FDA (Food and Drugs Organization) which is responsible for drug regulation and supervision in the US. Widely acknowledged as the most powerful drug regulatory authority in the world- mainly due to the status of the US as the world's largest pharmaceutical market, the FDA has had to face allegations of inappropriate behaviour since at least the 1970s. Abraham (2002) has analysed the potentiality of regulatory capture by showing that there has been an undue influence of the pharmaceutical industry on the functioning of the three major regulatory agencies in the world. The FDA, the British Medicines Control Agency (MCA) and the European Union's European Medicines Evaluation Agency (EMA) are taken up to highlight that the many policies which are adopted due to heavy industry lobbying, may be inimical to public interest. He also addresses that conflicts of interest may arise when regulatory bodies seek expert reviews, some of who may have funding or other relations with pharmaceutical companies (Abraham, 2002). He also sheds light on the politics of the 'revolving door' which

has also been addressed by Braithwaite (Braithwaite, 1986). Essentially, the revolving door phenomena refers to the fact that individuals may begin their career in the industry, then work as regulatory officials for some years before re-joining the industry at a higher level. Regulators are also frequently employed by pharmaceutical companies after their regulatory careers are over. Therefore, the possibility for regulators to have a sympathetic leaning or more crucially, even conflict of interest is not very remote. For instance, regulators with a background in industry may be motivated towards a pro-industry outlook keeping in mind that their future prospects are dependent on being perceived as industry friendly.

Marcia Angell (the erstwhile editor of *The New England Journal of Medicine*) and Richard Horton (the editor of *Lancet*) have also pointed to the suspicious nature of functioning of the FDA and the extensive influence of the pharmaceutical industry on the regulator's regulations and their decisions (Angell, 1997 and Horton, 2001). Carpenter (2013) has however argued that the problem of regulatory capture in the sense of a strong tendency of the regulators to act in the interests of the industry cannot be confirmed on the basis of historical evidence of legislation. Rather, he makes a case that over the last few years, the pharmaceutical sector has been characterized by the weak or diluted application of laws, almost amount to no regulation. This is what he refers to as *corrosive capture*, wherein the independence of the drug regulatory bodies has been compromised.

In a more recent account, the British physician Goldacre (2012) has also highlighted the problem of regulatory capture - firstly, due to the revolving door of employees between the industry and the regulator; secondly, as a result of the fact that the regulatory officials and the company employees have common interests and knowledge, friendships might develop between them. Goldacre is one of a number of doctors who have alleged that pharmaceutical fraud is an on-going problem, not one which has been dealt with. He has also pointed to the problematic nature of clinical trials where he alleges that there is reporting and publication bias in data. This is leading to a partial representation of the actual evidences, what he refers to as a 'slow and unnecessary pollution of almost the entire evidence base in medicine'. Like Petryna, he also raises questions on the functioning of the CROs and the treatment of subject participants. Finally, he has also pointed out that since doctors are also being misled by the claims of the pharmaceutical companies, the whole body of patients suffer through questionable drug administration (Goldacre, 2012).

The Indian Experience

Srinivasan has also written extensively on the clinical trials sector in India. She has compiled a list of some of the different unethical trials in India which have been documented in public record (Srinivasan, 2005). On the subject of the Indian government promoting itself as a global gateway to clinical research, she

raises questions on the vulnerable nature of the subject participants of such trials. She has raised questions regarding the regulatory mechanism in place and argued that there is a need to establish accountability in clinical trials. She also quotes a survey (McDonald, 2008) to show that a large number of the subject participants actually participated in trials on the advice of their family doctors who also happened to be the trial investigators. Further, a significant portion of the participants were also participating because they were looking for free and better health care. Public hospitals in India provide free or reduced cost treatment and poor people frequently seek treatment there. However, due to the limited number of beds in most such hospitals as well as the high burden of patients, there are serious difficulties in getting access to treatment. However, participating in trials gets the patients access to the treatment (Srinivasan, 2009).

Among others writing on clinical trials in India, Nayak has taken up the problem of objectification of the human body in clinical trials and by extension, in the medical scientific paradigm itself. She puts forward that doctors tend to look on the human body of the patient or the subject participant as an object and for pragmatic purposes, sites through which scientific knowledge can be gained. She has also highlighted the inherently hierarchical nature of the relationship between the doctor and the patient (Nayak, 2011). Ignoring the issue of the rights of the patient, doctors are seen to have an upper hand in all dealings with the patient and the interaction is largely a one-way traffic.

Kaushik Sunder Rajan has offered a nuanced understanding of the role of the larger Indian state (Rajan, 2006). In his comprehensive work *Biocapital*, he has shed light on the links between contemporary biotechnical advances and the social-political contexts and economic markets within which they emerge. Drawing on his ethnographic study of a private hospital in Mumbai which conducts a number of clinical trials, he displays how the very geographical location of the hospital may ease access to a large group of unemployed workers who provide a ready pool of participants. The hospital houses a biotechnology company which was seeded by a public sector organization in partnership with a private pharmaceutical company. While the state is frequently regarded as the protector of its citizens, Rajan has argued that paradoxically the state itself acts as a market agent because it makes these participants available to pharmaceutical corporate interests, which are frequently of western origins. Although allegations of a 'new colonialism' have been levelled at the way that unethical clinical trials have been organized in India mainly by western pharmaceutical interests (Nundy & Gulati, 2005), Rajan has looked at outsourcing in terms of both the expropriation of the subject participants in the developing world and the exploitation of the patients who are on medication in the first world. Looking at the larger phenomena of clinical trials and drug development, Rajan has shed light on the complex ways in which biomedical research &

financing, marketing practices and the regulatory mechanism are shaped by the global economic influences. Hence, there is a huge amount of buzz in different public and private sectors not just in building clinical research infrastructure in India but also in promoting India as a favourable clinical trial destination. The potential of Indian populations as trial subjects offers one of many advantages which significantly upgrade the market potential from increasing clinical trials into India. What Sunder Rajan also clearly points out is that this is happening at the precipice of a significant historical time where the Indian state is actively engaging in branding and marketing itself globally. Hence, the role of the neoliberal state in contributing to the growth story of the Indian identity finds expression in investments in infrastructure as well as resource building for clinical trials.

Significantly it will be interesting to see what are the changes which are being brought about by the new political regime which has come to power in India and what are the implications going to be? Since this is a period of flux in the official approach, it is fair to say that very many changes are anticipated on the basis of the ideology and philosophy the new government espouses.

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