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## **Editorial: ABC Returns to Korea**

We are honored that the Asian Bioethics Association (ABA) celebrates the Eighteenth Asian Bioethics Conference (ABC18) in Korea. ABC4 was held in Korea in 2003, and the proceedings were published as Song Sang-yong, Koo Young-Mo, and Macer, Darryl R.J., eds., *Bioethics in Asia in the 21st Century* (Christchurch: Eubios Ethics Institute, 2003). Looking through the papers from 2003, with the pleasant knowledge that the three editors of the 2003 conference are all present 14 years later in 2017, we can see that there has been progress in research development since the foundation of the ABA in 1997 in Kobe, Japan, out of the East Asian Association of Bioethics launched in Beijing in 1995.

*EJAIB* is pleased to publish the available abstracts of those who can attend ABC18. Authors are welcome to submit their full papers to *EJAIB* for publication. We express our regrets that at the beginning of the year we lost two long serving former ABA officers, Jayapaul Azariah from India and Umar Jenie from Indonesia.

ABA wishes to thank all those involved in the holding of ABC18, and all those who made their efforts to join us. Bioethics is just as relevant today as it was thirty years ago as some of us got together to develop the culture of bioethics, with many joining us along the way. We celebrate young scholars in the ABA tradition that all sessions are held in plenary, and all voices are welcome. This year has seen the 50<sup>th</sup> Masters in Bioethics and Global Public Health graduate of American University of Sovereign Nations (AUSN), a decolonized global bioethics degree program built on the work developed in Asia through numerous roundtables in Tsukuba, Kumamoto, and the ABCs, to educate professionals. We applaud the development of national bioethics associations for open and free discussion of bioethics, and it is 20 years since I organised the global forum of national bioethics committees in Tokyo in 1998.

For the past three years the attendance of ABC are available as postgraduate credit towards Masters and PhD degrees of AUSN, and many colleagues active in ABA serve as AUSN Visiting Professors. It is the stated goal of AUSN to materialize the dream of having a dedicated postgraduate bioethics degree program in every country in the world, and we must not give up in that necessary ambition and target. Let us celebrate bioethics together.

- Darryl Macer, Secretary, ABA

### **Overview of southern cooperation from Kaohsiung Municipal Kai-Syuan Psychiatric Hospital**

- Yu Shi Lu, Kaohsiung Municipal Kai-Syuan Psychiatric Hospital, Kaohsiung, Taiwan  
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Kaohsiung Municipal Kai-Syuan Psychiatric Hospital (KSPH) is one of the teaching hospitals in southern Taiwan and plays a dominant role in the regional psychiatric network. Four years ago, KSPH started southern Asia project along with Taipei Medical University and formed a professional team to attend some international meetings as well as visiting different countries annually. KSPH also exchanged staff training annually from Vietnam and Indonesia. The last is Thailand we visited on 2016 and made a deal to sign memorandum of understanding later.

Afterwards, the Taiwan government began to realize the importance of mental health issues, recognizing the need for kind foreign assistance and to take aggressive actions in searching for international collaboration opportunities. 2017 is a very crucial year for us; we are able to earn support from the New Southbound Policy of Taiwan Government as well as from experienced international institutes, such as Social Empowerment Alliance, Bjorgaas Social Welfare Foundation and Pingtung Christian Hospital (Taiwan).

True to our vision of improving the mental health of citizens, our most important mission is to promote the Kai-Syuan service models with southern partners and create the global engagement of Taiwan with supports from Southeast countries. This area is for mutual exchanges as well as learning excellence. In conclusion, we would like to use the collaboration as a platform creating the global engagement of Taiwan with supports from Southeast countries, to build a holistic, 360-degree framework for how we combine our expertise to improve mental health of human beings.

**Ethics and politics of mental health:** As the pioneer to establish Mental Health Act among East Asia, we discussed with staff members of psychiatric service about the progress, sameness and differences of policies on mental health between countries. We presented the intervention of involuntary community therapy and involuntary admission in our Mental Health Acts. We shared the advantages and difficulties during clinical practice under the current policies.

**Community psychiatry and Kai-Syuan model:** We had worked hard to strengthen our psychiatric service into the communities. The Kai-Syuan model of community therapy includes preparation before discharged from acute or chronic ward, day-care wards, halfway house and community rehabilitation center. The Qualified Community Service Program was built on 2016 to serve patient missing the follow up after discharged from our hospital. We aimed to help psychiatric patients go back to society gradually with basically social-economical functions

To sum up, we hope to extend and deepen the collaboration with other psychiatric service/hospital at Southeast Asia. The current project could also promote cultural and religious communication between countries.

### **The global experience of Kaohsiung Municipal Kai-Syuan Psychiatric Hospital: Asian culture ethic of Indonesian experience**

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The Kaisyuan psychiatric hospital integrated the resources and strengths of the public and private sectors to forge a new

mutually beneficial model of cooperation and a sense of mental health community with Indonesia since 2014, which is two years earlier than the New Southbound Policy by President Tsai Ing-Wen of Taiwan.

We've signed a memorandum of cooperation with Rumah Sakit Khusus Daerah Provinsi Maluku (RSKD), arranged staff training, onsite visits and communicated social and culture issues. There are culture-bound issues in Indonesia such as human right problem, which is just like Taiwan 20 years ago. The Taiwan mental health act law is established in 1997, which is specifically formulated to protect the right of psychiatric patients. However, there are always debates about the patient's right and harm. Taiwan is the first country in Asia with legitimate mandatory hospitalization and community treatment due to mental illness, which shall be reviewed by the Mental Illness Mandatory Assessment, and Community Treatment Review Committee for objections about the right of patients.

We are now cooperating with the Indonesian government for workshop and society rehabilitation center program, which helps the patients to take treatments without limitation of freedom. Taiwan and Indonesia government will go hands in hands to beat psychiatric diseases and promote the mental health of the population, prevent and treat mental illnesses, protect patients' rights and interests, support and assist patients living in community.

### **The Prevalence and Risk Factors of Psychiatric Disorders and Quality of Life among Kaohsiung Gas Explosion Survivors 12 Months**

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**Objective:** To investigate the prevalence and related risk factors of probable disaster-related psychiatric disorders, such as major depressive episodes (MDE) and post-traumatic stress disorder (PTSD), and quality of life in survivors of a fossil gas explosion in Taiwan twelve months after the event.

**Methods:** A community-based screening survey with cross-sectional assessments was conducted. Victims of a petrochemical gas explosion were surveyed six months after the event. We used two screening tools, including the Disaster-Related Psychological Screening Test (DRPST) and Short Form 12 (SF-12), to survey a representative sample of 486 participants (average age: 42.89 ± 16.05 years; M: 255, average age: 40.68 ± 15.92 years; F: 231; average age: 45.32 ± 16.20 years). The Chinese version of SPSS 17.0 software was used to obtain statistics and perform data analysis.

**Results:** Probable PTSD, probable MDE, probable PTSD & MDE, and non-PTSD or non-MDE (non-P or M) were present in 50 (10.3%), 14 (2.9%), 34 (7.0%), and 388 (79.8%) participants, respectively. There was a slight but insignificant negative trend in quality of life in terms of the physical and mental aspects of the SF-12 among survivors in the following groups: probable PTSD combined with MDE, probable PTSD or MDE alone, and non-P or M. The significant risk factors of probable PTSD or MDE in survivors were female gender, severe physical injury and financial loss. The risk factors of different quality of life subscales were older age, physical injury, occupation, educational level, financial problems, probable PTSD and probable MDE.

**Conclusion:** One year after the gas explosion, survivors still had a high prevalence of psychiatric impairment, and their quality of life was affected, especially those with probable PTSD combined with MDE. Mental rehabilitation requires not only short-term intervention but also long-term follow-up and regular psychiatric management.

**The global experience of Kaohsiung Municipal Kai-Syuan Psychiatric Hospital: The gradual regional collaboration with Southeast Asia** - Cheng-Chung Chen, Kai-Syuan Psychiatric Hospital, Kaohsiung, Taiwan, and Shu-Hui Wang, Ming-Chou Li, and Su-Ting Hsu, Kaohsiung Municipal Kai-Syuan Psychiatric Hospital  
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The Taiwan President Tsai Ing-wen announced that Taiwan will cooperate with Southern Asian countries as one of the new policies for future international strategies. Kaohsiung Municipal Kai-Syuan Psychiatric Hospital have extended the whole psychiatric treatment programs to Vietnam, Indonesia, and Thailand in the past 4 years included signed the MOU, staff training, on site visits, and learned social & culture from each others. Also these programs can offer new ideas or methods learning from each other's. During these few years we all learned a lot from new and creative methods that using in improving quality of care. We will present these four different Asian countries respectively and a perspective ideas & programs. Vietnam, Indonesia, Thailand and Taiwan are very different in backgrounds in religious, societies, ethnics, politics, and regulations. From the economic views they seem to quite the same in new developing countries except for Taiwan.

Vietnam formed their mental hospital in every province as their final goal. Now still developing and progressing. They also lack of occupational therapists & psychologists. Our interchanges include staff training for 27 persons in two hospitals & also onsite visiting for discussion & renewing for four times. The most progressing facts shows that rehabilitation programs can come truth in both our sister hospitals. One of the psychiatric hospitals also start to set up psychiatric social worker as well as hospital management. They also cooperate with local university.

Thailand & our hospital are still on learning from each other & at the initial stage that we visit each other for 3 times. Future plan include to sign MOU & more exchange programs. Also we should learn from Thailand in the fields of mental health promotions.

Indonesia had one sister hospital & being onsite visit once. Indonesia occupational therapy in psychiatric hospital presented in quite well. Also cooperation's medical school had started and we together started a new community rehabilitation center were ongoing. Also Indonesia government is looking formed to cooperate with social welfare to do more for psychiatric patients. We also try to set up a training center cooperating with medical school for setting their style & fit their culture. In conclusion Kaohsiung Kai-Syuan psychiatric model can extent some to apply locally with modification under these different backgrounds treating minorities are the same ethic in these. Detailed sameness & differences among us will present and discuss in this presentation. We also will share no health without mental health for all.

### **12 Years' Experience of National Bioethics Committee in Korea**

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Among the KNBC activities, I would like to introduce how the KNBC acted on major bioethics events. In the early days of the committee, the KNBC, in relation to Dr. Hwang Woo-suk's research, investigated bioethical issues and published the report as follow-up. Since then, the KNBC has been playing a role of improving specific bioethics issues and suggesting specific directions. When there was a need to discuss about Life-sustaining Treatment Decision process, the KNBC organized a specialized committee and suggested the enactment. Currently, the law is enacted and related policies such as designation of the responsible organization are being implemented. Last year, in order to create a social atmosphere

for the culture of respecting bioethics, the KNBC announced the declaration on respect for life and has been promoting it at home and abroad.

The National Bioethics Committee of Republic of Korea (KNBC) under the direct jurisdiction of the Presidential commission established in 2005 according to 「BIOETHICS AND SAFETY ACT」. The KNBC deliberates on the following matters according to Act and mainly discusses or reviews of basic national policies on bioethics and biosafety and social issues and agenda related to bioethics. The KNBC shall be comprised of at least 16 and not more than 20 members including one chairperson and one vice chairperson. The 4th committee is run now. The 4th members are composed 6 Ministers, 7 persons from among persons who have abundant expertise and experience in research on bioscience, biomedical science, or social science and 7 persons from among representatives of religions, ethics circles, judicial circles, non-governmental organizations or women.

Also the KNBC organizes 5 specialized committees for its efficient operation. Those are Specialized committees for Bioethics and Safety Policy, Specialized committees for Embryo Production and Research, Specialized committees for Research on Human materials and Biobanks, Specialized committees for Genetic test and Gene therapy, Specialized committees for Human subjects Protection and Ad hoc committees for Specialized Issues (If necessary).

Since the committee was established in 2005, each committee has carried out various activities during 12 years as follows:

1st (2005-2008): Discussion of Institutional Review Board (IRB)/ Institutional Bioethics Committee (IBC) Improvement; Review of somatic cell cloning embryo research

2nd (2008-2011): Discussion of stem cell lines registration system; Discussion of 「The Bioethics and Safety Act」 revision

3rd(2011-2014): Review of regulation of genetic testing; Recommendation of Life-sustaining Treatment Decision process

4th(2014-2017): Announcement of Declaration on Respect for Life ('16.5.12); Review of somatic cell cloning embryo research and regulation of genetic testing; Host the Asia-Pacific Regional Meeting for National Ethics/Bioethics Committees (AP-NEC) ('17.10.23~25), The Westin Chosun Hotel, Seoul)

### **Exploring with whom humans will live in a transhuman society?**

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Exploring With Whom Humans will Live in a Transhuman Society?

The article forecasts the condition of humanity in 2050 by considering how current breakthrough technologies will drive the future. The technologies that the article considers are ones by which humans are radically changed into transhumans. The definition of transhumans includes being able to eliminate the aging process and greatly enhance intellectual, physical, and psychological capacities by developing technologies. At the same time, we have to forecast others types of beings besides humans and transhumans in 2050, namely, humanoids. Furthermore, we can also conjecture on the existence of future generations that the humanoids will bring forth. The second generation of humanoids can be called machine-sapiens. So, there will be four different beings coexisting in the future: pure humans, transhumans, humanoids, machine-sapiens. The four types of beings are typified based on two axes: the area of human desires divided into naturing and denaturing, and technology application approach divided into bio-centered and machine-centered approaches. If one wants to denature humanity by the bio-centered approach, then he or she can be a transhuman. This radical imagination is not merely science

fiction. It is based on real possibilities. The article attempts to address political issues, which focus on membership in a transhuman society. Who will be members and strangers in this transhuman society? How will the four different beings co-exist in peace and harmony? What human wisdom can be brought to bear in a transhuman society? We will explore various aspects of discussions that have been conducted in Korea on the topic of transhumans. Finally, the article discusses alternative ideas on pluralism and equality in relation to a transhuman society.

### ***ELSI Issues in Precision Medicine: Focusing on Korean Perspective***

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South Korea society is known as a country for one of the lowest in birth rate and since 2017 the productive population begins to decline. With one of the highest in life expectancy among OECD countries, Korea performs below average in employment, income and wealth, and has a considerable gap between the richest and the poorest, according to Better Life Index of OECD statistics in 2016. Meanwhile, as National Health Insurance (NHI) program covers 95% population, it is continuously burden to manage the NHI program in our society due to major diseases as well as rare diseases. To overcome inevitable social changes and problems, precision medicine and big data (as a part of) policies become core agendas for health care sector in the new economic and political wave, so called the fourth industrial revolution in Korea. However, there are newly arising ethical, legal and social issues (ELSI) regarding the precision medicine (PM) and big-data. Therefore, in this article, we would like to analyze the challenges and to insist the need of international framework for health-related data non-discrimination.

The first challenge is about privacy. These are the lists of the database in the field of public and private. Currently, it is all segmented but they start the basic research to integrate some of the data sets. However, Korea's experts start to agree that we might need different concept of privacy since there are some research already shows that even the anonymized personal data can be identifiable when the data are combined together. Considering the efficiency and minimizing the risk to infringe privacy, our concern is whether we really need to combine all those databases. In addition, perception of privacy is changing rapidly in our society. Whereas the public is very sensitive to share their own information to general companies and the government, they have low awareness to disclose and share their own data as well as others' through Social Networking Service (SNS).

The second issue is the discrimination on genetic and other health-related data. The Nation-wide Survey on Public Awareness for Human Genome Research (participants: 1000, method: computer assisted telephone interview, duration: March 7-12, 2012) was conducted to identify Korea's recognition regarding genetic information. As a result, 21.9% answered that they would accept person who has a cancer-susceptibility genes as a spouse, whereas 78.6% answered that they would accept person who has a cancer-susceptibility genes as a friend.

From the results, we found that we need to investigate social and cultural hurdles of genetic (and data) discrimination in the national level. Especially, from the big-data of PM cohort,

research would show the different level of importance in data types (gene data, lifestyle data, etc.) from disease to disease. It means such data can affect individuals and society in many ways, including insurance as well as employment, personal credit rating, education, and even career path, etc. Therefore, it needs to be discussed on a further framework for the genetic and healthcare data non-discrimination to prevent social discrimination and to protect individual autonomy while we will be utilizing the data for a rational reason.

Next is data sharing and commercialization. There is a big concern of data monetization from private companies, such as mobile carriers, wearable devices, web-portal service and SNS companies internationally. Data monetization means to make profit strategies using genomic and health-related information. However, what kind of data do the companies have now, and how do they plan to generate the secondary and tertiary data as commercial resource? Regarding the problem, the Bioethics and Safety Act (BSA) does not have provision to regulate it. BSA only regulates when genome data is shared at no cost to researchers and biobankers.

The last issue is public trust and transparency in PM cohort and its application track to the field of healthcare. The ultimate goal of precision medicine would be to make higher accessibility in medicine (medical service for anytime, and anywhere) and to improve quality in long-term perspective and it would be able to affect to increase healthy-life years and life expectancies in Korean population. However, there are remaining questions for attaining public trust and transparency in PM cohort and its application track: How can we obtain the informed consent from participants in PM cohort, and which type/contents of informed consent are affordable in further R&D in health care sector using the cohort data?; How can we compensate the participants of precision medicine cohort who provide his/her personal information giving up their own privacy?; How can the new medical technology/products relating to PM, such as algorithm/application services through mobile, be included to payment items covered by NHI from the non-payment items? How can we compensate the errors of the algorithm/application services which would be covered by NHI? Therefore, before initiating the project, Korean government, should make a public deliberating process responding to the challenges.

So far, this article investigated some issues, such as privacy, data sharing, commercialization, public trust and transparency regarding precision medicine and big-data. To enroll PM cohort and to use some service of private companies would mean not only to give up individual's own privacy but also to provide personal information for R&D in the part of the 4th industrial revolution. Within this circumstances, it will reveal that the importance of data is varied from disease to disease or more generally case by case, and such data can affect individuals and society in many ways, including health, employment, insurance, and etc. Therefore, as a conclusion, it would be needed to discuss on a further framework for 'the healthcare data non-discrimination' to prevent social discrimination and protect individual autonomy while we are utilizing the data as a reasonable reason.

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### ***Review of discussions of the ELSI committee for 15 years in the BioBank Japan***

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In large patient biobanks, which are based on participants' collaboration, efforts to address the related ethical, legal, and

social implications (ELSI) have been recognized as a part of genome research. Accompanied by changes in the research environments, including new genomic technologies and new regulations regarding privacy and human subject protection, discussions of ELSI have been modified to protect the participants.

With the government's support, Japan initiated a patient biobank known as "BioBank Japan" (BBJ), in 2003, to promote personalized medicine. This project has two aims: first to establish BBJ by collecting DNA samples, and clinical information from patients with target conditions, and second to promote research to identify genes for common diseases, adverse reactions to drugs, and to conduct evidence-based genetic testing and drug development. By 2017, BBJ has collected DNA samples and lifestyle and medical records from 260,000 patients suffering from 51 diseases. Concomitantly, in order to adequately promote the project, BBJ established an ELSI committee as an independent external organization with external members who advise and make recommendations.

In the present study, we chronologically analyzed the points of ELSI from a total of 112 records of ELSI committee activities to discuss the changes in issues of ELSI and research environments by the ELSI committee of BBJ. In the analysis of the agenda, we organized the levels separately for policy, scientific, regulatory, ethical, and technical aspects.

The following periodical features were observed as changes in the ELSI considerations:

(1) During the first phase (2003.4–2008.3) of the initiation of the project, there were concerns regarding the collection of a large number of DNA samples and clinical information from people on a nationwide scale and collecting them in one place. In addition, the project was required to attain its goals, and the members of the ELSI Committee also monitored whether informed consent was appropriately obtained at medical institutions. (2) During the second phase (2008.4–2013.3), a major ELSI issue involved changes in research design from initial case control studies to cohort studies; participants were not informed regarding possible changes in research design at the informed consent. Because BBJ had assured that the participants would not be contacted again, we considered following the new procedure instead of procuring individual consent. Therefore, ethical procedures to conduct follow-up surveys were examined. (3) During the third phase (2013.4–2018.3), the discussion of issues for ending the research project as well as maintenance and continuation of biobank functions are being emphasized. Specifically, urgent issues being addressed include data sharing which, based on international trend, entails the return of research results (incidental and secondary findings from genomic analysis) as the research progresses, and deadlines for withdrawal because of the completion of contract with cooperating hospitals.

As described above, ELSI have been changing with modifications in research designs and environments. Such as deadlines for withdrawal of consent and follow-up surveys, BBJ is influenced by basic Japanese government policies and subsidies, leading to contradictions between best practices and practices that can be implemented.

### ***Shall we "pause" PGS?***

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Many IVF patients, vulnerable from past failed experiences, strive to improve their chance at live birth and often with all costs. Preimplantation genetic screening (PGS) of embryos for chromosomal aneuploidy is offered at an additional cost to IVF. In the US, approximately 22-33% of all cycles utilize PGS.

Marketed for several decades, PGS advocates are pressuring and criticizing institutions, even countries that restrict PGS as unethical, violating the right of patients to have a viable embryo and a healthy baby. Japan, such a country, just approved PGS this year since there seems to be increasing evidence and performed in the US and Europe. However, while PGS is increasingly performed worldwide, some institutions in the US are beginning to put PGS on "pause." Two major factors contribute to this "pause": the ongoing absence of a convincing randomized control trials (RCT) using appropriate populations and outcome measures, and human failure to presume that technology can accurately predict an embryo's intrinsic nature to err and self-repair during its development. For patients to discard or transfer what has been diagnosed "abnormal" of a developing embryo can be harmful due to the loss of potential viable embryos, burden pregnancy and health concerns for a child from an "abnormal embryo", and the financial burden of 100 fold to repeat IVF cycles with PGS in order to attain that "normal" embryo. For providers, distress of ethically providing a test that has limited evidence, and explaining what abnormal truly means without inflicting a patient is challenging. In my presentation, I will argue that countries and institutions should always consider sufficient evidence prior to incorporating testing, even if it has been marked over decades and seem less controversial with rapid technological advancements. I also argue that despite demands from patients and pressures from society, institutions and countries should boldly put a testing on "pause" that is found to have insufficient evidence or may harm patients. This act may inspire and support other institutions and countries considering putting a testing on "pause."

### ***Ethical aspects of genome editing***

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A detailed study of the genomes of plants, animals and humans opens up the widest possibilities for applying the acquired knowledge in biotechnology and medicine. In the postgenomic era, methods are actively developed that allow manipulating DNA in genomes, as well as visualize and control gene expression and the work of regulatory elements. Nevertheless, by no means all methods meet the high requirements for their effectiveness, safety and accessibility for a wide range of researchers.

Directly change the structure of DNA in a target place is the technology of the genome editing. Technologies of genomic editing have revolutionized both the fundamental life sciences and their practical application. Targeted modification of the genome of any organisms - from bacteria to humans - suddenly became available to virtually every biological laboratory.

This has given rise to a whole range of challenges for the world as a whole. Many experts hope that new technologies will allow treating many diseases. At the same time, genomic editing is still a contentious issue, including ethical issues. Even some supporters of the method recognize that people are not yet sufficiently prepared to safely manipulate DNA. For 4 years since the discovery, CRISPR has been used to edit human cells, cereals, insects (e.g. butterflies), yeast and many others. The branch, which can be changed almost immediately by CRISPR and editing in principle, is agrotechnology.

Genomic editing based on CRISPR can be used to simultaneously edit each gene in the genome of plants (or each gene of a particular type - for example, R genes that are responsible for resistance to diseases) thus creating a wealth of information and potentially opening useful alleles that can be inserted back in already applied plant varieties. Genomic editing is another form of mutagenesis. An important difference here is that old methods rely on random events, while genomic editing is accurate and focused, which leads to a sharp decrease in the time costs from mutation to sowing of experimental plants. Once a breeder or scientist has found a

useful allele, with the help of genomic editing, they can transfer it to another variety or even a plant kind of practical immediately, without the need to obtain a series of generations.

### **CRISPR-Cas9 - mediated Human Germline Editing through the Lens of Shariah**

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The recently developed CRISPR-Cas9 technology heralds a brave new revolution in genome editing and genetics as a whole. It offers a wide range of potential uses in research and therapeutic applications including prevention of genetic diseases as it provides an efficient yet inexpensive way to edit human gene. Research on the use of this technology in modifying human embryo, however, has revived the long debate about whether it is ethical to alter human germline. This paper reviews Muslim scholars' writings on human germline gene therapy to identify ethical principles in Islam that should be considered in dealing with related ethical issues. Producing healthy progeny is highly encouraged in Islam. This can be seen through its encouragement for Muslims to marry a healthy spouse. Nevertheless human germline gene therapy would not be considered permissible unless it has met several conditions. Among them are; a) it should be used only to achieve benefits that are compliant with shariah. Human genetic enhancement is not allowed; b) the procedure should be declared as safe and efficient; c) no harm or greater harm would be inflicted upon the resulting child and his lineage. The main principles to be abide by in this context are 'preventing harm takes precedence over securing benefit' as well as maqasid al-shariah's principles of preservation of human's life, intellect and lineage.

### **Bioethics and Reproductive Health Care: Biological Mechanisms – Bioethical Challenges**

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The foundation of adult health is set during the differentiation of the gametes when normal maturational processes may be disrupted by harmful genetic and epigenetic variables. Consequently, the health and living conditions of both parents from the time of gamete formation to the conception of the offspring are just as crucial as the mother's situation during pregnancy and lactation. While genetics focuses on how organisms retain traits by inheriting genes from their parents, epigenetics refers to additional methods of biological inheritance that do not directly relate to the inheritance of collections of genes. Thus, under certain conditions a gene can be switched on or off. If it's switched off, then it will not spell out the message to give instructions to make the protein for which it is responsible. Characteristically, modulated gene expression represents a response to environmental dynamics and is the result of genetic-environmental interactions over time. For example; the most common behaviours in any particular environment are typically more successful, in evolutionary terms, compared to available alternatives. However, there are certain epigenetic variables if operative during critical periods in development that may permanently impose an adverse change in the offspring's genetic program, which, in turn, may also affect subsequent generations. Epigenetic influences may collectively be referred to as social determinants which include the kind of housing and environments we live in, the health and education services we have access to, the income we generate and the nature of work we do all influencing health and lifestyle decision making. Consequently, the major responsibility of the modern ethicist is

to integrate current scientific understanding of practical and cultural significance with traditional wisdom. The major responsibility of the scientist is to ensure that scientific information is not omitted or corrupted in the process. Bioscience ethics can assist in this process of integration. Bioscience ethics facilitates free and accurate information transfer from applied science to applied bioethics (<http://www.bioscience-bioethics.org/>). By integrating the life sciences with bioscience-ethics it becomes possible to highlight issues that relate directly to our lives and bring to the bioethical discussion a better awareness of the socio-ethical implications of the current biological dimension on which ethical tradition and technological applications function.

### **Humanoids and the Shrinking Society**

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Though, nowadays, the development of humanoids is flourishing in many developed countries, including Japan, I have been raising many questions about it (See Tsuyoshi Awaya, "Humanoids in Human Desires", in Ethics of Life and Technologies, Naoki Morishita (ed.), Maruzen, Japan, 2016, pp. 160-182; Tsuyoshi Awaya, *Singularity and bioethics*, 12th International Scientific Conference of the International Society for Clinical Bioethics, "Bioethics in the Future: Technicization of Man or Humanization of Science?", Bol, Croatia, Sep. 21-22(22), 2015, etc.).

This time I would like to present some doubts from a totally different viewpoint. There is a group which advocates, "the shrinking of society" in Japan. This group proposes to reduce the size of our society in preparation for the coming depletion of fossil fuels. According to Dr. Hiroshi Matsuhisa (Professor Emeritus, Kyoto University, Japan) who is the representative of this group, robots in general including humanoids have limitations in terms of energy efficiency. He says as follows. "Humans act by consuming energy of about 100 watts. However, factory robots need over 1,000 watts. In addition, humans use 21 watts when thinking, but the artificial intelligence of 'Go', or 'Alpha Go', the board game played by computers, consumes 250,000 watts."

When fossil fuels run out, it will be impossible to maintain humanoids equipped with artificial intelligence. Professor Matsuhisa's opinion reinforces my skepticism about humanoids. The development of humanoids seems to be an example of human foolishness.

### **The fourth industrial revolution and robot tax: Do firms have a natural duty to employ humans?**

-Cheol Kang, Yonsei University, Korea

The Fourth Industrial Revolution represented by big data, artificial intelligence (AI) and Internet of Things (IoT) is prompting the advent of an age of ultra connectivity and ultra intelligence. There are both optimistic and pessimistic views on the kind of future that those technologies will bring. We have a keen interest in technological innovation and societal changes in the age of digital revolution. However, we don't seem to be as much interested in how to control and manage businesses – the agents that develop, advance and socialize innovative technologies.

One of the biggest concerns caused by the Fourth Industrial Revolution is the issue of AI and robots replacing human jobs. This replacement has been taking place on two fronts - technology and economy. On the technological front, the World Economic Forum 2016 predicted that the progress of the Fourth Industrial Revolution would make more than five million out of seven million jobs disappear across the globe. A 2015 report by the consulting firm McKinsey says that even with current technologies robots can replace 45% of human jobs. However, there has been debate over whether AI and robots replace human occupations themselves. Some argue



that those technologies replace human tasks not occupations, which means the net impact of AI or robots on human job replacement would be minimal. Time will ultimately resolve this debate but it is certain that striking advances in science and technology are set to diminish the number of areas previously thought to be reserved for human intelligence.

On the economy front, a new threat to human employment is growing with the emergence of digital platforms in the virtual space of ultra connectivity. Now we can look for jobs by logging on to a digital platform wherever and whenever we please. This allows businesses to operate without hiring regular workers. They can avoid costs and uncertainties involved in full-time employment. With the Fourth Industrial Revolution, new employment practices will spread rapidly as the so-called gig economy or online economy dominates the world.

From the perspective of both technology and economy, the replacement of humans by AI or machines will eventually lead to a condition where productivity increasingly decouples from employment. As is well-known, technology-driven productivity gains in the First, Second and Third Industrial Revolutions created new jobs and expanded employment. With the Fourth Industrial Revolution, however, productivity improvement through digital automation rapidly diminishes, not creates, jobs - which make the issue even more serious. We must now ask again "Does a firm have a natural duty if any to employ humans?" "Where does the meaning of life come from?" We need to reunite economics and ethics.

This paper shifts the focus from the question "What is a solution to the issue of human jobs being replaced by digital technology?" to "How should businesses be managed, controlled and supported as they drive the Fourth Industrial Revolution?" I will address this question mainly by discussing the recently emerging issue of robot tax.

The issue has sparked debates after Bill Gates mentioned it in a recent media interview that took place on February 17, 2017. He claims robot tax needs to be introduced to resolve massive unemployment triggered by robotic automation. He says governments should impose taxes on human-replacing robots at a similar rate that would be levied on incomes if humans are employed. Advocating for taxing robot users, Gates emphasizes that robot tax can be used to re-educate those who have lost their jobs due to the expansion of robot use so they can work again and get paid. He also believes robot tax could slow down automation that has been accelerated across the economy.

However, the rationale of the opponents sounds reasonable as well. One of their main points is that robot tax will undermine technological innovation. There is also the epistemological difficulty of how to distinguish taxable robots from exempt ones. Moreover, given the inherent task of businesses to maintain their competitive advantage in order to survive in the market, replacing human labor with automation is desirable, or at least unavoidable, and thus robot tax is detrimental to the nature of business entities.

This paper contends that addressing the rapid decline of human employment in the age of Fourth Industrial Revolution should start with two fundamental questions: "What are firms?" and "Why do they exist?" Answering these questions is critical to finding the right direction and policies to address the issue of unemployment in this new environment.

In identifying the nature and mandate of businesses, this paper will try to answer the question "Do firms have a natural duty to hire humans?" In order to deal with this question, I will critically review the existing theories of firm including the neoclassical economic theory, the transaction cost theory and the firm as a nexus of contracts. Then I will use the review as a basis to present a new perspective on businesses.

The Fourth Industrial Revolution necessitates deep introspection on the value and meaning of human labor in life and it also requires a new approach to the nature and mandate of businesses. Humans used to give orders to machines in order to get their job done more effectively. In the age of the Fourth

Industrial Revolution, however, they may be reduced to following orders for the purpose of meeting the needs of AI and machines. In order to respond as active agents to new technologies, we should look deeply into how to control and manage businesses that develop, advance and socialize digital technologies.

### ***Forge New Asian Intellectual and Medical Horizons with Service Learning - a bioethical reflection***

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There are three aims in this paper. The first is to bridge community psychiatric rehabilitation, health promotion with LTC, as well as the concept of living lab in shaping a learning environment across national borders for just regional planning oriented comparative action research. The second is to develop a Work-Based-Learning-oriented education model for nurturing professional competence and teamwork spirit. Such development will begin with education program for professional training in medicine, health and LTC. Social education for the general public will be arranged later as well. The core value should be ubiquitous learning for life. The third aim is to provide a total solution on regional planning for smart living in collaborative manners, wherein Taiwan could serve as a facilitator as well as model case for nurturing regional bioethical practices. While exploring medical professionalism and national cultural identities with collaborative partners in different counties, we attempt to propose an international bioethical horizon wherein Taiwan could serve as a role model in shaping Asian civil society by mutual learning and understanding.

### ***The Future Perspective of Research Ethics concerning the Japanese New Regulations and Ethical Frameworks for Medical and Health Research Involving Human Subjects***

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We stand at crossroads of research ethics related to international harmonization of various regulations and ethical frameworks. Recently, Japanese regulations and ethical frameworks for medical and health research involving human subjects have become more complicated. In 2014, the MEXT (Ministry of Education, Culture, Sports, Science and Technology) and MHLW (Ministry of Health, Labour and Welfare) of Japanese government integrated previous two guidelines; 'the Ethical Guidelines for Epidemiological Study' and 'the Ethical Guidelines for Clinical Study' into the current guidelines. The guidelines were revised again with the amendment of 'The Act on the Protection of Personal Information' in 2017.

On the other hand, the Bill of 'the Clinical Study Law' has been established in 2017. Some serious incidents of research misconduct led to the establishment of the new law in Japan. In this new law, the following in particular was emphasized:

- 1) Regulation for clinical study receiving funds by pharmaceutical industry,
- 2) Imposing duties to obey the practice standards which are equivalent to the GCP,
- 3) Making notification for study plan which shall be reviewed by the certified IRB,
- 4) Improvement order / Stay order of clinical study by MHLW of Japanese government,
- 5) Obligation applied to pharmaceutical industry to publish the fact of funding to clinical study.

Moreover, the Pharmaceutical and Medical Devices Act, Ministerial Ordinance on GCP and other complicated regulations have existed in Japan.

**Methods:** I extract important issues from the Japanese ethical guidelines and regulations systematically. We also put the new

Japanese 'Clinical Study Law (2017)' in range. I analyze the above issues from the following points of view particularly: 1) Informed consent according to risk levels, 2) Responsibilities of investigator, principal investigator and director of research institute, 3) Archiving / Management of biological samples and medical information, 4) Functional enhancement of IRB including central IRB frameworks, 5) Informed assent for non-autonomous person, 6) Criteria of research ethics according to "invasion / minor-invasion / non-invasion" and "intervention / non-intervention", 7) Management of conflict of interest, and 8) Monitoring / Audit requirements related to Quality Control / Quality Assurance, and so on.

I also discuss the perspective of Japanese regulations and ethical frameworks for **Medical** and Health Research Involving Human Subjects. And we also consider research ethics related to international harmonization of various regulations and ethical frameworks.

**Conclusion:** Will we never be daunted or push on toward successful research and development of medicine? It is required to continue to accumulate and scrutinize cases of solution in order to ensure consistency of value judgments concerning research ethics. In addition, we should examine how to manage regulations and ethical frameworks based on unified or systematized criteria of research ethics, for example, IC (and assent), RCR (Responsibility of conduct of Research), Protection of human rights, IRB administration, COI management, QC / QA, and so on.

#### ***Reflections on Global Justice and International Partnership - Lessons for professionalism at different contexts***

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Quest for global justice have been predominate at international sphere; however, health inequality are still most difficult barriers to be overcome across national boundaries. International partnership is therefore proposed between the developed and the developing to this end. Professional gaps in all aspects still put such effort into questions. We propose a synergic way of international collaborations with professional empathetic understanding for fulfilling these challenges. Our participatory collaborative efforts in Malawi, Vietnam and Taiwan has been compared and evident the valuable part of such efforts. Contextualized patient-center approaches with a special emphasis on professional competences as well as training are presented. Financial sustainability is the most crucial in the maintenance of international partnership. Reflections on the contextual features of these endeavors, we argue that financial accountability should be essential in developing professionalism for global justice. Such lessons are crucial for all professional practices in either developing or developed countries, especially questing for partnership overcoming economic barriers.

#### ***Reflections on Tuberculosis control strategies in Taiwan Medical History —implications for Just Health theory***

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We review the "National Mobilization Plan to Halve TB in 10 Years," which has been implemented during 2005 and 2015. Accordingly, the annual TB incidence rate in Taiwan has lowered by about 6%. The number of MDR-TB cases decreased from 440 cases in 2007 to 184 cases in 2015. Analyzing this project through the lens of just health theory, this paper aims to: 1) take a utility approach to clarify the effective outcomes of the control programmes in Taiwan; 2) use an institutional approach to analyze the organizational role play in TB control; 3) apply principle of justice as fairness to analyzing the procedures leading to Just Health; and finally, 4) summarize

bioethical reflections on the ethical issues of TB control for supporting or questioning just health theory. We conclude the just health theory as desirable. Further suggestions for developing and developed countries are proposed.

Health care is the important social goods for healthy living. The objective of health care is to maintain people's daily functions for ensuring equal opportunities. However, the health disparity is not easy to overcome. Hence, the just health care becomes major concerns in all societies from time to time, especially for the task in control tuberculosis. At present, it is still the world's top infectious disease killer, claims 5 000 lives each day. The heaviest burden is evident in communities suffering from socio-economic disadvantages. Taking a historical approach, we will use the just health theory of Norman Daniels, the follower on Rawlsian theory of justice as fairness.

#### ***On Nanotechnology: Overcoming the Limitations of fMRI Research***

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Functional neuroimaging techniques are highly limited in today's world in terms of capability and breadth of function. As such, they must necessarily exclude certain groups of patients due to potential medical risks that could arise from their use. Taking from a fictitious device found in various media formats, we can determine what qualities it may have and therefore make it a device that does more than allow the user to entertain themselves. While this device cannot effectively be made with current (or foreseeable) technologies, it is possible to make a facsimile that relies upon nanotechnology as opposed to electromagnetic radiation as envisioned by the device's creator. Other advances will need to be made to allow this device to penetrate the blood-brain barrier in a medically safe manner; however, this device will have the potential to reshape functional neuroimaging and conventional medicine as practiced today. As such, a viable concept needs to be generated to display the potential benefits, harms, and moral concerns that surround the development of such a device.

#### ***Overview of Korean Bioethics and Safety Act***

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#### ***The practice of central IRB in Korea***

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Besides clinical trial regulations, Korean Bioethics Law designates one IRB functioning as a central IRB for individual researchers and small institutions. The amendment of the Korean Bioethics Law in 2013 has changed the horizon of IRB in Korea because all research involving human participants must be reviewed by an IRB. The demand for IRB review has dramatically increased and the IRB review service is in short not to mention quality review. Diversified areas of professional demand and limited resources calls for a central IRB review service. Analysis of this new demand and the opportunities should be followed by societal discourse.

The history of IRB practice in Korea has been initiated by academic medical institutions since 1990s. The agents targeted to use in patients were mainly pharmaceutical products in the earlier times. The efficiency in time management of IRB review was the first goal when initial attempts to reduce the redundancy and inconsistency of each IRB's decisions. The demands were positive but the legal mandate of establishing an IRB at each institution was the first step to overcome. The author has first initiated "IRB mutual recognition program (MRP)" and five institutions have participated in the program in 2003. IRB MRP is to use one IRB of participating institution and recognize its review decision by the rest of participating



institutions for multi-center trial studies. The second trial was initiated in 2010 by the Korean Association of IRBs with participation of five academic medical institutions. Both MRP trials concluded with lessons and new opportunities. The Catholic Medical Center has been in operation of a central IRB since 2009 providing services for eight general hospitals, a medical college and a nursing college.

### ***The challenges of patient's informed consent in multilingual and multicultural countries***

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Regarding the cultural issue, it should be noted that although the majority of the medical community and the patient population have Chinese values, the existing law is still basically the one inherited from Portuguese administration. Thus, it is recurrent that day-to-day medical practice violates what is established by law regarding informed consent.

Patient's informed consent - that is, the communication of all relevant information to the patient and the subsequent recall of his consent - is the corner stone of modern medical law.

However, informed consent becomes a challenge when the parties do not share the same idiom and/or the same cultural values. To demonstrate our thesis we will present the case of the Special Administrative Region of Macao (SARM), which, even though it is a part of China, retains some western traces from the centuries in which the territory was subject to Portuguese administration.

In effect, by constitutional imposition SARM has two official languages, Chinese-Putonghua and Portuguese, and in addition two predominant languages *de facto*, Chinese-Cantonese and English. On the other hand, although the large majority of the population has Chinese roots, many Portuguese citizens still live in the territory and a part of the Macanese community actually shares Portuguese (i.e., western) values.

These disparities become evident in what regards informed consent in medical practice.

In what concerns the language issue several solutions are applied: the use of a language understood by all the involved parties, even if poorly; the disclosure of written information in the patient's language, though sometimes the translation is not accurate; the use of a relative as translator, disregarding patient's privacy and the specificities of technical medical language.

### ***To examine the necessity for the volunteer activities in order to enhance the QOL of the senior through the belly dance care*** - Hitomi Irizawa, Hyogo College of Medicine and Juntendo University, Hyogo, Japan and Gotoh Akinobu

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Japan is a super aged society that is unprecedented in the world, so it is necessary to reform the welfare system for the purpose of justifying social security expenses toward 2025 when the baby-boomer generation becomes the late elderly. As the aging of society is accelerating, the long-term care insurance system is revised every three years and some experts propose that we should reduce the payment for the low-level care recipients to ensure a budget for the recipients who need severe care. Therefore, the facilities for the aged should try to prevent the decline of physical functions of them to extend the healthy life expectancy of them. We examine the influence of volunteer activities on facility users from the viewpoint of changes in physical functions and subjective QOL.

### ***Bioethics Teaching for Medical Postgraduate***

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Ethics teaching to medical undergraduates in the medical faculties of Sri Lanka is well established. While the specific subject of Research Ethics has been included in the research methodology modules of postgraduate medical courses for several years, bioethics teaching in its wider aspects is relatively new. I will briefly describe two such programmes that take place at the Postgraduate Institute of Medicine (PGIM), University of Colombo.

*Ethics in Health Care module for MD trainees in Medical Administration* This is a 15 hour module included in the Postgraduate Course conducted by the Board of Study in Medical Administration for the degree of MD (Medical Administration) of the PGIM, University of Colombo. This was started in 2011 as part of the revised syllabus, and has continued each year for all the postgraduate trainees in Medical Administration, since then.

*Ethics teaching in the Professionalism and Ethics in Medical Practice strand* This strand was introduced for all MD Trainees at the PGIM, University of Colombo, starting in July 2014. The 24 hour Introductory Module is spread over four days, and includes an ethics component of 6 hours.

### ***We Can and Must Rebuild the Bridges of Interdisciplinary Bioethics***

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Although we can argue that bioethics is holistic and found in every culture, and still alive among people of many indigenous communities as well as the post modern ones, the academic discipline of bioethics as interpreted by many scholars has attempted to burn bridges to both different views as well as persons with different life trajectories and training. The bridges between different cultural and epistemological foundations of bioethics have also been strained by the dominance of Western paradigms of principlism and the emergence of an academic profession of medical bioethics.

I challenge us all to reconsider the manner in which we conceive of bioethics, as well as the range of literature and scholars that are considered to as legitimate sources of wisdom. Such a new approach will breath fresh light into not only the important work of all scholars, students and teachers, but also offer some fresh references for contemporary policy changes that face us. We should go beyond the usual boundaries of time and space – look through history and globally and understand bioethics as the love of life can be argued to be pre-human and thus is as old, or older, than cultures themselves.

The academic term "bioethics" was coined 90 years ago by Fritz Jahr (1927) in his paper, "The bioethical responsibilities of human beings to plants and animals". We see efforts throughout bioethics scholarship to emphasize the inclusion of other beings into bioethics, but in the United States almost all bioethics scholars and departments focus on medical ethics. Yet the term "bioethics" has often replaced the former term "medical ethics". We cannot simply blame the "bioethicists" for this however, since often those in the minority field of "environmental ethics" stress to emphasize that it is distinct from bioethics, as they try to mark their own turf.

I would argue that all public health issues are bioethics issues, but those in the field of bioethics often focus on individuals rather than systems. However, work is needed to build bridges between all these and other related fields to promote a holistic understanding and approach to bioethics. Even more

important than the name is the ideology we use, one of inclusion, and one that includes a comprehensive understanding that our individuality is a social construct.

We cannot simply look at religious texts on their own, but in the way that they were applied by societies. In Asian bioethics there has been a dialogue for decades on whether the principalism of American textbooks is applicable to other societies, which may place more value on harmony, love, relationships, or virtues. However we can see debates over principalism, virtue ethics, relational ethics, feminist approaches, and so on, in public health ethics, environmental ethics and bioethics. There is much to do in bioethics and public health, and bridge building through time, space, culture and discipline is essential to ensure we have solid research-policy linkages to build our bridges to the future. Through effective work of bioethicists we can bridge all the artificial boundaries that stifle the progress of our society, for the sake of all beings, our dear planet, for our heritage. Heritage includes the concepts of past, present and future in one word, Let us renew our efforts to make informed decisions so we can all make better choices in all realms of life. We thank all the scholars and our ancestors for what we have been given, and let us promote evidence-based policy as the message of bioethics for empowering individuals and our communities.

***Adapting Bicultural and Bioethical orientations to construct an action model of mental health on aboriginal Taiwanese***

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Health is a basic human right, and advanced countries worldwide prioritize health care. The indigenous Taiwanese have endured over a century of colonial suppression and have long been culturally, economically, and politically marginalized under the development of capitalism in contemporary society. However, indigenous Taiwanese have always been a disadvantaged minority with little prospects due to sociocultural asymmetry and inequality in resource allocation, and thus tend to resort to overdrinking in order to escape the injustice and disadvantaged position of health minorities they face in the mainstream society.

A 3-year integrated plan is developed, which will, with the biocultural and bioethical orientations, integrate the resource networks of subprojects to create a model of mental health and cultural sustainability for indigenous Taiwanese. Following an indigenous tribal meeting and a research ethics review of this main project, both qualitative and quantitative action research was adopted in urban indigenous communities and indigenous tribal villages. Through the perspectives of ethnic and cultural diversity, the existent limited biomedical approach and conventional ethnic essentialism were challenged as the defaults of indigenous Taiwanese mental health module. The intricate relationships between body, mind, society, and culture were rigorously considered to create a platform for intersubjective multicultural dialogue, mutual support, and action motivation. The creation of a working model with the three dimensions of health, well-being, and society that promotes the mental health of indigenous Taiwanese can both elucidate mental health knowledge production that exhibits cultural sensitivity, as well as shape social impacts for the use of reflection and application by interdisciplinary fields.

The main project of this 3-year integration project will construct internal and external quality control mechanisms year-by-year to coordinate the vertical and horizontal

integration of the main project and each subproject. Specifically, the following will be established: a shared intelligent living cloud platform, research process archive, and study findings database. The teams assigned to each subproject will co-participate in and expand mutual exchanges between organizations regarding their research processes and findings, in order to 1). Construct a working model of indigenous Taiwanese mental health with the biocultural and bioethical orientations, 2). Generate social impact regarding the mental health of indigenous Taiwanese, 3). Promote the creation of indigenous communities and enhance the cultural industry. Subsequently, through the mental health workshops, seminars, and academic journals established by our research teams, we will emerge on the international academic stage to produce indigenous mental health knowledge that follows the principle of "Think globally, act locally" for exchange on the international academic stage.

***Introduction of Life-Sustaining Treatment Decision-Making Act in South Korea and its Limitation***

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In February 2016, the 'Hospice, Palliative Care, and Life-sustaining Treatment Decision-making Act' was legislated, following six years' debate about forgoing life-sustaining treatment after the Korean Supreme Court's Decision on Grandma Kim's Case in 2009. The law is highly anticipated and will respect the patient's right of self-determination and guarantee his/her dignity by defining decisions regarding life-sustaining treatment. However, current legislation has some limitations. First of all, the law strictly applies to the patients in 'dying phase expecting rapid death,' not in 'terminal-stage,' which can restrict choices of terminal-stage patients. Secondly, it has no definition of the surrogate decision and prohibits the surrogate decision without the consent of all members of immediate family, which gives no protection of the interest of patients without kinship. Thirdly, there is room for confusion in the introduction of the 'plan for life-sustaining treatment=POLST,' which will be written by a physician in consulting with the patient as the patient's prior intention other than the advance directive. Meanwhile, the law emphasizes patient-centered advance care planning, which may go ahead current culture of discussion by patients' families in end-of-life. However, Current legislation limits the patient's self-determination right by the concern of abuse, and further revision is necessary.

***Is Bioethics relevant today for Climate Change Deliberations and the Future of Health?***

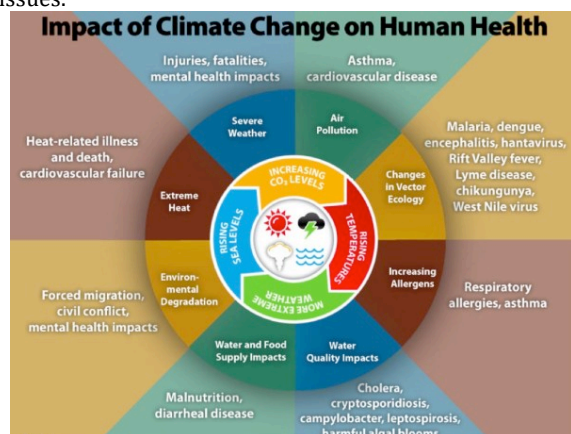
- Mariadoss Selvanayagam, Loyola ICAM College of engineering and Technology, India; Jesuits worldwide Learning, Chennai, India and Francis P Xavier, Jesuits worldwide Learning, Geneva

The World Health Organization (WHO), the world Meteorological Organization, and the United Nations Environmental Program have noted with grave concern, the implication of climate change on human health. A legally binding international treaty on climate change was signed by 195 countries in 2016. There are apprehensions and President Trump announced on 1<sup>st</sup> June 2017, that the United States has withdrawn from the Paris climate accord. The withdrawal, a political decision by the Trump administration, does not change the science of how our planet works. Policies may change, but the science does not. To ensure economic prosperity and global health, we need a broad understanding of the societal consequences of a warming planet as well as honest and open communication of scientific evidence to the public policy makers.

The climate change impacts are numerous which threatens our own survival in terms of economic growth and sustainable development. Climate change also threatens the health of our people-children and grandchildren through increased disease, freshwater shortages, worsened smog and more.

As citizens of our nations and of our Earth, we are endowed with certain rights, powers, and obligations, which demand that we act both individually and as well as collectively to protect and preserve the ongoing evolution of life on Earth, including our future generations. The human health is greatly affected by the environment, but the provision of health care can have substantial, adverse environmental impacts. The bioethicists can explore the moral, philosophical, theological, and legal foundations of environmental policy affected by climate change.

Therefore, the bioethicists should take part in the discussion about global warming with special reference to human health and contribute their perspectives to these urgent issues.



### Health Care, Justice and Rights: Examining Approaches Based on Welfare and Opportunity

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The value of good health and consequently of proper health care to us is undeniable; and this is at least for two reasons. One is that they are necessary for us to achieve or maintain well-being or to live a flourishing life. Another is that they enable us to access opportunities that are usually available to normal people relative to existing social conditions. The resources necessary to keep us healthy or to satisfy our health-care needs, however, are usually insufficient. Regardless of its causes, this unfortunate reality is bound to result in human sufferings and even deaths. For this reason, the accessibility and allocation of such resources have become a serious moral concern. There are, among others, two related ethical issues raised in this regard. The first concerns the justice of allocating these resources. If allocating scarce resources were unavoidably unequal, what principle of prioritization would give justice to this kind of allocation? The second concerns the nature and justification of the right to health care. This relates to the first question in that justice in resource allocation assumes that people get what they deserve; but what people deserve to receive from a certain distribution are defined by their rights or entitlements. And so, if access to health care is a right, then what kind of right is it, and what justifies this right? In this essay/lecture, I shall critically examine the following two currently dominant philosophical approaches to these issues. The first is *utilitarianism*, which defines a just allocation of resources as one that maximizes the aggregate welfare of everyone involved in the allocation. This approach accordingly regards the right to health care as a conditional right being determined by the principle of maximizing aggregate welfare. The second is the *fair equality of opportunity approach*, which

defines a just allocation of resources as one that secures everyone's normal range of opportunities by maintaining or restoring everyone's normal functioning. This approach regards the right to health care as a special requirement of the right to equal opportunity (in the sense that the right to health care guarantees the possibility of the right to equal opportunity). And since the right to equal opportunity is regarded as unconditional, the right to health care is accordingly deemed as an unconditional right. After analyzing the respective strengths and weaknesses of these two approaches as pointed out by various scholars, I shall argue for the relative advantage of the fair equality of opportunity approach over utilitarianism. Be this as it may, there are, however, some practical instances where the two approaches supplement one another.

### Constitutional Perspectives on the Paradigm Shift of Decision-Making At the End of Life

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As such, this presentation will focus on problems that the current Korean law on decision-making at the end of one's life has, as well as highlight the constitutional perspectives on each issue that involve a person's right to maintain life with dignity, self-determination, and right to health. Furthermore, suggestions to improve current methods of involuntary decision-making at the end of one's life and better approaches to the true will and preference of terminally ill patients will be proposed.

In Korea, for the first time, relevant laws have come into effect regarding decision-making at the end of one's life. Over the past 10 years since Kim's case (Severance Hospital case) in 2008, the controversy of death with dignity and euthanasia has been topics of major interest in Korean society. Experts from different fields participated for several years in discussing and deciding on a social consensus that include essential factors of decision-making at the end of one's life, i.e., scope of patients, the extent of diseases, the process of withholding or withdrawing life-sustaining treatments, the procedures of advance directives, etc.

Initially, there were seven bills submitted by congressmen related to a social consensus. Later, these seven bills were conformed into one amended bill and passed by the national assembly. This bill that passed became the first Korean law that enforces patients to make self-determinations at the end of their lives. However, this law still has points of controversy because its contents include involuntary euthanasia. Furthermore, for patients who are incapable of voicing out their decisions are to be decided by their legal guardians, and although the method of decision-making is stipulated, it still remains controversial because some consider this unconstitutional or unethical.

### New End-of-Life Decision Making Act in Korea: Right to Self Determination is Lacking

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The first legislation on end-of-life decision making in Korea, "Hospice/Palliative Care and Dying Patient's Decision on Life-Sustaining Treatment Act" will go into effect next year (2018). This research discusses how the law can and should be implemented, given that the law reflects certain values that, while considered typically "East Asian," can create problems. The law enables individuals to decide their own life sustaining treatment or that of their family members. This is made possible by legally authorizing documents such as advance directives or Physician order of life sustaining treatment (POLST), or by acknowledging two or more family members'

statements, or by following the family's unanimous agreement. Although the law allows individuals some freedom to decide future life sustaining treatment, confusion or undesirable outcomes are anticipated in the future. This is because the law does not recognize the individual patient's self-determination at a fundamental level. As for the anticipated confusion and undesirable outcomes, the author demonstrates five issues: first, disapproval of a competent patient's treatment refusal; second, impracticability of advance directives; third, risk of surrogate decision making that does not reflect the patient's interests; fourth, unfair options for patients whose significant others are outside the legal family; and lastly, low participation and confusion in advance care planning or shared decision making. These problems may become obstacles to implementing the new law in a clinical setting and patients in their end of life stage will be harmed. Therefore, there is a dire need for a solution. Because the author believes that the lack of self-determination is the root cause of the problem, the way to prevent harm is to recognize individuals' self-determination at a more fundamental level. However, two rebuttals are frequently raised in opposition to individuals' rights of self-determination. One rebuttal is based on unique East Asian values and customs in end of life issues; this is the claim that East Asians do not give primacy to self-determination in end of life issues. The other rebuttal reflects different characteristics of East Asian biomedical ethics arising from its different development history. This is the claim that founding East Asian bioethics on the concept of rights is not feasible, because the concept of rights is the product of Judeo-Christian tradition, liberalism, and the civil rights movement. Nonetheless, the author rejects these rebuttals, for two reasons respectively: First, the need to guarantee an equal chance of significant interest in end of life in East Asia; and second, discernment on the accuracy and justificatory power of description on cultural difference. As a result, the author concludes that achieving self-determination should be given the highest priority in implementing the new end of life law in Korea.

### ***Influence of Universal Health Coverage Era in withdrawing and withholding life support issue: Indonesian situation***

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Problems begin to arise when hospitals or health care facilities must continue to conduct medical treatment while the costs must be exceeded the ceiling has been set costs. So, there is a shift in ethical dilemma from patient / doctor to the hospital or health service facilities. One of the Government of Indonesia's efforts through the Ministry of Health has issued a regulation on the allowance of withdrawing and withholding life support with certain procedures. However, this is not expected to show significant changes, especially from patient families who continue to ask for treatment although the issue of futility has been well explained by health care.

Towards the end of life, physicians face dilemmas of discontinuing life-sustaining treatments or interventions. In some circumstances, these treatments are no longer of benefit, while in others the patient or family no longer wants them. This is an emotional, ethical, economic, social and medicolegal issue. The patient did not deserve the withdrawn of life support, rather he deserved the appropriate interventions for treatment and minimization of pain and ultimately to gain justice, but here the preference was given to patient's autonomy and life support was withdrawn, but there is no literature through which the withdrawal of life support on patients' wishes can be proved in conditions, where there are still some hopes and chances of survival. The medical treatments are financially burdensome to some patients; hence easy accessibility to quality care at affordable cost can lessen

the financial issue adherent to the end-of-life care considering the increase in the unaffordability of healthcare.

Since 2014 Indonesia began to implement universal health coverage program. All citizens are guaranteed optimal health care. The health financing system is implemented by actively involving the community. For every medical treatment applies cost system packages with a certain ceiling. Regarding withdrawing and withholding life support issues in terminal patients, this will have an impact on the reduced financial burden in medical care. Likewise, with the treating physician, the financial guarantee then the doctor will give the best.

### ***Ethical Issues about Truth Telling and DNR of Terminal Situation***

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Background: The Hospice Palliative Care Act has been legalized for fifteen years in Taiwan. However, it still be recognized not to be helpful in the promotion of the autonomy of terminal patients which might be due to the difficult to practice in our cultural context. It's also lack of research about advance care planning. The research purposes were to find out that the relative factors of truth telling and the DNR order

Methods: This study was designed with cross sectional survey by questionnaire to collect data. The sampling method was two stage of non-proportional systematic randomization. The 1600 research participates were come from medical center or district Hospital. The data was analyzed by the SPSS version 18 was used.

Results: Cancer patients and their families for "terminal cancer patient told more positive", more inclined to think that the patient should be informed of late disease; in addition to patients, health care professionals, patients and their families to "hospice care more positively, more inclined to inform the patient end of the illness, predictors of explained variance effectively was 18.8 % ~63.1 % . Health care professionals, cancer patients and their families conscious of Health indicates that the higher level of understanding, you are more inclined to provide patient's information of AD. Predictor to provide patient's information of AD explained variance was 22.7 % ~69.5 % . Cancer patients and their families, "consciously on the higher level of understanding of AD, I signed up at the end of life choices palliative care of wills is more likely, more inclined to sign ".

Discussion: The anticipatory results will be to establish an appropriate model of advance care planning in Taiwan, and be helpful to promote the quality of end-of-life care under the Taiwanese cultural contexture.

### ***Some Ethical Issues in Prehospital Emergency Medicine***

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Prehospital emergency medical care has many challenges which are basically classified into four groups: the process before medical interventions, including justice, stigmatization, dangerous situations, and safe driving; the treatment process, including triage, refusal of treatment or transport, and informed consent; the end of life and care, including life-sustaining treatments, prehospital cardiopulmonary resuscitation (CPR), withholding or withdrawal of CPR, and family presence during resuscitation; and some ambulance perception issues, including ambulance misuse, care of minors, and telling of bad news. unpredictable patient profiles, emergency conditions, and administration of care in a non-medical area. Many conflicts occur in a prehospital setting that require health care Professional to make ethical decisions,

immediately. Prehospital emergency medicine is quite different from emergency medicine services in hospitals, and almost all patients and situations are unique. Consequently, it needs to focus on this unique health service in future, because of some developments in technology create new ethical problems in prehospital emergency medicine. It is important to have well-educated emergency health care providers recognizing the ethical conflicts that occur in prehospital emergency medicine and then acting ethically to the patient in needs of emergency medicine.

**Ensuring bioethical competence through experience learning - lessons from medical humanities curriculum reform in Taiwan**

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Although bioethical discourses have been seemly predominate in medical arena, bioethical competence is rarely sufficiently put on focus in most recent humanistic medical education reform in Taiwan. We define bioethical competences through each clinical, researchers', professional and sustainable lens. This paper accordingly reviews all experiences learning designed courses we have offered in 16 years and identifies the attributes of student's achievements with these dimensions. We will match the different course designs, learning procedures and engaged contexts with the desirable student achievements. In consequence, bioethical core competences will be identified and categorized through aforementioned four lenses. Further curriculum designs for bioethical core competences are also proposed.

**A Critical Examination of Organ Transplant: Ethical Discourse on Family and Human Beings in Japan**

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The purpose of this paper is to consider ethical and cultural factors affecting the peculiar trend of organ transplant from the extremely few deceased and many living donors in East Asia, particularly Japan, compared to other Western countries. Over the past decades, the reason behind this huge gap has been ascribed to the wide belief that the remarkable rise in the number of living donors in Japan occurs in response to the severe shortage of deceased donors due to cultural differences about people's views on life and death between Western and Eastern societies. For instance, brain death is unclearly defined and not well recognized as human death but rather determined by each individual under the current Organ Transplant Law in Japan. However, this argument does not suffice because it fails to fully consider the influence of family among people in ethical decision-making. The power of family is also evident in the law that states the necessity of a family's consent in harvesting organs from a brain-dead donor. In this study, the author firstly provides an etymological analysis of the word 'family' as *miuchi* (literally meaning 'within one's body') with the perception of *mi* ('body') as actualizing the great potentials beyond its physical boundary, which can be opposite to the Cartesian way of thinking. Secondly, in relation to family as *miuchi*, the author examines the people's conception of humans as 'in-betweenness' or 'a relational being' and its connection to the philosophy of Zen Buddhism. Based on the conceptual analysis of family and humans, the paper discusses the ethics of interdependency as in-betweenness and its relevance in the context of organ transplantation in Japan. By addressing these elements, the author argues that the boundary-less attitude of ethics based upon the sense of interconnection as a family unity greatly impacts organ donation because the living donor is typically a family member of the recipient while the deceased donor is not. This ethics of unity, or a sense of togetherness, works positively with the closest relationship, or family

members, among people in Japan, as sharing their body through living donation is a way to stay connected with their family as *miuchi*. Finally, the study draws attention to the need for the advancement of ethical discussion on organ transplantation from the cultural perspectives on family and human beings.

**Doctors Attitude Towards Breaking Bad News Doctors Experience In Banyumas Regency, Indonesia**

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The results of this study indicated that each doctor was aware that information about the disease was the patient's right and the duty of a doctor was to deliver it to the patient. Based on their practical experience, many patients with poor conditions expected the doctors to provide information about the disease. Although few doctors could deliver bad news directly to patients, most others could not perform these tasks well. There were still many doctors who had difficulty in breaking bad news. It was shown that the practicing doctors tried to avoid the task of delivering bad news, especially in cases of end of life, by, among others, 1) transferring their duties to other doctors or other staff considered to have better capabilities; 2) delivering bad news to families without the knowledge of the patient; 3) choosing to be dishonest to cover the actual condition of the patient; and 4) not conveying the prognosis of the disease by distracting patients.

Most doctors felt uncomfortable to deliver bad news to patients. They tried to avoid such task by redirecting it to someone else, such as paramedics or the patient's family. Some doctor argued that in certain circumstances such as the end of life, patients did not need to know the condition of the disease. They preferred a way to protect patients from harmful situations. Concealing the bad condition of the patient was considered more humane and ethical. Therefore, they chose to conceal the real state of the patient and just pass it on to the family.

The hardest part of the process of breaking bad news was at times when explaining the prognosis and life expectancy of patients. The difficulty led some doctors to choose to be dishonest to cover the patient's actual condition. Another strategy often used by the doctors was to provide incomplete information. The information given was only the diagnosis and its management while the prognosis was not communicated to the patient. When the patients asked, the doctors tried to distract the patient or asked the patient not to think about it. Explanation of poor prognosis or low life expectancy was feared to harm both patients and doctor<sup>12</sup>.

This research could also identify some of the difficulties underlying the doctors' attitudes and behavior in delivering bad news. The difficulties included 1) lack of knowledge and skills to break bad news; 2) the existence of perception of death as a sad and scary thing; 3) the emergence of guilt on the patient's condition; 4) lack of confidence so that the doctor is not able to communicate well; 5) the emergence of fear about the patient's response or condition after receiving information; 6) the knowledge gap between doctor and patient; and 7) the limitations of space and time.

Nevertheless, there were some things that could help the doctors break bad news, such as the role of the family in the context of Indonesian cultural and religious beliefs and traditions of the local community. These were widely used by the practicing doctors as one of the strategies in delivering bad news to patients.

In Indonesia, with or without the permission of the patient, the family was always involved in the process of delivering bad news. Circumstances that befell on the patient were not an individual problem, but a family problem. This was one of the characteristics of families in Asian countries, especially countries in the predominantly Muslim. Conditions experienced by the patient would be felt also by the family. A

disease that required a long term treatment might weigh on the family, both psychologically and economically. The family also had an important role in providing support and was involved in the management of patients.

Discussing with the patient's family could help the doctors in overcoming the difficulties in the process of breaking bad news. Patient families could help the doctors ensure the information required by the patient and the right time for the process of delivering bad news. Families could also assist the doctors in preparing the patients mentally to accept the conditions of their body.

Indonesian people were known religious and still held local traditions that became the guideline of the doctors in delivering bad news. Sickness was believed to be the will of God and provided specific lessons for the sufferers. Pain was an opportunity to abort the patient's sins. Caring for sick family member could also be a field of reward.

### Respecting patients as self-governors

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Respecting patient autonomy by providing full medical information, which includes telling the truth regarding fatal diagnosis, is considered one of the most important ethical principles in contemporary medical practice. However, in East Asian countries, such as Korea and China, where familism plays a prominent role in medical decision-making, allow medical practitioners to withhold information or even deceive patients with the assent of the family to prevent further exacerbation of their health. In this paper, we plan to argue that familism cannot overcome that only patients themselves can govern their life.

In addition to being receivers of medical treatment, patients are governors of their life. Therefore, medical practitioners and moral supporters must provide medical information to patients not only as data but also as life-changing options under any circumstance. Having multiple options, patients can take the initiative in making decisions that affect both themselves and people around them, forming a nexus of relations. It is undeniable that making even a simple decision can be burdensome to patients, whose mental and physical conditions are temporarily or permanently declined. This is the main opposing view on contemporary medical ethics that emphasizes individual patient autonomy. Likewise, advocates of familism assert that family members, the closest people to patients, are suitable candidates for patients' spokesmen. To compromise such two conflicting stances, we propose a new interpretation of patients' identity as a self-governor of one's life, which is interwoven within diverse familial and social relations. Moreover, our interpretation will discuss how medical practitioners and moral supporters can help patients to lead such role throughout the treatment process. One's autonomy is established if and only if she is the governor of her life; being able to respect others follows afterward. This strategy, which considers both individual patient autonomy and social influence upon patients, offers a way to vindicate why even an inconvenient truth, must be disclosed to patients.

### *Philia- or sympathetic concern-based model of decision-making procedure in medicine*

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In this paper, I examine different decision-making procedure models in the field of medicine and determine the most adequate model in accomplishing the goal of medicine. Before examining the decision-making procedure models, it should be made clear what the goal of medicine is, since the subject itself is a source of many misunderstandings. Simply put, the goal of medicine is securing the best interest of patients and there is a

general consensus as to defining the goal of medicine as such. Nonetheless discord usually occurs when the topic concerns how to best achieve the goal of medicine, the discord with regard to decision-making procedure in the field of medicine being one of them. Thus constructing coherent model of decision-making procedure can dissuade at least one source of disagreement among field of medicine.

I assess three familiar models and identify critical flaws in each model, with which they cannot serve the goal of medicine. They are respect-for-the-autonomy-of-patients (RAP), paternalism and familism. In contrast, *Philia-* or sympathetic concern-based model does not share defects of the three models and is, therefore, the most suitable model for the decision-making procedure in medicine.

First I assess the RAP model and identify its deficiencies. This model argues that respect for patient's autonomy is necessary in realizing the goal of medicine since someone other than a patient is unable to correctly examine the best interest of the patient. The best interest of a patient is most apparent to herself and thus respecting autonomy of the patient is the most appropriate way to achieve her best interest. However respect for patient's autonomy thus understood has certain shortcomings when applied to actual practices of medicine. There are cases in which serving the best interest of patient conflicts with respect for her autonomy, when a patient uses her autonomy in a way that will evidently bring harm to herself.

As RAP model's shortcomings are now exposed, we need to find other models that can better accommodate the goal of medicine. One possible candidate is a paternalistic model whose legitimacy has often been claimed on a ground that the best interest of patients is secured under this model. Physician's therapeutic privilege in withholding information from patients is a representative case of paternalism. Nonetheless paternalism also poses problems that stem from a disagreement in situations where the best interest of patients conflicts with the wishes of patients. Thus, paternalistic model is also deemed inadequate to successfully account for the goal of medicine.

Recently, familism has been developed in response to RAP and paternalism. This model maintains that it can secure the best interest of a patient while accommodating the East-Asian values that have often been overlooked in Western societies. Familism answers to the problem of uncertainty with the best interest of patients, as shown in RAP model, by expanding its scope to a patient's family and is able to preserve objective benefit for a patient by obtaining family's assent in medical setting. Nonetheless familism fails to defend important values that it should have by limiting the scope of decision-making unit to a patient's family.

I argue that the decision-making procedure in medicine should not deny the importance of professional opinion or maintain blind respect for patient's autonomy. From this understanding, it follows that decision made by physicians or by someone-related-to-a-patient is permissible. And its permissibility can be explained from *Philia-* or sympathetic concern-based model of decision-making procedure.

### *Scientists' Responsibility to Science and Technology*

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#### **Posing the problem**

Science and technology's development may sometimes impact humanity negatively. But how much responsibility should a scientist contributing to such advancement take? And, if so, how long should responsibility be taken?

In 1921, Thomas Midgley, Jr.<sup>1)</sup> discovered that the addition of tetraethyllead (TEL) to gasoline prevented "knocking" in car engines. General Motors (GM) Company named the substance "ethyl," avoiding all mention of lead in reports and advertising.



In 1923, Midgley took a prolonged vacation to cure himself of lead poisoning.

In the late 1920s, air conditioning and refrigeration systems employed compounds such as ammonia (NH<sub>3</sub>), propane, and sulfur dioxide (SO<sub>2</sub>) as refrigerants. Although effective, these were toxic or flammable, and in the event of leakage, could result in serious illness or injury. Midgley's team eventually synthesized the first chlorofluorocarbon (CFC), which they named "Freon." Freon and other CFCs soon replaced various toxic or explosive substances previously used as refrigerants and were later used in other applications, such as aerosol spray cans.

However Midgley's fame has been scarred by his innovations' negative environmental impact. His work led to release into the atmosphere of large quantities of lead all over the world, from large-scale combustion of leaded gasoline. High atmospheric lead levels have been linked with serious long-term health problems from childhood, including neurological impairment. Since the late 1970s, ozone-depleting and greenhouse gas effects of CFCs in the atmosphere have become widely known, but not until 30 years after Midgley's death. Currently it is said that his research has had the most negative impact on the atmosphere in Earth's history.

Regarding TEL research, GM, including Midgley, knew that ethyl contained lead components and certainly had negative influence on human society. Therefore, Midgley and GM are unavoidably condemned for how leaded gasoline negatively affected the atmosphere and humanity. However, we have used Freon conveniently as a refrigerant without toxicity, inflammability, leakage, etc. And more than 50 years later, Freon in the atmosphere destroyed the ozone layer, and the greenhouse gas effect of Freon became widely known. As a scientist who developed it, is Midgley charged with responsibility for its ill effects? In this paper, I consider scientists' responsibilities to science and technology.

#### **Dual-use nature of life science research**

Scenarios in which results of well-intentioned scientific research can be used for both good and harmful purposes give rise to what is now widely known as the "dual-use dilemma." Debate has been growing about the dual-use nature of life science research with implications for creating biological weapons.

Since late 2003, H5N1 viruses have infected at least 600 humans, mostly in Asia, and killed more than half of those infected. But the virus, which can be acquired through close contact with domestic fowl, does not easily transmit from human to human, a phenomenon that led some scientists to believe H5N1 posed little threat as a potential agent for a global flu pandemic.

In May 2012, the British science journal *Nature* published a controversial study arguing that the deadly avian H5N1 influenza virus could become transmissible from person to person if it were engineered to do so<sup>2)</sup>. Research on this was led by Y. Kawaoka, a professor at the University of Tokyo and the University of Wisconsin-Madison. The U.S. government tried to block publication of these findings, fearing a terrorist group might use the information to create a biological weapon.

The published study said that laboratory-modified bird-human flu hybrid virus could become transmissible in an animal model for human infection with just a handful of mutations. Because in nature flu viruses are constantly changing as they circulate and easily swap genes with other flu viruses, the possibility of circulating H5N1 viruses became a much bigger threat to human health.

A voluntary 60-day hiatus in avian H5N1 influenza virus transmission research was announced in January 2012 by the international community of scientists who work on influenza, to provide time to explain such work's benefits and its risk mitigation measures. The pause provided time for organizations and governments around the world to find best solutions for opportunities and challenges that stemmed from

the work. Since the hiatus in H5N1 virus transmission studies began, international organizations and governments have reviewed biosafety and biosecurity required for this research. Some governments have implemented new policies or regulations (e.g., the U.S. Government Policy for Oversight of Life Sciences dual-use research of concern).

#### **The Japanese special situation in dual-use science and technology research**

The Science Council of Japan (SCJ) was established in 1949, to reflect on scientific research's effects in the nation's administration, industries, and people's lives. Despite its position as a special organization under the Cabinet Office, it conducts its mission independently. Its 210 members represent some 840,000 researchers in such fields as natural science, engineering, social science, and the humanities.

The SCJ has adopted a statement and a report that calls on universities and other organizations to regulate research that could be used for military purposes to "establish a system to examine the appropriateness of the research from technological and ethical viewpoints." The report raises the important point that for scientists to control how their research results will be used is difficult. It notes that since scientists cannot completely control their research's "exit," they must judge carefully at its "entrance." Depending on their content, research projects will be halted or modified during the process of such examinations. The SCJ's opinion has no binding power, but the call itself to examine research content has a chilling effect on researchers.

Reflecting on scientists' roles in World War II, the SCJ issued statements in 1950 and 1967. In 1950, reflecting on Japanese scientists' past cooperation with government war efforts, it declared "firm determination" that scientists in Japan will never engage in research projects designed to achieve military purposes. In 1967, it renewed this resolve by issuing a new statement, following a revelation that the U.S. military had provided funds to the Physical Society of Japan to help it hold an international conference the previous year. The SCJ plans to continue in this spirit.

Discussions were spurred by the spread of dual-use technologies that can be used for both military and civilian purposes, as well as by the launch of a Defense Ministry program to provide research funds to institutions for developing dual-use technologies. The ministry then has the right to use the research results. The budget set aside for the Defense Ministry program has rapidly increased since its launch, doubling from ¥300 million (\$2.7 million) in 2015, to ¥600 million (\$5.4 million) in 2016. The fiscal 2017 budget now before the Diet features ¥11 billion (\$100 million) in such funds.

SCJ members' views on the issue are mixed. Opinions calling for changing or dropping the vow against defense-related research were strong among natural science and engineering scholars. Despite dissenting opinions, the SCJ did not discuss modifications. SCJ chief Prof. T. Onishi himself is facing criticism for his position that appears to contradict the statement and report's cautious stance. A researcher at his university successfully applied for the Defense Ministry program in 2015, proposing to develop a gas mask. Prof. T. Onishi finds nothing wrong with that because a gas mask is not an offensive weapon and can also be used to protect workers at chemical plants in case of accidents.

#### **The U.S. military's widespread provision of funds to Japanese researchers**

The SCJ has made clear its rejection of participation in military research, but has failed to deliberate a related and significant issue: the U.S. military's widespread provision of funds to Japanese researchers. The latest revelations by a newspaper investigation<sup>4)</sup> that Japanese researchers are accepting funding from the U.S. military watered down those important arguments.



The United States Air Force provided funds totaling at least ¥800 million (\$7.3 million) to 128 university researchers and others in Japan over 6 years, beginning in fiscal 2010.

Receiving funds from the U.S. military constitutes no legal problem. But in 1967, the SCJ issued a statement banning military research after revelations that some researchers and academic societies had received funds from the U.S. military. Those professors and others who have received such funds have explained that their research was not military, that it was conducted for peaceful purposes. But there remains the possibility of the U.S. military using such research results for military purposes.

The fields of research conducted by Japanese professors included artificial intelligence (AI) and laser technology. In its technological strategy released in 2014, the U.S. Department of Defense said it would attach importance to autonomous systems leading to unmanned weapons equipped with AI. The laser technology on which Japanese researchers conducted studies overlaps with fields to which the U.S. military attaches importance as technology for future weapons because it leads to development of new weapons to replace bombshells and missiles.

#### How is the US coping with dual use?

America has the strongest military power in the world, and military and related research is actively and vigorously conducted to maintain that power. Therefore, their worries about dual use concern exclusively life science (e.g., a modified virus of H5N1). In early 2017, at the National Academy of Science meeting, researchers discussed the spread of dual-use research's findings and methods, and who should be responsible for controlling their dispersal<sup>5</sup>). The following options were considered:

- Subjecting biology research to security classifications, even in part.
- Relying on scientists to control their own communications responsibly.
- Export controls, of the type used by the Australia Group with its concerns about military/civilian dual-use of chemicals. The Australia Group is a collection of 42 nations that together agree to control export of certain materials to countries that might use them to create chemical weapons.

#### Discussion

In a survey of Japanese students, respondents supporting research in technologies that can be used for military purposes outnumbered opponents. The most popular reason cited by supporters was that avoiding research in technologies with potential military applications would hamper research for civilian purposes. To be sure, in this day and age, clearly discerning in the first place whether scientific technology can be used for military purposes is difficult.

Rocket and missile technologies have no great difference. Computer and Internet technologies constitute military systems' mainstay. The Global Positioning System, with its origins at the heart of U.S. military technology, has been used for car navigation systems, observations of earthquakes and volcanic eruptions, and self-driving technology.

Many forms of technology have dual uses, that is, they apply to both military and civilian purposes. Narrowing research activities' scope just because of possible military use could inevitably lead to decline in Japan's technological strength.

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Authorship is an important sign to the researchers, the scientific community, institutions and funding agencies for recognition, evaluation, promotion and financial gains. Misattribution of authorship undermines the public trust, challenges the integrity publication and damages the prestige of the scientific community. According to International Committee for Medical Journal (ICMJ), authorship is justified by substantial contributions in conceiving the ideas of the research, designing the study, conducting the study, analysis the data, or drafting the manuscript. A study showed that of 44% of the articles among 18,41 manuscript published in *Lancet* did not meet the ICJME criteria of authorship. There are worldwide controversies on authorship based on criterion of "substantial" and "contribution". Can we consider authorship in return for providing main equipment or sampling of an unusual reagent or cell line as substantial contribution? Some assertion that these contributions do not permit authorship but warrant only an acknowledgment. Some have dilemma about how may author should be in author byline in a manuscript. Some justified as many as authors can be the authors in byline of manuscript. Other limit the number authorship into six. Ordering of authorship is another problem in publication. However, Multi-centers research study, Pharma industries and device Company have complicated the authorship criterion, who have not participated in conducting of research or in preparing the manuscript nevertheless appear as an author byline in the manuscript. In these case they appoint researcher on behalf of them. This phenomenon is harmful not only because it suppresses the contribution of authors but also bestow underserved credibility to "ghost"- authors. These questions need some core principles to answer for authorship. It is unfortunate that researcher has no comprehensive knowledge on authorship. Moreover, ethical principles and professional guidelines for authorship have not been delineated more clearly and in concise form. With the aim to decrease problems related to authorship this section focuses on principles to guide authorship-related decisions, practices, responsibilities and policies.

#### Explore the evolution of campus smoke and drug volunteer groups

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**Background:** On average it takes only nine months to start smoking from time to time to use drugs. Therefore, the prevention of drug, access to the campus for tobacco control is more important. Volunteers are informal staff can reduce the opposition between students and authority, more easily found in the campus of the hidden population, To carry out volunteer groups for the growth group, to strengthen its campus to prevent the vanguard of drugs

**Purpose:** The aim of this study is to explore the evolution of subjective feelings of campus volunteer groups in order to establish an effective training mode

**Methods:** This study was used convenience sampling. The subjects were 15 Campus volunteers in Kaohsiung City. Phenomenological method was used to analyze the quality data which was suggested by Cloazzi (1978). Purposive sampling was designed to collect data from Campus volunteers in South Taiwan. The participants were recruited and data was collected after granting the permission of IRB and informed consent was noticed.

**Result:** The result was showed there were three essential issued, which was " Breaking ice" 、 "Resonance" and "Deep plowing" was extracted from the quality data. The meaning of " Breaking ice " is to adjust the value of widening tolerance limit. The meaning of "Resonance" is adjusting the frequency and coming and going. The meaning of deep plowing refers to the maintenance of counseling and continuous learning.

**Conclusion:** The evolution of the volunteer growth group is a change in the attitude of the campus smokers. Because of the evolution of attitudes, the willingness of counselors of the volunteer groups will be deepened

### ***On the Moral Status of Maternal Somatic Support***

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Maternal somatic support after brain death occurs when a brain-dead patient is pregnant and her body is kept alive to deliver a fetus. The moral controversy cracks into two different extreme parties which one praised the worthiness on the dignity of dying mother and the other insists the rights to life of the unborn child. In other words, the moral status of the brain-dead mother and that of the fetus are of ethical question. This paper aims to resolve the conflicting point-of-views in the matter of maternal somatic support.

### ***ABA President's Lecture***

- Bangook Jun, ABA President

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### ***Special Lecture: AI and Next Medicine***

- Uhn Lee, Gachon University Gil Medical Center

### ***How to make a Korean Watson***

- Changrok Jeong, Department of Ethics Education, Teacher's College, Kyungpook National University

### ***The Fourth Industrial Revolution and Bioethics from the Perspective of Catholic Teaching***

- Jinil Choi, The Catholic University of Korea

### ***Seeing the Trans-Humanism through the Creation of Christian Theology: related to the Createdness (as Passive Form)***

- Kan-Pyo Lee, Incheon National University, Institute of General Education

### ***Buddhist Interpretation of the Boundary Between Life and Death - Focused on Human Life and Desires***

-Hwan-Ki Ahn, Seoul University of Buddhism

This paper aims to examine the change of the boundary between life and death due to advances in science and technology from a Buddhist viewpoint. Especially I focus on human life and desires. Today the development of medicine made us live healthier and longer. However, we also face many problems such as preparation for old age, environmental pollution and disconnection of communication. Modern civilization, the result of human desire, is beneficial to us, but leaves some difficulties to solve. At this point, I think it is necessary to scrutinize the human desire itself.

For this discussion, firstly, I examine the Buddhist interpretation that the life is formed from the desire. Secondly, I analyze the mechanization extending the realm of the life in view of human desire. Thirdly, I try to find the way in Buddhism to overcome the problems of a machine civilization. As part of that, I will analyze the Buddhist doctrines, the four wisdoms of true-suchness[四如實智] acquired through the four analytical inquiries and insights[四尋思觀]: a thorough and deep insight on 4 things, i.e. names or meanings[名], things or materials that originate from conditions[事], essence or self-nature[自性] and differences of things or ideas[差別]. Finally, I suggest that it is very important to see 'the real' correctly by controlling secular desires.

### ***Role of Religion in Bioethical Decision Making***

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Progress in science and technology in the 21<sup>st</sup> century gives human beings new power to change and control the developmental processes of all living species and the environment. One of the most salient technologies is modern biotechnology and GMOs. Although modern biotechnology holds many promises for the betterment of economy and improvement of people's lives, its "too rapid" advancement have become the object of doubts, fears, concerns and as well as an intense and divisive debate worldwide. The complexity of issues related to modern biotechnology making it difficult for people to decide whether to support the technology or vice versa. Much of the controversy associated with development in modern biotechnology and commercialization of modern biotechnology products such as GM foods has been the result of regulatory bodies failing to take account of the actual concerns of the public, which has fueled public distrust in the motives of regulators, science, and industry. There is a wide gap between how scientists and risk experts think about, define and evaluate risks compared to the lay public. The experts have lamented that the public reactions to scientific risk assessments as ignorance and irrational but researchers have shown that the public understanding of risk is driven by factors not taken into account by the experts. These are two very different starting points and not surprisingly, experts and consumers often rank the relative importance of various risks very differently. Scientists, in general, define risks in the language and procedures of science itself. They consider the nature of the harm that may occur, the probability that it will occur, and the number of people who may be affected. Most citizens, in contrast, seem less aware of the quantitative or probabilistic nature of a risk, and much more concerned with broader, qualitative attributes, such as whether the risk is voluntarily assumed, whether the risks and benefits are fairly distributed, whether the risk can be controlled by the individual, whether a risk is necessary and unavoidable or whether there are safer alternatives, whether the risk is familiar or exotic, whether the risk is natural or technological in origin, and so forth. According to the cultural approach of risk research, the evaluative process of risk perception is determined by the norms, value systems and cultural idiosyncrasies of societies or societal groups. The religious beliefs of many people do not allow unrestricted interference of life by means of genetic engineering. This paper will highlight the role of religion in bioethical decision making related to modern biotechnology.

### ***Principles of Biomedical Ethics in the Universal Concept of Islamic Religion***

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Bioethics is an interdisciplinary study of the problems posed by developments in biology and medicine and their impact on large society as well as its value system, present and future.

Society is always changing from time to time. Therefore, ethics becomes an important thing in the life of society. In interacting, ethics is used as a guide to do things for some reason. As more and more medical issues requiring this moral solution, secular medical ethics developed into a new discipline.

Medical bioethics is one of the special ethics and social ethics in medicine that satisfy the praxeological (practical) and moral (normative) norms that serve as a guideline (das sollen) as well as a reflective critical attitude (das sein), which is based on the four basic moral rules and their derivative rules (autonomy, beneficence, non-maleficence and justice). Initial understanding of basic moral rules is expected to be a provision for the doctors' reflective-analytic ability in order to constantly remind each other and to prevent deviations among members of the profession that will ultimately foster ethical responsibility in accordance with the morality of the medical profession.

The universal norm of general morality consists of a set of actual and worthy moral norms. Morality in this universal sense refers exclusively to the norm in the same morality. On the contrary, "morality" in the peculiar sense of society includes moral norms derived from certain cultural, religious and institutional sources.

In Islam, morality and ethics are absolute and are rooted in divinity. Human consensus that does not come from divine decisions cannot be a source of ethical guidance. All that humans do is apply moral and legal teachings into real life situations.

Law is the expression and practical manifestation of morality and is universal. Morality is wrapped in the term akhlaq means temperament, character or system of behavior that one made. Therefore, akhlaq (morals) can be good or bad, though sociologically in Indonesia, the word of akhlaq has a good connotation.

The universalism of Islam or the validity of Islamic teachings for all and for the whole world is a teaching accepted by Muslims as a creed. Talking about the teachings of Islam will not be separated from Islamic law. In general, the main source of Islamic law is the Qur'an, the holy book of Muslims. It is a source of Islamic teachings, occupying a central position not only in the Islamic sciences but also an inspiratory, guiding and integrating Muslim movements throughout the century. Therefore Islam considers medical ethics to be the same as ethics on other aspects of life.

There are many verses in the Qur'an that describe the concept of Biomedical Ethics and are in line with these principles. It is appropriate to make them a moral foundation in maintaining professional behavior so that doctors remain a noble profession in the future.

### ***Reframing Ethics Course for Science Students via Problem-Based Learning (PBL) and the use of a Cultural Matrix: A Case Study***

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Ethics courses have been developed for the medical and engineering profession but none have been developed as a stand-alone course for the science profession. This paper explores the development of an ethics course and effectiveness of the Problem-Based Learning (PBL) method to teach ethics for science undergraduates of Faculty of Science, University of Malaya. The course content is centrally based on the discipline of ethics, which primarily utilizes the application of basic ethical theories such as utilitarianism and deontology, four

principles autonomy, beneficence, non-maleficence and justice, as well as Mertonian norms in any ethical dispute. Scientific research involving human and animal subjects, in particular, would entail the use of these theories and principles. Various issues such as unethical research and publication, laboratories safety and risks as well as animal and environmental ethics were given to students as case studies. A value-added ethics learning session is provided for science undergraduates, which consists of the application of ethical theories and principles with a reflection of inherent religious value systems. Lesson plans are enhanced through the employment of an expanded ethical matrix. The use of the matrix develops a structured and contextual tool for students that assist decision-making. The decision will later be assessed through harm test, faith test, professional test and publicity test and be presented in the form of poster presentation. The study was carried out throughout three semesters and the data was retrieved from the students' online survey called Course and Teaching Evaluation (CTES), in which it reflects students' evaluation and responses about the course. The outcome of this learner-centered program is an intense awareness of ethics and a reengagement of religious ethics, which enriches the Malaysian student's thinking about his or her responsibilities as a scientist.

### ***Nursing ethics research in Korea***

- Shinmi Kim, Department of Nursing, Changeon National University

### ***Ethical Education using a Computer Program***

- Eun-Jun Park, Department of Nursing, Konkuk University Glocal Campus

Ethical practice, as a nature of nursing, differentiates nursing from other sciences or techniques. It is challenging for nursing educators to foster nursing students to have competency for ethical decision-makings. Traditionally ethical vignettes have been utilized in nursing ethics courses to teach ethical values. However, vignettes in text have limitations to deliver reality, severity, or complexity of clinical dilemmas and different positions of relevant stakeholders. Nowadays computer simulations are widely adopted in education with high fidelity audio or video functions. Therefore, a case-based computer program was developed with seven clinical dilemmas using Integrated Ethical Decision-Making Model (IEDM) and Flash animation and tested for its effectiveness as a complementary tool in nursing ethics course.

A six-step IEDM includes (1) the identification of an ethical problem; (2) the collection of additional information to identify the problem and develop solutions; (3) the development of alternatives for analysis and comparison; (4) the selection of the best alternatives and justification; (5) the development of diverse, practical ways to implement ethical decisions and actions; and (6) the evaluation of effects and development of strategies to prevent a similar occurrence. Using a pre- and posttest comparison design between a computer group and a control group, (1) perceived ethical preparation to deal with ethical issues, (2) moral reasoning using the P (%) score, (3) analysis of hypothetical ethical cases in the pre- and post-test, and (4) satisfaction of ethics course in the post-test were evaluated. The computer program was effective not only for enhancing ethical competency of nursing students but also for provoking their curiosity and interest in learning ethics. Though, there are some challenges to utilize a computer program for training ethical decision-making: for example, there is insufficient knowledge of diverse cognitive or affective responses to ethical issues.

### ***The influencing factor of Consciousness of Biomedical Ethics, Moral Sensitivity and Critical Thinking Disposition on the Code***

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**Background:** Nurses who are working in clinical settings need to solve some bioethical ethical problems wisely in their working area with medical health personnel and keep their working according to the Code of ethics of nurses in Korea.

**Purpose:** This study was conducted to identify the influencing factors of consciousness of biomedical ethics, moral sensitivity and critical thinking disposition to Code of Ethics for nurse in nursing students.

**Method:** A descriptive correlation research design was used for this study. The subjects were 299 nursing students in two big cities from 1st June to 31st July 2015. Collected data was analyzed using t-test, ANOVA, Scheffe's test and stepwise multiple regression by SPSS 22.0 program.

**Result:** There are results of this study. Female subjects are 87% of subject on this study, mean age is 21.67 years. Awareness of Code of Ethics for nurse has a positive correlation of between the consciousness of biomedical ethics ( $p < .001$ ), moral sensitivity ( $p < .001$ ), critical thinking disposition ( $p < .001$ ). However there are negative correlations of between the grade ( $p = .017$ ), marital state ( $p = .012$ ), the possibility of increasing of ethical problem according to the development of bioscience ( $p = .012$ ). The influencing factor of the awareness of the Code of Ethics for nurses, there is significance in the grade ( $p = .013$ ), marital state ( $p = .030$ ), consciousness of biomedical ethics ( $p = .017$ ), moral sensitivity ( $p < .001$ ), critical thinking disposition ( $p = .001$ ), and power of explanation was 26%.

**Conclusion:** The results of this study show that the consciousness of biomedical ethics, moral sensitivity and critical thinking disposition are influencing factors in the ethics for nurses in nursing students.

### ***Institutional Care for the Elderly People in Bangladesh: A Challenge of Change***

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Elderly is a fast growing population group in the world. In this stage they become more vulnerable and destitute due to lack of proper attention of society, particularly in physical and mental health care. Globally, developed and developing countries are seeking better ways to provide the best care for elderly people and take initiative to formulate improved policies to ensure proper care. The Government of Bangladesh recently has become more aware of the elderly services but this is not enough for their nursing and caring. In this regard, ethics is a fundamental part of older care and socio-legal settings are significant factors for the protection of elderly people. Moreover, the living arrangement and the familial relationship are considered a major determinant of elderly care and well being. In the Bangladeshi society, there are two types of approaches to offer services for the elderly, family and institutional care. But, institutional care for the elderly in the country is still extremely limited. From both settings, they suffer from sufficient health and medical care, proper food and clothing, recreation and financial support. Unfortunately, there are no separate geriatrics departments for elderly care in both private and public hospitals all over the country. However, there is no statistics whether the elderly prefer live in institutions or in family and how far the family or institutions meet the needs of the elderly. This has remained as an important question in the field of elderly care. Thus, elderly population presents considerable challenges to governments and the society to provide innovative and efficient ways to deliver essential care and facilities. In this backdrop, this paper attempts to analyze the present institutional care services and challenges whether it is sufficient for the elderly people in Bangladesh.

### **The well-established cultural identification in East**

### **Asia -Truth Telling to Terminal Cancer Patients: As analysis on willingness survey of in Japan, South Korea, and China**

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The students were asked whether they want to be informed their own disease, and whether they want their family to be informed of truth in hypothetical situation that respondents or their family had a cancer. Relatively high proportion of students in South Korea, especially female students want their family member not to be informed of the truth. The differences may be attributed to the degree of solidarity in a family or bond-age of family traditional Japanese ethics. We conducted two questionnaire surveys for university students in South Korea (Maruyama 2006), and in Japan and China (Maruyama 2008).

### ***Environmental protection as an ethical requirement for community health***

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Environmental ethics and sustainable development are inexorably bound together as the decline of environmental conditions affect the population health resulting in increase the morbidity and mortality rates. The objective of this paper is to analyze the different factors contributing to environmental protection identifying the roles and responsibility of government, community and individuals. The methodology used is a literature review and critical analysis showing the environmental factors affecting community health, the socioeconomic conditions and quality of life and the responsibilities for protection of the environment. The different strategies for environmental protection are outlined in this paper. The conclusions of the study is that the main threats to the world health, to stability and even to mankind's existence itself comes from the synergetic interaction of the following three factors: poverty, population and environment. The study recommended the application of some strategies for better environmental protection such as policy, changing organization behavior, education protection, and promoting community educator and strengthen individual knowledge and skills.

## **POSTERS**

### ***Social aspects of ethics***

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Recently, it was reported that US lawmakers have banned the issuance of patents for human cloning, which implies the inadmissibility of issuing a patent for the replication of a living person. And there are a lot of such examples of using scientific and technical progress for the "good" of mankind. The question arises, should everything be technically possible? Where is the line through which it is not permissible to step over and how should we regulate or control such experiments (including the transfer of information, socio-economic relations) from the ethical point of view?

In the same place, new sciences appear, such as: sectorial ethics, biological ethics, Nano ethics, ethics in the media... The society needs to regulate these disciplines, which implies the development and establishment of generally accepted measures and standards. Thus, we need laws based on ethical principles to prevent the emergence of a "new" specialist with deviations from human and ethical norms.

In history, there are examples when industry experts (doctors, technologists, scientists) worked in concert with politicians. The ugliest face of this cooperation is the massacre

of millions as a result of the movement of the Nazi eugenics "for the purity of the nation", the exploitation of other peoples, seizure and aggression for the sake of building up their economies, conducting scientific experiments on living people. Discussions on ethics began then at the Nuremberg Trials, when the truth about the terrible deeds of Nazi specialists became known to shocked humanity.

An important aspect of raising the consciousness of society on ethics is a long education, from schools to universities. In our opinion, training programs should include such topics for discussion and teaching as the ethics of advanced technology (information and communication technologies - ICT, nanotechnology, biotechnology), ethics in economics and development (equality, access, environmental responsibility) and ethics of intellectual property (Use of development, copyright protection, principles of duplication, traditional property).

For example, when studying a discipline such as Ethics in Economics and Development, there should be a section containing ethical themes derived from the process of social and economic change, called "development", and usually correlated with modernization. Relevant topics should include the dynamics of technology transfer, environmental sustainability, gender and law, exploitation and inequality.

When studying the course "Information Technologies in Economics" there should be a section "Ethics of Information and Communication Technologies (ICT)". So, this is justified by the fact that in the countries with a transition or developing economy, which is Tajikistan, the most notable problem regarding ICT is the "digital division". That is, the inequality in access to information and communication nodes through technologies such as the Internet.

The progress of science, undoubtedly, is not only impossible to stop, but it is senseless. The challenge is to follow ethical principles, take control of newly developed methods and technologies as soon as they have reached the experimental stage, and also before they become the subject of commerce.

### ***An intervention for improving the informed consent process in trauma patients undergoing the surgery of debridement***

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**Background:** Transnational marriages are already very popular in Taiwan. The number of new immigrant's pregnant women has increased rapidly. The children of new immigrants in Taiwan have a direct impact on Taiwan's future. Therefore, it's very important to construct a physical and mental health care program for new immigrants pregnant women, from prenatal to postpartum physical care and care for newborns. In the promotion and implementation "Humanity oriented" and into the "Different culture", to strengthen human rights, to enhance physical and mental health and welfare to promote the work.

**Purposes:** 1) Constructing Cognitive Groups of new immigrants pregnant women; 2) Explore the effectiveness of cognitive groups.

**Methods:** This study used convenience sampling. The subjects were 36 new immigrants pregnant women in Kaohsiung City. Evaluate before and after participating in cognitive groups. In addition to the descriptive analysis of statistical methods, also using the t-test set to participants.

**Result:** After the cognitive group, the physical and mental care can be significantly improved from 85.33% to 97.59%, the t-test  $p = .001$ , showing significant differences in the course of intervention.

### ***Ethical framework for public health emergency: reflecting MERS outbreak in Korea***

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In a public health emergency occurring due to an epidemic or pandemic situation, population-oriented public health policies and programs have raised various ethical issues. In the 2015 MERS incident in Korea, several ethical issues were faced because there were no prepared ethical principles of public health to aid the situation. Thus, this study focused on defining the ethical framework in public health that suite our context. The important values were identified for each of the 4 stakeholders, namely individuals, groups, public agencies, and experts, during an outbreak causing a public health emergency, and the important ethical principles were derived. Preparedness for a public health emergency and appropriate compensations based on reciprocity should be considered as a key point for all 4 stakeholders. The principles outlined in this study can contribute to establishing public health policies and decision-making in the next public health emergency.

### ***Cross Cultural Issues in Prenatal Testing***

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Among the industrialized countries, the frequency of women taking prenatal testing is the lowest in Japan (3-4%). Such a low percentage has been partly attributed to the availability and knowledge of the testing. Most other countries offering testing, a higher proportion of women take these exams since offering all prenatal tests has become a standard of care. The purpose of this presentation is to explore the reasons and social implications of this difference through a case of a 35-year-old Japanese woman, who had a prenatal check in the U.S. and unexpectedly found that the fetus had a sex chromosome condition XXY (Klinefelter Syndrome). Her impression of the test was screening for Down Syndrome and was also surprised to find the sex of her fetus. Skipping her referral to a genetic counselor, she returned to Japan. After meeting with an obstetrician and pediatrician, she decided against diagnostic tests and continued the pregnancy. Autonomous decision-making is difficult when faced with multiple choices and especially for those whose culture has negative and unclear images associated with words like "counseling," and "genetics." The degree of availability and use of the prenatal testing technologies has a profound impact on the perception of pregnancy and the future child. These are reflected in Japanese guidelines and practice, though they are based on the availability of the testing in the West. With increasing medical tourism around the globe, medical professionals need to be better prepared to offer routine testing to women from another country.

### ***Ethical Issues Surrounding Non-Invasive Prenatal Testing in Japan: a Content Analysis of Newspapers***

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**Introduction:** Non-invasive prenatal testing (NIPT) is designed to screen for Down syndrome (trisomy 21), trisomy 13, trisomy 18, and sex chromosomal aneuploidies. Clinical research on NIPT, which aims to evaluate genetic counseling, was launched in April 2013 in Japan. Seventy-six facilities have been certified to provide NIPT to pregnant women and their partners. There are, however, some ethical problems with NIPT (Nuffield Council on Bioethics, 2017). For example, parents with positive NIPT results need to undergo the amniotic fluid test if they want to obtain a definite diagnosis. These ethical issues have not been openly discussed, despite that NIPT has

been documented by Japanese newspapers from the time the above-mentioned clinical research was launched.

**Objective:** This study aimed to investigate the variety and frequency of ethical issues surrounding NIPT reported in Japanese newspapers.

**Methods:** We conducted a traditional content analysis of four major newspapers in Japan: *Asahi Shimbun*, *Mainichi Shimbun*, *Nihon Keizai Shimbun*, and *Yomiuri Shimbun*. First, we searched articles referring to NIPT in each newspaper archive using the term "prenatal testing," not "non-invasive prenatal testing," to identify all relevant articles. Second, we categorized ethical issues surrounding NIPT based on a pilot analysis of newspapers and discussions of categories. Ethical issues identified were divided into four main categories based on a time series of screening programs:

**Results:** Seventeen categories were identified. <<Ethical issues before undergoing screening tests>> included the following three categories: <appropriateness of genetic counseling>, <autonomy of the decision-making process>, and <unequal accessibility to screening tests>. <<Ethical issues from the time of screening to diagnosis>> included four categories: <miscommunication of screening test results>, <securing the option to refuse receiving the results after screening tests>, <quality control of screening programs>, and <decision-making about pregnancy continuation before diagnosis>. <<Ethical issues after diagnosis>> concerning true positive results included <decision to continue or terminate pregnancy after diagnosis>, <decision-making process of pregnancy continuation or termination after diagnosis>, and <psychological burden of parents>. <<Ethical issues after diagnosis>> concerning false-positive results included <psychological burden of parents> and <necessity of invasive tests (amniocentesis) for diagnosis>. <<Ethical issues after diagnosis>> concerning false-negative results included <psychological burden of parents>. <<Ethical issues through all processes of screening programs>> included <stigma with undergoing screening tests>, <psychological burden of people with Down syndrome, trisomy 13, and trisomy 18>, and <possibility of financial burden for implementing screening programs>. Major Japanese newspapers frequently reported ethical issues on <decision to continue or terminate pregnancy after diagnosis> and <appropriateness of genetic counseling>. On the other hand, ethical issues such as <unequal accessibility to screening tests> and <the possibility of financial burden for implementing screening programs> were rarely reported.

**Conclusion:** Frequency of reports pertaining to each category of ethical issues reflects medical, legal, and social situations surrounding NIPT in Japan. Less reported ethical issues should also be brought to light.

### ***From Taiwan to Vietnam, the Regional Communication, Collaboration, and Prospect-Experiences from Kaohsiung Municipal Kai-Syuan Psychiatric Hospital***

- Shu-Hui Wang, Dian-Jeng Li, Ming-Chou Li and Cheng-Chung Chen, Kaohsiung Municipal Kai-Syuan Psychiatric Hospital

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Our hospital provided experiences and discussed with staff from psychiatric hospitals in Vietnam, including treatment of patients, rehabilitation of patients, and outreach service from hospital to communities, social security network for severely ill patients, and organization of medical settings. Furthermore, we visited our collaborated hospitals in Vietnam to deepen the communication and give our feedback. To date, we had successfully interacted with specialists from Khánh Hòa hospitals, Đà Nẵng hospitals, Xuân Dũ hospital, Hanoi First hospital, and general hospitals in Nha Trang. Moreover, some hospitals had signed Memorandum of Understanding with us

for advanced training and cooperation. The focuses of communication are listed as following:

**Promotion of concept of mental health:** In Vietnam, stigmatization of psychiatric disorders continued to be the burden for patients and family. We visited local health department and discussed with experts and supervisors of mental health. We shared our experiences of de-stigmatization to publics, including publishing newsletters (The Communication of Kai-Syuan hospital), submission articles or giving talks on all kinds of social media routinely. We also psycho-educated the importance of timely medical intervention for better treatment outcome.

**Ethics and politics of mental health:** As the pioneer to establish Mental Health Act among East Asia, we discussed with staffs of psychiatric service about the progress, sameness and differences of policies on mental health between countries. We presented the intervention of involuntary community therapy in our Mental Health Acts, which was legislated firstly among Southeast Asia Countries. We shared the advantages and difficulties during clinical practice under the current policies.

**Community psychiatry and Kai-Syuan model:** We had worked hard to strengthen our psychiatric service into the communities. The Kai-Syuan model of community therapy includes preparation before discharged from acute or chronic ward, day-care wards, halfway house and community rehabilitation center. The Qualified Community Service Program was built on 2016 to serve patient missing the follow up after discharged from our hospital. We aimed to help psychiatric patients go back to society gradually with basically social-economical functions

**Organization of systems among doctors, nurses, rehabilitation therapists and occupational therapists:** We shared our organization on different departments of employees in comparison with those in Vietnam. We hoped to interact the sameness and differences between countries to improve the systems.

To sum up, we hope to extend and deepen the collaboration with other psychiatric service/hospital at Southeast Asia. The current project could also promote cultural and religious communication between countries.

### ***The Effect of Cognitive group on physical and mental care and Newborns Care on New Immigrant's Pregnant Women***

- Ying-Se Kuo (Chief), Shu-Fang Su, Joh-Jone Huang, Yin-Ju Huang, Kaohsiung Municipal Government Health Bureau, Taiwan

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Good maternal and child health is related to the overall health of a country, so it is necessary to promote the physical and mental health care programs for new immigrants pregnant women. The results show that cognitive groups can care for the physical and mental health of new immigrants pregnant women and provide a healthy and healthy environment for the next generation of children of new immigrants in Taiwan.

### ***Effectiveness of Mindfulness-based Stress Reduction Program for Trauma experience of the government officials in Taiwan***

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**Background:** Traumatic events have a great influence. If the supervisor can not cope with the traumatic situation, it will affect the department's morale and work efficiency. Mindfulness-based Stress Reduction Program (MBSR) can



enhance self-awareness through experiential activities, learn self-care, and deliver positive warm energy care around staff.

**Purposes:** 1. Constructing Mindfulness-based Stress Reduction Program for Trauma experience of the government officials. 2. Explore the effectiveness of Mindfulness-based Stress Reduction Program.

**Methods:** This study was used convenience sampling. The subjects were 26 government officials in Kaohsiung Municipal Government Health Bureau. The the Cognitive, Attitude, Behavioral (questionnaire KAPQ) (Expert validity.96)., and qualitative interviews were used as assessment tools

**Results:** Quantitative research results show: the overall satisfaction was 6.46 ( $\pm$  0.65) to 6.84( $\pm$  0.11)  $t=4.24$   $p=.000$ , The KAP scale results showed:(1)the cognitive was 5.46 ( $\pm$  1.53) to 6.67 ( $\pm$ .52)  $t=3.29$   $p=.003$ , (2)the attitude was 6.31 ( $\pm$  0.84) to 6.83 ( $\pm$ .41)  $t=2.25$   $p=.039$ , (3)the behavior was 6.27 ( $\pm$  0.78) to 6.90 ( $\pm$ .10)  $t=4.79$   $p=.000$ , showing significant differences. The Qualitative research results show :Change the turning point (1) The practice of life (2)The baptism of time(3)The urgency of demand.

**Conclusion:** The results show that members of MBSR Program are consciously able to assist in mental health and execution.

### ***Swinging between Destigmatization and Demonization: Social Perspective of Psychotic Disorder on Taiwanese Mass Media***

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Previous studies have suggested that that common association of psychotic disorder with crime in many articles in the mass media is one contributing factor to discrimination and stigmatization of schizophrenia. However, there have been no comprehensive studies exploring the mass media portrayal of psychotic disorder in Taiwan. A quantitative content analysis was performed to investigate prevalence of stigma-related contents in four of the most read online news media in Taiwan. We used text mining to draw wordcloud and categorize the text into stigma frames and stigma-challenge frames. We also examined the relationship between different media framing and the spreading and impact of the news. We associated the trend of stigma framing to the milestone of human rights protection and destigmatization movement. The results showed some nonuniformity and may provide us a chance to re-exam our current strategies of reducing stigma. From our result, we also suggest that the socio-economic factor of psychotic disorder and did not receive adequate attention. Debate on the priority between human rights and social security was another important ongoing issue. We suggest that experts of mental health should work in cooperation with media professional in order to provide the accurate and complete picture of mental health in social and cultural backgrounds.

Mass media shapes our perspective toward public issue and may affect mental health-related stigma. Previous studies showed destigmatization movement and public psychoeducation about stigma might result in the improvement of quality of life for patient suffered from psychotic disorder. Thus, understanding the trend and interactive opinion formation of mass media is critical for policy making of public health.

In Taiwan, as in other Eastern Asian countries such as Japan and Korea, the name of schizophrenia was changed in order to reduce stigma. The medical term of schizophrenia was officially revised in 2014 from "Jing-Shen-Fen-Lie-Zheng" (mind-split disorder) to "Si-Jue-Shi-Diao-Zheng"(dysregulation of thought and perception disorder). Meanwhile, the legislation reform of Taiwan Mental Health Act in 2007 and Habeas Corpus Act in 2014 highlighted human rights protection as the common

value in clinical practice. However, negative comment or implication from mass media and debate on broadening practices of compulsory psychiatric admission reappeared after several episodes of indiscriminate killing recently. The clinical practice of forensic psychiatry or community model of recovery was also called into question in some mass media.

### ***Management Ethics for Developing International Partnership in Mental Health Arena: Vietnam as an example***

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Professional competence and ethics are always major concerns for the international mental health collaborations. Such concerns are essential professional reflections on the rights of the mental ill patients. However, professional manpower shortages as well as limited resource allocations are inevitable barriers in such collaborations. We therefore propose management competence and ethics are nonetheless important, as comparing to professional competence and ethics. A participatory action approach between mental hospitals in Taiwan and Vietnam has been taken. With management supports, service oriented approach are adopted to replace the approaches on professional training. Patient-center considerations are the essential part in such paradigm shift. While contextual features predominating the international mental health collaborations, we find that management competences and ethics are very important as professional competence and ethics. Contextually sensitive holistic approach is far more important in all efforts attempt to reduce mental health gaps.

Kai-Syuan Psychiatric Hospital (KSPH) has had a longtime relationship with the Psychiatric Hospitals in the Southeast countries since 2010. Vietnam can be a very practical example for the detail description:

According to the MOU between KSPH and the three Vietnamese hospitals, the Vietnamese hospital's trainees have been invited to KSPH for a short-term training course for the psychiatric medical nursing and occupational therapy programs. Since 2015, KSPH dispatches the work team including the medical doctors, nursing/OT staff and administrative members to Vietnam periodically (in six months span) to review/feedback the training effect if the trainees can expand their works practically as on sit visiting and discussion. In response to the request from Ching-Ho Psychiatric and General Hospital, KSPH's Ms. Shu-Hui Wang (Planning Office Chief) was invited to Vietnam on March 2017 to lecture the SWOT analysis and BSC (Balance Score Card) techniques which will be used for them to establish the future short/medium/long-range targets of their hospitals. The one-day course for nearly 100 trainees (including the top-level superintendent) covers the theory introduction and the two-way communications, and the afternoon's activities of the group discussions and presentations actually agglomerate their common consensus. Due to the enthusiastic response and the necessary demand, a follow-up invitation for Ms. Wang can be expected in the coming days include the assessments and discussions.

KSPH, as a hospital with the specialized field, has been working together with the Vietnamese Psychiatric Hospital in the application of the nursing and occupational therapy program as well as the start of a new business model for their good future.

### ***A Study on the Taiwan Patient's Autonomy Right Act***

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In the CASE of LAMBERT AND OTHERS v. FRANCE (2014), the European Court of Human Rights argued that restoring the patient's life to a natural state of death didn't violate the State's obligation to protect the right to life.

The Taiwan Patient's Autonomy Act was enforced in June 2019, which was not euthanasia or suicide bill. One purpose of the Act is to implement the patient's will, the other one is to protect the physician. Through the clear legal basis for the protection, the physician performed the pre-medical plan and kept civil liability from arising. In the criminal law, also to avoid criminal liability. So as to solve the case of patients who do not comply with the Medical Mitigation Act and comply with the provisions of Article 14 of that Act, and then restored their life to natural death, rather than the soul being detained under the living body.

However, this Act still faced several controversial issues: First, is the right of patient autonomy or others? Second, "Medical Appointment Agent" has the authority to act positively or negatively? Third, some concepts are too vague, such as severe dementia or patient suffering unbearable, etc. Fourth, "lack of the mechanism to confirm by third party about the will of the patient. This article will explore from the perspective of medical appointment agent has positive or negative authority, and make some suggestions.

#### **Review for studies dealing with ethical aspects in cancer clinical trials published in Korea**

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To our regret, there have been few recent studies about ethical issue of cancer patients participating in clinical trials. When the investigators conduct clinical trials related to cancer patient, it is very important to obtain the informed consent properly for specificity of cancer patients. In the process of obtaining consent, it is needed that the subject could exercise self-determination with voluntariness and the informer consent form contains sufficient information. Furthermore, more research about ethical issue in the clinical trial for cancer patients needs to be done.

According to government figures announced by Ministry of Health and Welfare, the number of cancer cases in Korea has reached 210,000 in 2014. It is a significant increase compared to 180,000 in 2004. Since 2000, the introduction of the bridging study system has enabled the approval of new drugs through various clinical trials, and the clinical trial market has expanded rapidly in Korea. In the case of clinical trial for terminal cancer patients who have limitations in conventional treatments, there are important decision-making questions about whether to participate in the trial that can be the last resort, or to finish the life without pain induced by the intervention. Because of the nature of cancer, treatment and clinical trials are recognized as the same concept. Therefore, it is difficult to obtain sufficient information and understanding from patients when obtaining consent for clinical trials. The autonomy of patient decision-making in the hope of the last opportunity for treatment and the choice of palliative care should be more ethically protected. Therefore, we reviewed the literature dealing with ethical aspects in cancer clinical trials published in Korea to grasp the current situations. The database such as Research Information Sharing Service (RISS), KISS (Korean Studies Information Service System), NDSL (National Digital Science Library), Data Base Pia (DBPia), and National Assembly Library, Oriental Medicine Advanced Searching Integrated System (OASIS) was used. We used the

search term such as 'cancer', 'clinical trial', and 'ethics'. There were 9 studies in total; 4 cases of RISS, 2 of KISS, 3 of NDSL. We excluded 2 studies unrelated with ethical issue by reviewing the full text. Two studies were published before 2000 and five were after 2000. Only two studies were published within the last 5 years. One study was published in the journal of medical law. Most of the researches used the questionnaires, and there was a study conducting both qualitative and quantitative studies. A legal paper discussed precedents and legal principles. All seven articles focused on the informed consent received during clinical trials and the contexts varied. One study analyzed objective and subjective perception of informed consent and proposed the policy. The other study focused on voluntariness when the investigator obtained consent from subject. So, the author examined the difficulty of informed consent form and analyzed the consent process. In addition to these substances, the contents were various as follows: investigating the subject's overall awareness about the clinical trial and consent, analyzing the necessity and problem of consent, and taking self-determination.

#### **The actual situation of providing education/training programs for Research Ethics Committee members in Japan**

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Currently, there are more than 1,800 institutional Research Ethics Committees (RECs) in Japan. As cases of research fraud have increasingly been coming to light since the 2010s, quality enhancement of reviewing at the REC has become an agenda. The government has, therefore, undertaken initiatives to rectify this, such as establishing an accreditation system for the REC.

In order to raise the quality of reviewing, it is important to provide education/training opportunities to REC members so that they can fully understand the roles of each position, such as an expert in the field of natural science, expert in the fields of human/social sciences or a person with a general background, and conduct appropriate reviews.

Since 2015, Japanese ethical guidelines that regulate medical studies involving humans have been strictly imposed, and each REC member is required to attend education/training programs at least once a year. The guidelines also obligate universities and other institutions where RECs have been established to take measures to ensure the participation of REC members to education/training programs.

There are, however, no particular provisions regarding the contents and methods of imparting education/training. These programs are therefore diverse in terms of their methods: some institutions conduct original education/training programs, some use e-learning programs for researchers created by external organizations, some just provide the information of seminar conducted by external organizations, and some only distribute books and materials related to research ethics to the members.

From our survey, we found that most universities and other institutions provide education/training opportunities to their REC members no more than three times a year. Reasons for such circumstances are that it is not easy for REC secretariats to secure resources, manpower, and time for conducting education/training programs.

In order to improve the quality of ethical reviewing, the following points are pragmatically important: (1) to provide education/training programs on a regular basis, such as more than four times in a year, to REC members, (2) to hold discussions for REC members in order to deepen their understanding, (3) to not overburden the secretariat of the REC, and also (4) to not overburden the REC members.

From these points, we believe that educational programs that can be conducted before or after the reviewing meeting are necessary for providing education on a regular basis. However, there are no such programs in Japan. Therefore, since FY 2016, we have been developing video educational programs for REC members and offering these free of charge on the website <http://rec-education.org/>. We have more than 130 registered members.

In this presentation, we would like to demonstrate the actual situation of providing education/training for REC members and then extract the problems specific to Japan. We would also like to introduce the video educational programs we have developed.

**Objective:** This study is an attempt to determine whether educational videos are superior to conventional discussion for informing trauma patients undergoing surgeries about the procedure, benefits, risks, alternatives, and postoperative care.

**Methods:** Audiovisual videos including information about the procedure, benefits, risks, alternatives, and postoperative care for the surgery of debridement were developed and applied. A prospective randomized controlled trial was conducted, and all trauma patients meeting the study interest scheduled to receive the surgery of debridement in the emergency department were included. Patients were assigned to the video group, in which patients watched an educational video illustrating the surgery of debridement, in terms of the procedure and its benefits, risks, alternatives, and postoperative care, or to the control group, in which patients had conventional discussion and received information from their surgeon. A knowledge test and questions evaluating satisfaction with the process of informed consent were completed by the participants after their educational sessions. Primary outcomes were to evaluate whether the educational videos were superior to conventional discussion for informing patients. Secondary outcomes were compared to assess the patients' satisfactions and refusals to sign consent.

**Results:** A total of 185 adult patients were solicited to participate during the seven-month study period. One hundred and forty-nine of the 185 patients were enrolled in the study when research associates were available. Of these, one declined and six were excluded owing to clinical instability. One hundred and forty-two patients were enrolled, and 70 were assigned to the video group and 72 to the control group. Mean scores of knowledge test were higher in the video group in comparison with conventional discussion. Patients in the video group had greater satisfaction than patients in the conventional discussion group. No patient refused to sign consent to receive the surgery of debridement.

**Conclusions:** Using educational videos are a good tool for improving informed consent process for surgery in trauma patients. Video-assisted informed consent may improve patient understanding of the surgery and satisfaction with the process of informed consent in trauma patients undergoing the surgery of debridement. Future studies are recommended to accord with the results of these precursory findings and explored among trauma patients with different types of injuries and severities.

### ***The Complex fiduciary relationship model - a normatively reasonable and practically fit Doctor-Patient Relationship***

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The Doctor-Patient Relationship (DPR) traditionally started with the paternalistic relationship model, which doctors authoritatively intervene over patients. However, as the importance of human rights emerged in the 1970s, movements for patient rights began, and a shift to the contractual model was made. The contractual model, which has been a popular

model that explains the current DPR, establishes an equal partnership by informed consent. Meanwhile, medical essentialism emphasizes that the goal of medicine is to promote patients' health, but this view might easily be overlooked by the caveat of the contractual model. From acknowledging this weakness, the fiduciary relationship model was first introduced. It concerns innate asymmetrical relationship between doctors and patients. Patients trust their doctors and give them a discretionary power and, in return, the doctors promote the best interests of their patients.

Among the three models, the fiduciary relationship model seems to be the most fitting model to account for the DPR. This model is able to secure both patients' interest and autonomy by recognizing patients' authority to devolve discretion to doctors. On the other hand, the paternalistic relationship can only recognize doctor's authority while ignoring patients' autonomy. And the contractual relationship fails to embrace the goal of medicine from giving too much emphasis on the equal status between doctors and patients.

In this paper, we introduce the complex fiduciary relationship model; a refined version of the current fiduciary model for the DPR. It is similar to the previous fiduciary relationship in that patients put their trust in their doctors thereby giving them discretionary power, and in return doctors take up a duty to protect the patients' health with the best of their judgment. In addition to the shared foundation and features, the model has three new major aspects that distinguish it from the current fiduciary model. First, the level of doctor's discretionary power varies depending on patients' condition and situation. Doctors' discretionary power over patients is determined by level of contributions doctors can make on patients' health. Second, the complex fiduciary relationship understands the DPR to be a subset of general human interactions, thus it should reflect universal values and common sense found on such settings. Third, the complex fiduciary relationship is rather trilateral with the additional third party, 'authority,' appended to the previously bilateral DPR. The 'authority' functions as a regulator of the doctor and patient partnership and whose role manifests in the form of medical policies and ethics. This new approach is able to assimilate both specific and universal aspect of the DPR, while, at the same time, retaining doctors' discretionary power and patient-centered thoughts.

Thereon, we will assess persistent ethical issues plaguing medicine such as truth telling based on the complex fiduciary relationship.

### ***Systematic review of studies for Withdrawing of life-sustaining treatment in South Korea***

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A systematic review was performed in order to gain a comprehensive understanding of domestic studies conducted on the withdrawal of life-sustaining treatment. A total of 211 studies were found by researching the database with withdrawal of life-sustaining treatment as keywords for the period beginning Jan 1, 2000 and ending Dec 31, 2015. Of the 211 studies, 76 were determined to be appropriate in the context of this systematic review. 51 of the eligible studies were categorized as pertaining to legislation and policies, 16 to philosophy and sociology, and 9 to theology. 13 of the 76 studies adopted quantitative methodologies while 63 utilized qualitative analysis. Collectively, the selected studies featured a total of 348 keywords categorized into patient conditions, treatments, and legislation and policies. The most common keywords for patient conditions included vegetative state (7), terminal illness (6), and terminally ill patients (5), those for treatments included withdrawal of life-sustaining treatment (69), euthanasia (12), and passive euthanasia (16), and those

for legislation and policies included death with dignity (27), advanced directives (16), presumptive agreement (10), living wills, and adult guardianship. A survey of the studies revealed that awareness of the need for legislative reform and specificity of studies regarding life-sustaining treatment increased since the occurrence of Mrs. Kim's case in 2009. Several studies were especially focused on proving the legitimacy of the said policies and legislation in the face of the Constitution and criminal justice. Some studies also delved into specific supreme court precedents to devise solutions to potential issues that may arise should certain aspects of withdrawing of life-sustaining treatment, such as obtaining advanced directives, presumptive agreement, living wills, or adult guardianship, be ruled unconstitutional or criminal. This systematic review clearly reveals that the application of policies around withdrawal of life-sustaining treatment in clinical setting is minimal. It is also clear that future implementation of such policies cannot be accomplished merely through agreement between academia and coalition of physicians.

### **Bioethics in the Kyrgyz Republic**

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In 2007, the Commission on Ethics of Clinical Research and Clinical Pharmacology, within the Department of Pharmacological Support and Medical Equipment, was transformed into the Committee on Bioethics under the Ministry of Health of the Kyrgyz Republic (KR). Since this transformation, all researches must pass ethical review taking into account national, cultural and mental values. Since 2007, the 100 research projects have been conducted. This Committee is a member of the Forum for Ethics Committees in the Commonwealth of Independent States (FECCIS). In the framework of this Forum, representatives of the Committee have presented the results of studies to several international conferences. Our research has been carried out in close cooperation with regional and international organizations, including the WHO, Country Office in Kyrgyzstan, the National Commission for UNESCO of the Kyrgyzstan, the European Forum for Good Clinical Practice (EFGCP) and representatives from different national ethics committees, particularly from Belgium and CIS countries. The Committee was involved in the Project for CIS states which focused on the creation and publication of the book "The development of the ethical review of biomedical research in the CIS states (social and cultural aspects)". The Project was based on the results of Expert Consultations on networking in the sphere of ethics and bioethics. Research bioethics, applied aspects of health care system(s) and medical education are among the scope of activities of the Committee. This Committee was awarded a grant from UNESCO for publishing the book "The Current State of Bioethics Education in the System of Medical Education in the CIS Member Countries: Analytical Review". There is a separate part, which is devoted to Kyrgyzstan: historical and cultural background, legal regulations, education in bioethics, the system of ethical review, perspectives and forms of international cooperation. The concept of present work is based on the implementation of the global trend in UNESCO activity on the development and unification of bioethics education in universities. This book is the first presentation of a detailed analysis, with results and conclusions concerning bioethics education in the system of higher medical education in the CIS countries. Since 2009, the interdisciplinary subject, Bioethics, has been introduced to undergraduate students of the KSMA. Curriculums for this subject have been elaborated and include: general medicine, pediatrics, public health, dentistry, advanced nursing and pharmaceuticals. In each program, special attention is paid to priority issues of that

specialty. Two conferences have been organized and conducted in Bishkek: "GCP is the Ethical Standard of Clinical Trials" and the Central Asian Conference "Clinical Trials in the KR: Current Condition and Aspects of International Collaboration". There were the heads of health care organizations, representatives of the Ministry of Health of the KR, practitioners, representatives of pharmaceutical companies, and faculty members of the KSMA. It is hoped that this introduction to the work of the Committee will provide an opportunity to expand cooperation and establish links with colleagues involved in bioethics from different countries.

### **Deciding for Family: New End-of-Life Act in Korea and Its Authorization of Family**

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In East Asian bioethics, the family's "unique" role in a patient's end of life decision-making was allowed in practice. For example, (1) withholding the diagnosis of terminal illness to the patient and informing family members only; (2) medical decision making by family even when the patient is competent; and (3) designating "family spokesperson" on a patient's life-sustaining treatment by family rather than by the patient. In this culture, families are uncritically assigned a fiduciary duty for the patient. Moreover, several East Asian bioethicists justify these practices with the theory that family, not the individual, has autonomy. However, since family can have both a supportive and oppressive effect, giving family these powers can cause either benefit or harm. Especially in the context of end-of-life decision-making where family members are the ones who both affect and are affected by a patient's decision making, critically examining current norms and practice is essential. The new law on end of life decision-making, "Hospice/Palliative Care and Dying Patient's Decision of Life-Sustaining Treatment Act" was passed in 2016 in Korea and the powers of family under this Act are worth examining. Although the law seems to follow a three tier standard --following advance directives principle, substituted judgment principle, and best interest principle in lexicographic order—in general, its lack of explicit acknowledgement of best interest as a criterion, in the situation of no known patient's wish is problematic and contrasts with widely endorsed bioethical standards. This, along with the law's lack of provision for Durable Power of Attorney and with the current "family-centric" practice in everyday life, can give excessive and exclusive power to patients' families. This excessive and exclusive authorization of family will trigger harm to individual patients and to society as a whole. In order to prevent harm to individual patients, the author anticipates the probable sequence of decision making in life-sustaining treatment, based on current practice. Starting with low participation in advance care planning on one's own terminal illness and continuing with the inactive role of Medical Institution Ethics Committees, the decision making process may lack the patient's input, and therefore may conflict with the patient's own interests. Moreover, the harm is not confined to individuals, because the practice of medical decision-making has a role in shaping society in general. The author concludes that medical professionals should pay heed to possible risk of family-centric rules in end-of-life decision making and that hospital-level policy should be put in place in order to prevent the possible harms of over-authorization of family.

### **Current Review of the Influence of Chinese Tradition and Catholic Church Teaching on Advance Directive**

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Advance directive is part of advance care planning which indicates the types of medical treatment to be used when one is incapacitated for decision making. When one is no longer capable of making health care decisions for oneself, aspiring to maintain health and well-being is complicated by many issues. These include, who would be responsible for making decisions for the incapacitated individual; given the options of care available, what kind of care would the incapacitated individual want; and, what would be best for the incapacitated individual. Confronted with an aging population, the deterioration in health, accidents and certain diseases can also cause a loss in decision-making capacity. Indeed, various factors including religious beliefs, ethical concern and cultural influences can affect one's views and philosophy about decision regarding advance directives. In a westernized city like Hong Kong, the population comprises people with different cultural and religious backgrounds. As the majority of the population is still ethnic Chinese, this presentation will, by means of a literature review, explore how Chinese tradition and Catholic Church teaching affect one's decision in the choice of advance directive.

### PODCASTS

#### **Motivated Reasoning and Disabled People: Ethical Implications**

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**Background:** Motivated reasoning describes how individuals generate explanations that are adopted to explain a particular decision or event [1]. It refers to the influence wishes, desires, and preferences have on individuals' cognitive processes including assessing, constructing, and evaluating [2, 3]. Research on motivated reasoning indicates that individuals have the tendency to accept favourable information and be dismissive or critical of threatening information [2, 4, 5]. Motivated reasoning is found to impact partisan affiliations, inequality and is seen to enhance discrimination and injustice. Researcher have emphasized the presence of motivated reasoning in public debates whereby one author mentioned disabled people as part of a listing of marginalized groups [6]. However the impact of motivated reasoning on disabled people has not been analyzed so far.

**Purpose:** This study is an analytical one with the purpose of exploring the impact of motivated reasoning on disabled people through various lenses such as the Bias Free framework (Building an Integrative Analytical System For Recognizing and Eliminating inequities)[7], Other-ism or Other-ness, risk perception, ethics, making use of the few articles that cover the linkage between ethics and motivated reasoning and to discuss how one can decrease motivated reasoning's negative impact on disabled people.

**Method:** N= 400 abstracts in addition to n=104 full text articles on motivated reasoning were downloaded from three academic databases (EBSCO All (covering 70 other databases), Scopus and PubMed) to obtain background literature on motivated reasoning from various disciplines and analyze how often the terms "disabled people" or "people with disabilities" were mentioned. We conducted a qualitative content analysis of the articles and abstracts as a foundation to examine the impact of motivated reasoning on disabled people, using atlas.ti, qualitative analysis software.

**Findings and Discussion:** Within the databases covered, not one article mentioned the terms "disabled people" or "people with disabilities". We found one article covering disabled people through Google Scholar [6]. Our presentation will focus

on the impact of motivated reasoning on disabled people using various lenses such as the Bias Free framework[7], Other-ism or Other-ness, risk perception, and ethics.

**Conclusion:** We submit that our work will provide incentive to deepen the understanding of the impact of motivated reasoning on disabled people. We also hope that it will entice the conference participants to investigate motivated reasoning from the angle of their own line of work since many aspects of motivated reasoning are under investigated.

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#### **Analysis of in HIV/AIDS health promotional coverage of disabled people in Canadian Newspapers and academic literature: Ethical Implications**

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**Background:** Health promotion is an essential communicative aspect of preventative measures to reign in the global epidemic of HIV/AIDS (1). Global health aims to address equity between various cohorts through dispersing health promotional information (2). Newspapers are one medium through which HIV/AIDS-related health promotional material is made available to the public. Academic scholars engage with health promotion with the aim to improve health promotion. Disabled people are one group that depend on health promotional campaigns to receive important messages and participate in effective health prevention of HIV/AIDS, as they face unique barriers to achieving health, including risks involving HIV/AIDS (3).

**Objective:** Purpose of this study was to ascertain the coverage of disabled people within Canadian newspapers as well as academic literature of health promotion with a particular focus on HIV/AIDS.

**Methods:** A total of n=921 newspaper articles were downloaded from the Canadian News stream database consisting of n=300 Canadian newspapers, that contained the term "HIV/AIDS" or "HIV" and "health promotion". In addition, a total of n=11512 academic articles were



identified from academic databases (EBSCO all (consisting of 70 databases, Scopus and Pubmed) that contained "HIV" or "HIV/AIDS" and "health promotion" in the abstract terms. An analysis was performed of how often and how the terms "disabled people" and "people with disabilities" were mentioned

**Results:** Within the n=921 newspapers articles, only one article contained the term "people with disabilities: none the term "disabled people" Within the 11512 academic articles identified only 19 articles contained the term "people with disabilities" or "disabled people" in the full text. We will present what the 12 articles cover in the presentation.

**Discussion:** We will discuss in our contribution the ethical problems such invisibility of disabled people poses and that such invisibility could be seen as unethical.

**Conclusion:** Disabled people face unique challenges in regard to HIV/AIDS. However, our findings suggest that the health promotion coverage of HIV/AIDS ignores disabled people causing them to be left behind. The exclusion of persons with disability in HIV health promotion discourse needs to be addressed.

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#### **Analysis of Engagement with Ethical Concepts and Theories in Return-to-Work Academic Literature**

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**Background:** There is great focus on return-to-work (RTW)/back-to-work (BTW) interventions [1, 2] due to the importance of being occupied for health and well-being of people [3]. Ethical discourses are to give guidance on how to do things and why, and ethical theories and concepts are used to express that [4]. Sherwin, an eminent ethicist, stated, "we [ethicists] lack the appropriate intellectual tools for promoting deep moral change in our society," ([5] quoted in [4]) however.

**Objective:** Given Sherwin's belief, the purpose of our study was to investigate to what extent ethical concepts and theories, the intellectual tools of expression, are employed to inform RTW/BTW discourses.

**Methods:** Data was generated in two ways. We searched three academic databases (EBSCO all, consisting of over 70 databases, Scopus, Web of Science) for either "back to work" or "return to work" in the article abstract, in conjunction with n=33 ethical concepts and theories derived from sources used in [6] in the abstract or full text. We then recorded the frequency of hits. We furthermore searched the three databases for either "back to work" or "return to work" in the article abstract in conjunction with the term ethic, downloading the resulting n=82 abstracts and using ATLAS-Ti©, a qualitative analysis software, to analyze them for how the term ethic was used.

**Results:** For the 82 abstracts found, the term "ethic" was found 113 times. In 25 cases the term was used to confirm ethics committee approval for studies. In 29 cases the term was

briefly used about how RTW professionals must display ethical considerations in their conduct. Personal work ethic was mentioned 18 times. There were only four cases in which ethical thinking was conceptually engaged in RTW literature. In three cases, gender-based ethics of care and work were utilized to evaluate the likelihood and productivity of individuals returning to work, while only a single case outlined key ethics concepts that RTW field should adapt.

As for the hit counts derived from the databases, only n=2 terms out of the n=20 ethics theories, egalitarian and care ethics, were mentioned in more than two articles. N=6 theories were mentioned in one or two articles and n=12 were not mentioned at all. For the n=13 ethical concepts, n=8 were mentioned more than 100 times, such as ethic, harm, autonomy, justice, whereas n=5 were mentioned in less than 10 articles, such as beneficence or maleficence.

**Conclusion:** Ethical theories and principles were not used extensively in RTW discourses. Given the existing and emerging ethical dilemmas linked to employment, such as the challenges of people staying occupied after retirement or when displaced by automatization and robotics, using ethical reasoning might be useful for RTW discourses to better deal with such challenges. Our findings adds to the literature that shows the lack of use of ethical concepts and theories outside of ethics discourses [6, 7], suggesting that Sherwin might be right with her claim.

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7. Ball, N. and G. Wolbring, *Cognitive Enhancement: Perceptions Among Parents of children with Disabilities*. Neuroethics, 2014. **7**: p. 345-364.

#### **Asian Bioethics Association (ABA) Board of Directors (Nov 2016-2018)**

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### **Proceedings and Abstracts**

**ABC1** (Beijing, China, 1995),  
**ABC2** (Kobe, Japan, 1997),  
**ABC3** (Tokyo, Japan, 1998),  
**ABC4** (Seoul, Korea, 2003),  
**ABC5** (Tsukuba, Japan, 2004),  
**ABC6** (Sanliurfa, Turkey, 2005),  
**ABC7** (Beijing, China, 2006),  
**ABC8** (Bangkok, Thailand, 2007),  
**ABC9** (Jogyakarta, Indonesia, 2008),  
**ABC10** (Tehran, Iran, 2009),  
**ABC11** (Singapore, 2010).  
**ABC12** (Taipei, 2011).  
**ABC13** (Kuala Lumpur, Malaysia, 2012)  
**ABC14** (Chennai, India, 2013)  
**ABC15** (Beppu and Kumamoto, Japan, 2014)  
**ABC16** (Manila, the Philippines, 2015)  
**ABC17** (Jogyakarta, Indonesia, 2016)

### **ABA Constitution**

#### **Article 1 (Name)**

The name of this academic organization shall be the: Asian Bioethics Association (ABA). Hereafter referred to as the Association.

#### **Article 2 (Definitions)**

In interpreting this Constitution the following definitions shall be used: **Bioethics** is the interdisciplinary study of philosophical, ethical, social, legal, economic, medical, therapeutic, ethnological, religious, environmental, and other related issues arising from biological sciences and technologies, and their applications in human society and the biosphere. **Asia** is the regions, peoples, and cultures which constitute the geographically largest continent of the world.

#### **Article 3 (Objectives)**

The basic objective of the Association is to promote scientific research in bioethics in Asia through open and international exchanges of ideas among those working in bioethics in various fields of study and different regions of the world. In order to achieve this end the Association will encourage the following work and projects: (1) to organize and support international conferences in bioethics in Asia; (2) to assist the development and linkage of regional organizations for bioethics; (3) to encourage other academic and educational work or projects to accomplish their goals consistent with the objectives of the Association.

#### **Article 4 (Membership)**

4.1 Membership of the Association shall be open to any individuals and institutions sharing the objectives of the Association.

4.2 A member of the Association shall be in good standing. There will be a voluntary payment of annual dues. The Board of Directors may tentatively set the suggested annual dues at a different rate for members with different income.

4.3 Membership shall be valid unless and until they are rejected by the Board of Directors and/or by the majority vote of members.

### **Article 5 (the Board of Directors)**

5.1 The Board of Directors shall be nominated from among the members of the Association.

5.2 Institutional or regional members may nominate delegate(s) for the Board, but the nominee, if elected, shall hold office in his or her own right, and not as a representative of the institution or the region.

5.3 The Board of Directors shall consist of no more than 15 members and no more than 3 members from any one nation state. The nation state of each member should be defined by the member on the basis of residence or nationality at the time of nomination for election.

5.4 The Board of Directors may appoint, or authorize the President to appoint, additional officers, sub-committees, executive staffs to carry out specific tasks of the Association. In particular a list of regional representatives will be maintained for promotion of the ABA.

5.5 The board can co-opt, by consensus, associate non-voting members to increase the diversity and geographical representation of the board for the current term. (Adopted by acclamation at the ABA General Meeting on 5 November 2008)

### **Article 6 (the Officers)**

6.1 Officers of the Association shall be the President, twelve vice-presidents (one from each of China, India, Indonesia, Japan, Korea, the Pacific, Pakistan, South Asia (East of Afghanistan), South East Asia (East of Bangladesh), Taiwan, West Asia (West of India), and Asian Ethnic and Religious Minorities, and a General Secretary. They are nominated and/or elected by members of the Association. The President can serve a maximum of two years in office. The Other Officers should stand re-election every two years

6.2 The Officers shall be responsible for the general management and the direction of business works of the Association. The President and/or Secretary shall have authority to execute, in the name of the Association, all authorized deeds, contracts, or other instruments.

6.3 The Vice-presidents shall provide secondary leadership for the Association, substituting for the President when needed.

6.4 A vice-president can be elected for a maximum of two successive terms as a vice president.

6.5 The General Secretary shall keep, or arrange to have kept, a true record of the minutes of all meetings.

6.6 The General Secretary shall have custody of the Association's funds, keep full and accurate accounts of the receipts and disbursements, and deposit all money in the name and to the credit of the Association in the depositories designated by the Board of Directors. The accounts shall be shared with all members of the Association every year.

#### **Article 7 (Amendment of the Constitution)**

This Constitution may not be amended, replaced, or annulled except by an affirmative vote of two-thirds of the members in secret ballot.

#### **Supplementary Note 1**

The principles of this Constitution were initially adopted at the Inaugural Meeting of the East Asian Association for Bioethics held in Beijing on the 5th of November, 1995, when the Officers of this Association were also nominated. At the UNESCO Asian Bioethics Conference, 4 Nov, 1997, the Association was broadened to become the Asian Bioethics Association, and several further members were nominated. This initial Board of Directors was replaced by a new Board in November, 2002, at the Fourth Asian Bioethics Conference in Seoul, and when the Constitution was formally adopted. The 2004 election was held on 10 November 2004, and elections have been held every two years since. Article 6.1. of the constitution was amended according to the provisions of article 7 on 12 September 2012, following a unanimous call for modification at the Annual General meeting held on 30 August 2012.

#### **Supplementary Provision 2**

The secretariat of the Association was placed in the University Research Center, Nihon University, Tokyo, Japan, from 1998 to February, 2002. From February, 2002 to February 2005 the secretariat was: Prof. Darryl Macer, Institute of Biological Sciences, University of Tsukuba, Tsukuba Science City 305-8572, JAPAN. From February 2005 the secretary and office moved to Prof. Darryl Macer, Apt 14C, G.P. Grande Tower, 55 Sukhumvit Soi 23, Watana, Bangkok, Thailand. From February 2013 the secretary and office moved to 14M9 Phetkasem Road Soi 50/3, Bangkok 10160, Thailand. The official email of ABA is asianbioethics@yahoo.co.nz, and the website www.eubios.info

**For forthcoming conferences see:**

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Email to [Darryl@eubios.info](mailto:Darryl@eubios.info) for more information.

**18th Asian Bioethics Conference**, Seoul, Republic of Korea, 25-27 October 2017

**Joint AUSN-Gangneung-Wonju (GWNU) National University Bioethics Conference**, 28-30 October 2017, Gangneung, Republic of Korea

**Joint AUSN-KAIST International Conference on Ethical Policy, Science and Technology at KAIST**, 30 October – 2 November 2017, Daejeon, Korea

**Eleventh Kumamoto University International Bioethics Roundtable: Philosophy and practice of bioethics across and between cultures**, 18-19 November 2017, Kumamoto University, Japan

**Nineteenth Asian Bioethics Conference (ABC19): Bioethics for Smart Living in Asia and Beyond: Taiwan as a hub for nurturing international partnerships and sustainable practices**, 13-16 November 2018, Kaohsiung and Pingtung, Taiwan.

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