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Henk A.M.J. ten Have *Editor*

Bioethics Education in a Global Perspective

Challenges in global bioethics

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In memory of Edmund Pellegrino (1920–2013)
and Stuart Spicker (1937–2013)

Preface

This book is one of the results of the first international conference of the International Association for Education in Ethics (IAEE) that took place in Pittsburgh, USA, in May 2012. The legal establishment of IAEE in April 2011 has created a scholarly platform for expert interested and involved in ethics teaching. There is a substantial number of professionals who are teaching ethics in various types of programs and schools, and in different areas of applied ethics. Their professional effort and engagement should be better recognized; experiences and models of teaching should be exchanged, so that ethics education can be further enhanced and expanded. The IAEE offers the opportunities for international exchange, functioning as global centre of contact for experts in ethics education. The first conference attracted approximately 200 participants from a wide range of countries. The best of many presentations were elaborated into contributions for this book.

The incorporation of IAEE as well as the first conference has been generously supported by the Administration of Duquesne University. Specific appreciation is due to President Charles Dougherty of Duquesne University, a bioethicist by profession, for his continuous encouragement and support. Thanks are also owed to James Swindal, dean of McAnulty College and Graduate School of Liberal Arts, and philosopher by profession, for his enthusiasm and generosity. I owe a special debt to my colleagues in the Center for Healthcare Ethics. Gerard Magill energetically provided feedback and ideas, while Glory Smith mobilized all our doctorate students in the successful planning and proceeding of the conference. Finally, special thanks go to my research assistant Gary Edwards whose sharp eye, clear brain, language skills and ethical competence substantially facilitated the editing of this book.

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Chapter 1
Globalization of Bioethics Education

Henk A.M.J. ten Have

1.1 Introduction

This collection of essays is a sequel of the Inaugural International Conference on Education in Ethics, organized by the International Association for Education in Ethics (IAEE), which took place in Pittsburgh, U.S.A. in May 2012. More than 200 scholars from 33 different countries participated in this conference. Since many of the presentations specifically highlighted the global development of bioethics education, an initiative was taken to elaborate several aspects of this development into chapters for this book.

1.2 The Development of Bioethics Education

One of the remarkable phenomena in the development of sciences is the rapid expansion of the new discipline of bioethics in the last few decades. Van Rensselaer Potter, who was the first to introduce and elaborate the notion of bioethics in subsequent publications from 1970, was surprised to note how quickly and widely the term became used in scholarly debates (Potter 1975). Potter, however, also lamented that the meaning of the term has deviated from the broader vision he had proposed. Bioethics had become redefined and restricted to 'medical bioethics,' focusing on ethical issues concerning individuals and relations between individuals, and neglecting ecological, population, and social problems. In this narrow vision, bioethics debates are addressing short-term issues rather than the continued existence of the human species. It therefore continues examining the old problems such as abortion and euthanasia instead of analyzing problems that really matter for the survival of humankind. In Potter's assessment, bioethics has in fact become a new name for medical ethics.

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The number of ethics teaching programs rapidly grew in the early 1970s, first of all in medical schools in the United States. In a relatively short period of time, almost all medical schools introduced ethics education. Currently, these schools are required to include bioethics in their curricula in order to be accredited. Other countries followed this pattern of dissemination. Since then, the scope of bioethics education has significantly widened. Ethics teaching came to be offered not only in the undergraduate programs but also in graduate, specialization and postgraduate education, and especially in clinical settings. Bioethics teaching was furthermore introduced in the professional training programs of other health professions such as nursing and scientific disciplines such as biology, genetics, and life sciences. Finally, bioethics education has become relevant outside of the professional training context as a resource for experienced practitioners, members of ethics committees, and also policy-makers, journalists, and interested parties in public debate (ten Have 2013a). This growth of bioethics education is in line with the wider notion of bioethics as a new discipline that combines scientific knowledge with philosophy and ethics in order to analyze and comprehend the contemporary challenges of science and technology for health, life, and care.

1.3 Global Bioethics

Potter has argued that bioethics is not merely a short-term ethics of individuals but should have a wider perspective. In order to better articulate this perspective he introduced the term *global bioethics* (Potter 1988). This concept of global bioethics is attracting more attention nowadays than 2 decades ago when Warren Reich could only identify a modest legacy for Potter (Reich 1994, p. 322). Today there is an increased interest in and retrieval of Potter's original interest in global bioethics. His work has received more recognition especially outside the United States, particularly in Latin America and Europe. In 2000, 1 year before his death, Potter was awarded the first Bioethics Prize of the International Society of Bioethics (convening in Gijon, Spain). More importantly, the idea that bioethics should broaden its mission seems to gain support. There is a growing number of publications that demonstrate how bioethics has disseminated throughout the world and how it is developing in many resource-poor countries (Myser 2011; ten Have and Gordijn 2013). But there is also a lot more attention to global issues such as global health, global justice, poverty, inequality, and vulnerability. More scholars are arguing that medical, social, and ecological issues are closely connected, for example in the phenomena of climate change and environmental degradation, so that bioethics will necessarily include environmental ethics and social ethics, as advocated by Potter (Dwyer 2009; Gruen and Ruddick 2009). Potter has also noticed that the search for a global scope for ethics was undertaken by world religions, especially through the activities of Hans Küng (Potter 1994). In 1993 hundreds of leaders from more than 40 religious and spiritual traditions agreed on a statement declaring that all traditions share common values such as respect for life, solidarity, tolerance, and equal rights (Parliament of the World's Religions 1993).

1.4 Global Dimensions of Bioethics Education

The term *global* in connection to bioethics has two distinct meanings: worldwide and comprehensive. Both meanings are reflected in the current process of the globalization of bioethics education.

1.4.1 Worldwide Scope

For bioethics education there are at least six reasons to address global dimensions.

The first is that international exchanges between medical schools and health professional training programs have enormously increased. The International Federation of Medical Students' Associations claims that annually 10,000 medical students around the world participate in exchanges (IFMSA 2013). The European student exchange program started in 1987 with 3,244 students studying abroad and in the academic year 2010–2011 more than 230,000 students participated. It is estimated that more than 4% of European students will participate in international exchange at some stage of their higher education studies. The overall average duration of studies abroad was 6 months. (European Commission 2012). Although student mobility in the area of health and welfare is relatively low (with only 10,781 students in 2010–2011) it nonetheless means that bioethics teaching programs involve a growing number of students from other countries. The same is true for teaching staff. In Europe, over 42,000 staff exchanges toke place in the above academic year with teaching assignments or training periods abroad.

The second reason is international migration of health professionals. For decades, approximately 25% of physicians practicing in the U.S. have been trained abroad. In New Zealand, Ireland, and the United Kingdom more than a third of all doctors are educated in other countries. The majority are coming from developing countries, notably India for doctors and the Philippines for nurses. More than 50% of medical professionals educated in countries such as Liberia, Angola, and Tanzania have migrated to developed countries (OECD 2010). In today's healthcare practice and education there is a mix of practitioners from various cultural and religious traditions. The assumption that a shared moral context or a common framework of values exists for health professionals may no longer hold; such common context and professional morality need to be created or reinforced through bioethics education.

The third reason is the new phenomenon of health tourism. Traditionally, wealthy patients from the developing world are used to seek sophisticated medical treatment in developed countries. But currently, patients from more developed countries are travelling to receive treatment in less developed countries. Thailand and Turkey, for example, are actively promoting medical interventions for visitors, ranging from cardiac surgery to hair implants. There are also specialized forms of tourism such as transplantation tourism to China and reproductive tourism to India. In most cases, people only visit for a few days, and then return to the healthcare system in their own country. It may, for example, imply that interventions that are ethically

problematic at home are performed elsewhere. The fact that health professionals will face a growing numbers of patients treated abroad within a different medical and ethical context is another reason to broaden the scope of bioethics education.

The fourth reason is the growing international cooperation in research and healthcare. One of the striking features of globalization is the rapid expansion of medical research across the world. Particularly clinical trials have become a global industry, increasingly outsourced and off-shored to developing countries. It is estimated that currently between 40 and 65% of clinical trials are conducted outside the United States (Levinson 2010). Also in the field of healthcare, the number of partnerships between institutions in different countries has steadily increased (Jones et al. 2013).

A further reason, related to the above, is that health resources such as drugs and devices are increasingly produced elsewhere, like most goods in the global era. This brings not only uncertainty concerning safety and quality assurance but can also lead to misjudgments, mistakes, and even fraud. An example is the scandal that broke in 2010 concerning silicone breast implants produced by a French company. Although the FDA had introduced a moratorium in 2000, implants were massively used in Europe and Latin America until it became clear that they had a unusually high rupture rate causing infection, and possibly cancer and death because substandard gel had been used (Chrisafis 2013). Professional competency therefore requires knowledge of where and how devices are produced, and whether they are reliable.

Finally, the sixth reason to address the global dimension in bioethics education is related to the nature of contemporary bioethics problems. Bioethics nowadays does not only examine the traditional topics such as abortion, end-of-life care, reproductive technologies, and transplantation medicine. The main ethical challenge of these topics is related to the power of science and technology: how are individual patients and citizens empowered to choose treatments and interventions that will benefit them or at least not harm them? Today, however, there is a plethora of new issues on the agenda that fundamentally have a global nature. Examples are pandemics, organ trafficking, climate change, hunger, malnutrition and obesity, corruption, bioterrorism, disasters and humanitarian relief, bio-piracy and loss of biodiversity, and degradation of the biosphere (ten Have 2013b). These topics are not the result of scientific and technological advancement but rather the consequences of processes of globalization. They present new challenges to bioethics and bioethics education in particular.

1.4.2 Comprehensive Approach

Global bioethics is increasingly using an encompassing and unified approach, incorporating various viewpoints and methods. Nowadays it is combining traditional professional ethics with environmental concerns and the larger problems of society, economy, and politics. This means that the focus of ethics is widening from relations between individuals, to relations between individuals and society, and ultimately to relations between human beings and their environment. However, the fact that there

are similar bioethical problems in many countries does not entail that the same ethical approach exist everywhere. It is clear that approaches are different, that cultures and religions have different values, and that similar ethical principles are applied in heterogeneous ways in various cultures. The global dimensions therefore invite us to rethink the usual approaches and ethical frameworks. On the one hand, they make us aware of the *locality* of moral views, while on the other hand, they encourage the search for moral views that are shared globally. In this bifurcation between universality and particularity, global bioethics is increasingly connected with international law, particularly human rights law.

A major step in the development of global bioethics has been the adoption in 2005 by the Member States of the United Nations Scientific, Educational and Cultural Organisation (UNESCO) of the *Universal Declaration on Bioethics and Human Rights.* This Declaration presents a framework of ethical principles for global bioethics. It goes beyond the four principles formulated by Beauchamp and Childress (2013) that is characteristic for the Western individualistic perspective of traditional bioethics. The UNESCO Declaration not only is the first political statement of a global framework, but it also reflects Potter's idea of global bioethics, covering concerns for health care, for the biosphere and future generations, as well as for social justice (ten Have and Jean 2009). The Declaration assumes the existence of a global moral community in which citizens of the world are increasingly connecting and relating due to processes of globalization but also sharing global values and responsibilities. This global community generates certain common principles, for instance the principle of protecting future generations, the principle of benefit sharing, and the principle of social responsibility. Various ethical systems are converging into a single normative framework for all citizens of the world (Veatch 2012).

1.5 Challenges of Bioethics Education

Bioethics education, particularly at the global level is confronted with several challenges. As indicated earlier, bioethics teaching programs have mushroomed in the 1970s and 1980s in the U.S. and European countries. The situation has stabilized since then and in many countries all medical schools now have ethics teaching programs (Eckles et al. 2005). But it is not clear that this situation will not deteriorate under economic and political pressures on universities replacing experienced staff with temporary adjuncts and online courses. Ethics teaching is also regarded by policy-makers as a curious type of palliative remedy. Every time when professionals infringe on important ethical norms, the need for ethics teaching is re-emphasized as the antidote. In response to a repeated cycle of cases of scientific misconduct and ethical problems concerning financial conflicts of interest, the National Institutes of Health and the National Science Foundation in the U.S. have required as of January 2010 that researchers funded by their grants must have received ethics education focused on promoting research integrity. Education in ethics is seen as a remedy against deficiencies in professional behavior. But it is obvious that the impact of

bioethics education is limited if the systemic and structural causes of such misconduct are not addressed. Also hardly any provisions and regulations are provided for ethics education so that a 1 day online course can be sufficient to meet the requirements. The almost general agreement that bioethics education is very important for healthcare professionals therefore is not translated into efficient practical arrangements. Although bioethics teaching is done, in most countries it is not very impressive in terms of volume, time, and commitment. Persad et al. (2008) point out that in the U.S. bioethics education, although required, comprises only 1 %of the medical school curriculum. Many educational activities are sporadic and occasional. In Europe most hospitals have only short-term educational initiatives instead of longer courses and programs, while nobody seems to take responsibility for the activities (Pegoraro and Putoto 2007). Moreover, there is a serious lack of qualified teachers. Not even half of the bioethics instructors in the U.S. have published a single article in bioethics (Persad et al. 2008). For many teachers of bioethics this is not their primary academic focus. A survey in 2004 showed that 20 % of medical schools in the U.S. and Canada did not even fund teaching in ethics (Lehmann et al. 2004). The first challenge therefore is that the professed importance of bioethics education should not blind us for the frail and anemic status of programs in many settings.

Another challenge is related to bioethics education itself. It is exemplified in the enormous heterogeneity of the field, as also shown in this volume. Within the same country, different types of programs are offered, didactic approaches and methods differ, the number of teaching hours has a wide range, and ethics courses are not scheduled in the same phases of the curriculum. Major controversies exist concerning the objectives, methods, content, and evaluation of teaching activities (ten Have and Gordijn 2012, 2013a). However, this diversity does not imply that there is no consensus. Over the last few decades scholars have come to agree that certain approaches of teaching are preferable, for example, that there is a need for longitudinal and integrated programs, making ethics not an isolated, one-time event but part of daily care routine; there is a need for team teaching with close cooperation between ethicists and clinicians. Also a student-centered approach in bioethics education focused on active learning is preferable since it encourages critical thinking and reflection. Furthermore, there is agreement on the need for comparative studies. Developing teaching programs is often not informed by experiences elsewhere. In many cases the wheel is re-invented since there are few descriptive and analytic studies of specific programs published. Finally more efforts are undertaken to define a common core for bioethics education, for example the core proposal in the United Kingdom, and the core curriculum launched by UNESCO (Stirrat et al. 2010; ten Have 2008).

1.6 A broader Philosophy of Bioethics Education

The mentioned heterogeneity reflects two diverging views of bioethics education. The question of what is good education requires a prior answer to the more fundamental question: why do we educate at all? Responding to this query one can

observe two different philosophies of bioethics education. One pragmatic view regards ethics teaching as a way of learning skills for analyzing and resolving the ethical dilemmas that will confront health professionals in their future practices. The role of bioethics education therefore is limited. It should focus on what is practical and measurable. In this modest educational philosophy it is not realistic to expect that ethics education can create morally better physicians and scientists. After all, how can a limited number of courses bring about a change in behavior or character of health professionals? The primary objective therefore is to teach skills so that it will ultimately lead to better professional decisions. The other view is broader and bolder. In this philosophy, bioethics education is not merely focused on skills to improve decision-making but is basically a long-term effort to create better health professionals and scientists. It is aimed at character formation, integrity, and professional virtues. Rather than enhancing professional skills it aims to improve the professional. Only in this way can bioethics teaching contribute to enhancing the quality of patient care. This broader philosophy is motivated by the fact that bioethics education was introduced and promoted to counteract dehumanizing and objectifying tendencies in contemporary medicine and health care. It is not just there to facilitate medical decision-making, but it should contribute to making medicine more humane. For this reason, bioethics education has a broader focus on the humanities, liberal arts, social sciences, and philosophy, so that medical activity is located in a wider human context.

It seems that the philosophy of bioethics education is increasingly moving towards this broader conception. While the focus on identifying and analyzing ethical issues has been characteristic for the early stages of bioethics education, at present there is more emphasis on how to influence students' attitudes, behaviors, and characters, emphasizing that the ultimate goal of bioethics education is to produce good health professionals and scientists (Goldie 2000). Good medical practice requires more than knowledge and skills. We expect health professionals to demonstrate good conduct and action. This is what education should train and nourish (Gelhaus 2012). The focus of bioethics education should therefore move beyond problem-solving and applying principles.

1.7 The Challenge to Global Bioethics

The need for a broader focus of bioethics education is even more necessary given the emergence of global bioethics as a consequence of processes of globalization. Nowadays, globalization is a major source of bioethical problems. While there are different interpretations of globalization, the common core of these interpretations has been identified as "the operation of a dominant market-driven logic" (Kirby 2006, p. 80). In other words, it is the specific neoliberal market ideology driving globalization that is generating bioethical problems. This ideology is shifting policies away from maximization of public welfare to the promotion of enterprise, innovation, and profitability. It also favors competition instead of cooperation. This

logic changed the nature of state regulation, "prioritizing the well-being of market actors over the well-being of citizens" (Kirby 2006, p. 94). Rules and regulations protecting society and the environment are weakened in order to promote global market expansion. A new social hierarchy emerged worldwide with the integrated at the top (those who are essential to the maintenance of the economic system), the precarious in the middle (those are not essential to the system and thus disposable), and the excluded at the bottom (the permanently unemployed). Increasing vulnerability, precariousness, inequality, and exclusion are characteristics of this new social order of globalization. Due to increasing risks and lower resilience, people all around the world but especially in developing countries have diminishing abilities to cope with threats and challenges. Neoliberal market ideology is seriously damaging health and healthcare at the global level, creating many of the global problems mentioned before. Thus, the same source that has produced global bioethics is also generating the relevant global problems of today (ten Have and Gordijn 2013).

This context clarifies the main mission of bioethics education nowadays and in the near future: bioethics should be a critical discourse that analyses and scrutinizes the current value systems pervasive in neoliberal globalization. If many ethical issues arise because of these value systems, bioethics cannot simply reproduce this ideological context but should take a critical stance towards it and present alternatives. This is the double bind of global bioethics. It has to critically review the context of globalization in which it has originated as well as the economical forces that are driving these processes of globalization. Because it has emerged in the context of globalization, the moral discourse seems already captured and determined with a preconceived value framework. Global bioethics therefore has to emancipate from its sources and should adopt the Socratic task of being a gadfly or the Kantian role of philosophy as critical thinking rather than merely explaining and justifying current situations. Otherwise it will merely serve to soften and humanize the neoliberal ideology that determines current globalization. This critical stance requires that global bioethics goes beyond the focus of traditional bioethics on individual autonomy and issues of science and technology and critically analyses the social, political, and economic context of healthcare and science. This critical refocusing is particularly important for bioethics education, now that in many countries education itself is significantly transformed into a commercial industry, remaking universities into businesses, students into customers, and academic research into an economic asset (Collini 2013). In the logic of marketization and quantification, the sole purpose of education is to provide graduates with capabilities that are demanded in the economy. If bioethics education accepts this logic it will be anointing neoliberal ideology; but if it is not, it will be in serious jeopardy.

Criticizing neoliberal market ideology requires a broader framework than the usual emphasis on individual autonomy. This emphasis is convenient for the neoliberal perspective since it regards human beings first of all as individual rational decision-makers and consumers. What they need is information so that they can choose what they value or desire. But a human being alone, as Charles Taylor has argued, is "an impossibility" (Taylor 1985, p. 8). Even economists nowadays argue that this conception of individual autonomy is an "anthropological monster"

(Cohen 2012 p. 34). Regarding human beings as self-interested, self-determining subjects disregards the basic importance of cooperation, the interconnectedness of human beings, and the interrelations between human beings and the environment.

1.8 International Exchange and Cooperation

The interconnected nature of ethical problems today requires international cooperation. For example, in order to address the proper conduct of international clinical trials, regulation at the level of the nation-state is no longer sufficient. The same trend is reflected in bioethics education; it is moving from a localized and individual effort towards more cooperative and interactive endeavors with exchange of information and harmonization of methodology and contents. A major event in this regard has been the establishment in 2011 of the International Association for Education in Ethics (IAEE), a non-profit organization with the aims (a) to enhance and expand the teaching of ethics at national, regional, and international levels, (b) to exchange and analyze experiences with the teaching of ethics in various educational settings, (c) to promote the development of knowledge and methods of ethics education, and (d) to function as a global center of contact for experts in this field, and to promote contact between the members from countries around the world. The establishment of IAEE was in fact a logical outcome of the Ethics Education Program of UNESCO, launched in 2004 (ten Have 2008). This program has identified and described ethics teaching programs, initially in Central and Eastern Europe, the Arab region, the Mediterranean region, and Africa. In order to analyze the programs in sometimes very different educational settings, UNESCO organized regional meetings of the instructors of those programs. Currently, 235 teaching programs have been validated and entered into the UNESCO Global Ethics Observatory database, covering 43 countries. The Global Ethics Observatory provides detailed information (concerning for example, for each teaching program the location, objectives, number of teaching hours, study materials, syllabus topics, teaching methodology and student evaluation) and the data is available in comparative format (UNESCO 2013).

Governmental policy-makers, administrators in universities, academies of science, and even bioethics experts themselves do not often have adequate information about what exist and what is lacking in the field of bioethics education. It is therefore necessary to provide and exchange accurate information about existing ethics programs so that the substance and structure of each program can be examined and various programs analyzed and compared. In many settings ethics teaching programs are vulnerable. They are taught by enthusiastic and motivated teachers but a firm institutional basis is lacking so that there is no guarantee that programs will continue when the teachers leave or the curriculum is revised. In many countries there is no systematic effort to create a future generation of bioethics teachers. Bioethics teachers often do not communicate with each other. They have no idea what their colleagues in the same and neighboring countries are teaching. Everybody apparently is inventing the wheel anew. The idea that something can be learned

from experiences elsewhere is not widespread. These weaknesses can possibly be addressed if there is a more scholarly perspective of bioethics education, regarding it as an activity that requires research, analysis, evidence, and creativity. The first step in this direction has been the establishment of a global platform for ethics education. Such a platform may facilitate the exchange of educational experiences, may bring colleagues from around the world in contact, and in the end may promote the quality of ethics teaching. Against this backdrop the IAEE International Association for Education in Ethics was founded. This volume is a first result of international cooperation.

1.9 Ethics Teaching Experiences Around the Globe

The first part of the book presents experiences with bioethics education in a selection of six countries. In Brazil, as explained by William Saad Hossne and Leo Pessini, bioethics has been practiced during the last 2 decades. The first bioethics journal was created in 1993. The Brazilian Bioethics Society was established in 1995. Its biennial conferences are major events with over one thousand, mostly young participants and a very diverse program. Bioethics in Brazil is also firmly institutionalized, following the enforcement of ethical guidelines for research with human beings in 1996. Bioethics education not only takes place within existing undergraduate and graduate curricula but has also resulted in specific post-graduate programs at master and doctorate levels, so that professional bioethicists are trained. It is interesting that deliberate efforts are undertaken in these programs to address a range of issues and problems that are specifically important within the Brazilian context of social and political inequalities, injustices, poverty, and violence. In the second chapter, Vina and Ravi Vaswani discuss the situation of bioethics teaching in India. In this vast and populated country bioethics is characterized by a religious as well as traditional context. Religions, particularly Hinduism and Buddhism, but also ancient health care systems such as Ayurveda have emphasized moral education since many centuries. Bioethics education, however, is rather recent and compared to Brazil, very slowly developing. There have been a few institutional achievements, such as the establishment of a professional journal, a national bioethics association, and several university centers for bioethics. But educational programs at university level are scarce; there is also lack of experts and research projects in bioethics. The chapter describes interesting initiatives to enhance this situation. Significant challenges are identified at the institutional and policy level giving the impression that bioethics education in India is mainly driven by enthusiastic and motivated individuals. It seems that in India, in distinction to Brazil, bioethics is less supported by medical and scientific institutions. There also seems to be less policy-makers who are convinced of the importance of bioethics education. This is also different from Japan as argued in Chap. 3 by Toshitaka Adachi. Although the term *bioethics* was introduced in the 1980s, Adachi argues that bioethics education has been quickly and firmly embedded in Japanese health professionals' curricula.

One reason is that there already was a tradition of teaching medical philosophy and history in the overwhelming majority of medical schools so that ethics could easily be added and introduced—a situation comparable to that in Germany. The other reason is that political and policy-making bodies requested the integration of ethics in the undergraduate medical curriculum and proposed a model core curriculum. The national medical examination now includes questions about bioethical concepts and issues. However, like in India, most teachers in bioethics do not have any educational background in bioethics themselves. Adachi also discusses the situation in nursing schools where most schools provide bioethics education, and most teachers have a background in nursing. Chapter 4 addresses the teaching of bioethics in Nigeria, Africa's most populous nation. Limited access to bioethics education existed until the decade 2000–2010 when bioethics education received a major boost in development through funding and training opportunities provided mainly by the American National Institutes of Health (NIH). The NIH funded training programs resulted in rapid increase in the number of bioethicists in the country. The availability of this group of professionals has contributed to the development of a national code to regulate the conduct of health research in Nigeria and the establishment of a postgraduate training program on bioethics in the country's premier university. In addition, NIH trained professionals have contributed to the improvement of the expertise for members of Ethics Review Committees in the country. Ademola Ajuwon argues that these improvements have led to the growing recognition of the importance of bioethics as a discipline and its role in ensuring the rights, safety and integrity of persons who participate in research. However, bioethics education seems to focus primarily on research ethics and does not have a wider scope. This is a drawback in a country characterized by a context of poverty and corruption.

A different perspective is in Chap. 5 by Nada Eltaiba who is reporting on her experiences with ethics teaching to social work students in Qatar. Bioethics education is very relevant since social work entails ethical values, in particular in relation to human rights and social justice. In Qatar this is a recent educational activity without much literature in the Arabic language. Eltaiba discusses problems that students encounter because of the specific cultural and religious context of their work. She also shows how the methods of teaching can be adapted to accommodate these problems and to teach students how to effectively cope with ethical issues. Hongqi Wang and Xin Wang in the last chapter in this section present the situation of bioethics education in China. Like in India, there is a long tradition of medical ethics teaching in China, but bioethics education is relatively new because western medicine only became popular since the last century. With the support of international agencies and organizations, bioethics started to develop in the 1980s with the founding of specialized journals and educational programs. Wang and Wang show that there are different academic schools interpreting bioethics as a universal approach or as a more specific Chinese approach, based on the country's tradition and history or based on communist ideology. The interactions between these different schools focus particularly on specific issues such as the tension between individual and collective rights. This tension is clear in the public health policies regarding epidemic diseases such as SARS, HIV/AIDS, and avian flu. The conclusion of the chapter

is that the development of bioethics education is still in its early stages. Although bioethics has been born and is showing signs of promising growth, given the size of the country, its population and the challenges of globalization, it will still take time before bioethics education will have reached a mature stage, benefitting every health professional.

1.10 Ethics Education for Professionals

Bioethics education for professionals is the subject of the second part of the book. The chapters in this part all focus on professional education but within the very different contexts of social philosophy, religion, and commercialism. Paul Ndebele (in Chap. 7) discusses the goals of ethics education for professionals in Botswana. Like in other African countries, society in Botswana is characterized by a specific social philosophy, Ubuntu (or Botho as it is called in the country). It was officially adopted by the Government of Botswana in 1997 as one of the guiding principles for national development and the University supports the national vision by teaching students on the ethics of Botho. It emphasizes that the individual person is intrinsically part of community. Rather than individual autonomy, the basic moral notions are community and shared humanity. This philosophy determines the goals and content of ethics education at the University of Botswana. The university itself is the result of public commitment, established with donations of cattle by the citizens. Educating professionals therefore serves a social purpose. Communal instead of commercial interests are driving professional education. The philosophy of Ubuntu also ensures that ethics education is diachronic, following subsequent stages of the education system, as well as synchronic, articulating the social philosophy of the country. Professionals are trained in regard to moral sensitivity, judgment, motivation and character that is typical for their profession as well as their society. In Chap. 8, Bahaa Darwish who has teaching experiences in the Arab region in the fields of business ethics, bioethics, and science ethics discusses the goals of ethics education against the background of religious traditions, particularly Islam. He distinguishes five goals of ethics education: identifying ethical issues, analyzing ethical issues, applying ethical analysis, moral reasoning, and moral conduct. These goals assume that ethics education can improve the behavior of students. But the results of education programs are different and mixed. It is often argued that in the Arab world religious observance is more important than ethics education. But Darwish rejects this conclusion. He argues that religious students, at least in his part of the world, need to learn ethics more than other students. Moral reasoning for example can make religious practice more consistent. It also provides justifications for religious convictions and it fosters tolerance for other views. Rosemary Donley examines the teaching of ethics to nurses in Chap. 9. Although nursing has a strong ethical tradition, it struggles to conceptualize and teach ethics to students of nursing. This difficulty occurs even with strong endorsement for the importance of ethics in nursing practice from nursing associations.