

PERSPECTIVES FROM SOUTH AND EAST ASIA ON CLINICAL AND RESEARCH ETHICS: A LITERATURE REVIEW

BRIDGET PRATT

*Johns Hopkins University (USA)
University of Melbourne (Australia)*

CASSANDRA VAN

Monash University (Australia)

YALI CONG

Peking University (China)

HARUN RASHID

State University of Bangladesh (Bangladesh)

NANDINI KUMAR

Kasturba Medical College (India)

AASIM AHMAD

Kidney Centre Post Graduate Training Institute (Pakistan)

ROSS UPSHUR

University of Toronto (Canada)

BEBE LOFF

Monash University (Australia)

ABSTRACT: A REVIEW WAS CONDUCTED OF ENGLISH-language peer-reviewed and gray literature on health and ethics written by authors from Bangladesh, China, India, and Pakistan. This was supplemented by the knowledge of co-authors who are involved in bioethics capacity building in these countries. Of the identified literature that focused on the application of Western principles, it largely discussed informed consent and revealed norms in clinical decision-making that include physician paternalism, family involvement in decision-making, and reluctance to provide information that might upset patients. It appears that Western ethical principles may be interpreted and applied in unexpected ways. The literature further indicates that, although there is some consistency with Western ideas, Islamic, Confucian, and Indian religious and philosophical traditions contain concepts not reflected in international guidance. Findings suggest scholars from these countries seek to enter into a bioethics dialogue with the potential to enrich and inform “international” frameworks.

KEY WORDS: research ethics, Asia-Pacific, cross-cultural, China, India, Bangladesh, Pakistan, Confucianism, Islam

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DRAWING ON PEER-REVIEWED AND GRAY literature from writers in Bangladesh, China, India, and Pakistan, this paper considers how religious, social, and cultural norms as well as differences in wealth affect the interpretation of ethical standards for clinical practice and health research. Our literature review explores the following questions: To what extent are Western bioethical principles consistent with the religious and cultural traditions in these countries? If Western guidance is applied, is it interpreted in the same way? Have scholars from these countries identified ethical concepts relevant to research ethics that are not known or understood elsewhere? Do scholars from these countries wish to reform or extend “international” bioethics paradigms? This paper is co-authored by scholars from each of the four countries (YC, HR, NK, and AA), and their knowledge and experience have supplemented this review.

As most discussion of Western ethical principles focuses on their realization in the clinical setting, we extrapolate from this in our consideration of the research context. We apologize in advance for the oversimplification and essentialism of this paper in its attempt to identify, capture, and reduce the complexity of the philosophies we discuss. Also, as English does not possess words that sufficiently reflect the meaning of many terms that follow, the brief descriptions we offer will, at best, be approximations of the concepts these words represent.

Background

DEVELOPMENT OF ETHICAL STANDARDS AND GUIDELINES

It might be assumed that international ethical standards derive from agreements of organizations in which nation-states (and minority and marginalized

interests) are fairly represented and no untoward pressure is exerted to obtain agreement (unlike in, for example, international and bilateral trade or aid arrangements). This ideal, however, is often distant from the reality.

The World Medical Association (WMA), the source of the most authoritative international ethical guidance on medical research, was founded in 1947. A year later, a former colonel in the US Army Medical Corps, Louis Bauer, was elected as its Secretary-General, and remained so until 1960 (ADK, 1964). In 1958, Bauer remarked:

We now have 53 nations within the fold, all of them from the free world. We have none from behind the “iron curtain.” There are two reasons for that. One is that they don’t have national medical associations behind the “iron curtain” anyway, so they would not be eligible. The second is that if they did get in, they’d want to run it or ruin it, so we are not particularly anxious to have them. (1958, p. 474)

During this period, the WMA was dependent on American funding, with the *British Medical Journal* noting that the WMA “leans too heavily on the generous financial support given it by the United States Committee” (Anon., 1952, p. 1032). Susan Lederer, writing on the development of the first iteration of the *Declaration of Helsinki* in 1964, notes that it

reflected the organizational politics and financial structure of the World Medical Association. Although the ostensible product of an international medical association, the Declaration of Helsinki, like the Nuremberg Code which it followed, bore a sturdy American stamp ... Finding appropriate language to reflect different national traditions created some discord among the delegates ... Differences over the practice of human experimentation in different national settings became quickly apparent. (Undated, pp. 1–8)

The differences to which she refers are not normally characterized as cultural differences, but as differences of opinion between American and Canadian delegates on the one hand, and English and French delegates on the other. The key difference related to whether institutionalized children and prisoners should be research subjects, which the Americans and Canadians favored.

The *Declaration of Helsinki* has been redrafted on several occasions, and other guidance such as the Council for International Organizations of Medical Sciences’s (CIOMS) *International Ethical Guidelines for Biomedical Research Involving Human Subjects* has emerged in the interim. These documents may now represent a more global consensus. Yet who is at the table and how

decisions are reached remain crucial matters that are perhaps discussed too little.

Beyond international guidelines, the *discipline* of bioethics may also exclude certain voices and perspectives. Unlike international human rights jurisprudence, where issues like alterity and historical location are commonly debated, not nearly as much attention is given to them in contemporary bioethics. In a commentary in the *American Journal of Bioethics*, Tod Chambers, responding to an article titled “Differences from Somewhere: The Normativity of Whiteness in Bioethics in the United States” by Catherine Myser, states:

Myser has introduced the notion of “whiteness,” but one can only hope that an entire array of additional critical terms will widen our world, such as episteme, hegemony, queer, orientalism, subaltern, habitus, alterity, fetishism, and gaze. If, as Wittgenstein suggests, “The limits of my language means the limits of my world,” one can only hope that bioethics will both come to recognize the limits of its conceptual language and expand beyond it. (2003, p. 15)

Further, and like others, Murray and Holmes believe bioethics has a legalistic, procedural focus in that it is:

pro-capitalist, pro-technology, and pro-governmental. ... [C]ritics must seek to understand the many broader contexts—sociopolitical, socioeconomic, historical, cultural—that provide the conditions under which mainstream bioethical principles have become authoritative. (2009, pp. 1–2)

The acknowledgment of, and response to, different cultural understandings in ethical guidance for research is at an early stage. Cross-cultural analysis in bioethics has tended to consider matters such as consent, confidentiality, and recognition of women’s personhood. Ethical differences between cultures that could be regarded as reasonable, such as an enhanced account of participants’ relationships with others and the burdens they may bear in treatment or research, are less discussed. Nonetheless, differences in cultural understandings mean that internationally “agreed” ethical principles can be interpreted in varied and unexpected ways. Although words may be able to be recited, meaning has not necessarily been embraced. Making pronouncements that concern ethical ideas without having accompanying and continuing conversations across cultures is not ideal.

ADOPTION OF ETHICAL GUIDANCE IN ASIAN COUNTRIES

For countries making the transition to “knowledge-based” economies, harmonizing regulatory requirements for health research with international standards

allows them to gain access to the fruits of international collaboration in science and markets for their products. Within knowledge-based economies, the science and technology sector is considered a key engine of economic growth. Salter and Renzong (2009, pp. 56–57) note that in order to boost

China's ability to compete in the global bioeconomy of stem cell science, the values embedded in its regulations and guidance (general and specific) for the conduct of basic stem cell research are readily compatible with the mainstream global position in the field. Such harmonization of national and international ethical standards has been promoted by Chinese bioethicists and scientists alike, and supported by the state, as a necessary condition for the legitimation of Chinese stem cell science and the integration of China into the international scientific community, with all the benefits that it can deliver.

National economic objectives, globalization, and the dominance of the Western approach to bioethics (among other factors) ensure that research ethics systems organized on Western principles are established in contexts that differ considerably from those in which such systems first evolved. For example:

- In 1998, China's Ministry of Health issued the *Norms for the Ethics Review of Biomedical Research Involving Human Subjects*. In 2007, the ministry promulgated *Regulations on Ethical Review of Biomedical Research Involving Human Subjects* that require, inter alia, ethical review to be consistent both with Chinese law and international guidance (Renzong, 2011). The State Food and Drug Administration and Ministry of Health also issued *Guidelines on Ethical Review of Drug Clinical Trials* in 2010. Western principles such as autonomy, beneficence, and justice and ethical review processes are reflected in the guidelines (Wang & Henderson, 2008).
- The Indian Council of Medical Research's (ICMR) *Ethical Guidelines for Biomedical Research on Human Participants* state that “[a]ll the research involving human participants should be conducted in accordance with the four basic ethical principles, namely autonomy (respect for person/participant), beneficence, non-maleficence (do no harm) and justice” (ICMR, 2006, p. 17). The Indian Medical Council Act (amended in 2002) and Schedule Y of the Drugs and Cosmetics Act (amended in 2005) require researchers to observe the guidelines (Kumar et al., 2008).
- In Bangladesh, guidelines on research ethics were incorporated into the National Health Research

Strategy in 2009 that identify “improvement and harmonization with internationally accepted guidelines and principles of ethics” as a health research challenge that needs to be addressed (Ministry of Health and Family Welfare, 2009).

Countries in Asia have also established systems for ethical review of research. In 2004, the government of Pakistan created the National Bioethics Commission to serve as an advisory body on all aspects of bioethics (Moazam & Jafarey, 2005). This commission works through two subcommittees: the Research Ethics Committee and the Medical Ethics Committee (ibid.). At the subnational level, research ethics committees are still a relatively new phenomenon in Pakistan, with few universities and hospitals having their own (Ghayer, Ghayer, & Janssen, 2007). Nonetheless, Farhat Moazam and Aamir Jafarey (2005) believe this is changing because local ethics approval is necessary to participate in international collaborative research and to publish articles in prestigious journals. Similarly, China's Ministry of Health established a national Biomedical Research Ethics Committee to oversee research ethics in China. Ethics committees exist at provincial and local levels (Li, 2008; Hennig, 2006). Most large hospitals, research institutes, and universities in China established research ethics committees between 2000 and 2007 (Salter & Renzong, 2009). India and Bangladesh have created research ethics committee systems as well (Talukder, 2011; Nair & Martin, 2004). ICMR's Central Ethics Committee on Human Research reviews research proposals of national significance and proposals referred from local ethics committees raising issues that may have a bearing on national policy. The Bangladesh Medical Research Council formed a national ethics review committee in 1979 and nine institutional ethics review committees were established between 2004 and 2006 (Rashid, 2006, 2007).

CONTRASTING TRADITIONS AND SETTINGS

In the Western philosophical tradition, a person is seen as a distinct and rational entity deserving of respect, with the right to make decisions independently of others. The principles underpinning research ethics reflect this conception of what is due to persons and their twentieth-century historical context. The Nuremberg Code (1947) was developed in response to torture perpetrated as research by the Nazis in Europe and the Japanese in Asia during World War II. The *Belmont Report* (1979) was written following the revelation of the Tuskegee syphilis research in the early 1970s and the publication of Henry Beecher's article in 1966, which described unethical projects undertaken by

American researchers (Beecher, 1966). However, Western standards are now being promulgated in contexts that differ considerably from those in which they were first articulated.

South and East Asian countries have religious and cultural traditions that promote value systems that emphasize the family and public interest ahead of a Western vision of individual rights. In the case of Islam, priority will be given to religious rulings. In India and China, indigenous systems of medicine that contain codes of conduct for physicians exist alongside Western medicine (Sujatha & Abraham, 2009; Wang et al., 2011).

These countries often do not have strong health systems (Mahmood et al., 2010; Li & Cong, 2008, Moazam & Jafarey, 2005). A person's family may be the only form of welfare or "insurance" available. Pakistani doctors have commented:

[h]ealth expenditure is borne by the family, giving it a central role in decision making. The concept of the financial survival of the family is a harsh reality. The health-care costs of one seriously ill member may jeopardize the survival of others by draining the limited resources (Aslam et al., 2005, p. e129).

Indian intensive-care physicians working in private hospitals also report the "common occurrence" of unilateral withdrawal of treatment and discharge of terminally ill patients against medical advice because of "unbearable financial and other burdens" (Mani et al., 2009, p. 1716). The allocation of scarce family resources inevitably requires discussion by family members.

Health research in South and East Asian countries is thus undertaken in hugely varying cultural, economic, political, and social contexts, where global inequalities in health care and research systems are stark. That all these differences have ramifications for research ethics has been repeatedly recognized (Macklin, 1999), and there is substantial literature on questions of exploitation in international research (Emanuel, 2008; London, 2008; Lurie & Wolfe, 1997). Yet there has been little examination of non-Western philosophical, religious, and cultural traditions and the ethics of research. This paper, therefore, canvassed literature from selected South and East Asian countries (Bangladesh, China, India, and Pakistan) in order to describe how local contextual conditions and beliefs affect the understanding and application of ethical standards for health research in those countries.

Methods

The Philosopher's Index database was searched for the terms "health and medicine" or "health and ethics and (Asia, Bangladesh, China, India, Pakistan, Buddhism,

Confucius, or Islam)" for articles and reviews written in English between January 1, 1992 and June 19, 2012. Nineteen articles that had first and/or last authors from institutions in Bangladesh, China, India, and Pakistan and discussed either Asian perspectives on medical or research ethics, or aspects of health care and research in the four countries, were selected for further analysis. Eighty-eight articles were found searching the Medline database.

International peer-reviewed journals recommended by YC, HR, NK, and AA (*Asian Bioethics Review*, *BMC Medical Ethics*, *Cambridge Quarterly of Healthcare Ethics*, *Developing World Bioethics*, *Journal of Medical Ethics*, and *Journal of Medicine and Philosophy*) as publishing articles written by Asian ethics scholars were canvassed using the same search terms. Seventy-five articles were identified. Searches conducted of the online versions of *Bangladesh Bioethics Society* and *Journal of the Pakistan Medical Association* yielded 28 articles. The *Indian Journal of Medical Ethics* does not have a search function, so all journal editions from initial publication in 2004 to June 2012 were searched manually. This identified 20 articles written by authors from India, Bangladesh, Pakistan, and China.

Additional articles, books, bioethics courses, conference presentations, news reports, and ethical review committee websites by authors from Bangladesh, China, India, and Pakistan were identified online primarily by entering the search terms "country name and (bioethics, research ethics, medical ethics or ethical issues)" in www.google.com. The first 100–150 hits for each online search were selected for further investigation until hit repetition occurred or the hits were no longer relevant to the selected themes and countries. Subsequently, new search terms derived from these initial data sources were entered into www.google.com and electronic databases until the resulting hits were no longer relevant. All identified URLs, web pages, documents, news articles, human interest articles, and conference and course presentations were collated in a database of literature produced by each country.

Results

VOICING A NEED TO MAKE BIOETHICS CULTURALLY RELEVANT

Scholars from China, Pakistan, Bangladesh, and India state there is a need for a more culturally relevant bioethics. Chinese bioethicists Michael Cheng-tek Tai and Chung Seng Lin (2001) opine that "Asian people have the impression that bioethics is a Western product" (p. 51). They believe that for bioethical principles to be respected, Asians must develop a bioethics that is based

on the traditions, philosophies, religions, and perspectives of their own cultures. Tai and Lin (2001) state that “transferring an idea from one place to another is just like transplanting an organ from a donor to a recipient—rejection is to be expected. Human cultures respond to new ideas from different value systems in very much the same way” (p. 51). They conclude that “[d]eveloping culturally relevant principles of bioethics has become a major task for Asians in the new millennium” (p. 53). Jing-Bao Nie recommends that a cross-cultural bioethics also reflect the plurality *within* Chinese culture, as there is great internal diversity in the understanding of medical ethics in China. Dichotomizing bioethics in terms of Eastern and Western or communitarian and individualistic is overly simplistic, as a range of moral traditions exist within China (Nie 2000, 2007).

Indian writer M. R. Maithreyi asserts, in a preliminary report mapping the history of bioethics in India between 1980 and 2010:

[i]t cannot be disputed that bioethics has come to India as an import from the West, but bioethics in India cannot be restricted or comprehended within the parameters of research ethics guidelines, ethics committees or even bioethics training courses. (2012, p. 52)

Other Indian authors suggest “the current paradigm should be made contextual to India by incorporating Indian philosophies, belief systems, and moral values” (Kumar et al., 2008; Chattopadhyay & Simon, 2008). Like China, there is much cultural and religious diversity within India that can be drawn upon to inform bioethics (Chattopadhyay & Simon, 2008). Maithreyi (2012) also calls for the incorporation of ideas promoted by the women’s rights and consumer rights movements in India into bioethics discourse (p. 52).

Pakistani bioethicists argue that Western bioethics is incomplete. Muslim beliefs and values are central to the comprehension of ethics in Pakistan, creating tension with the secular Western model (Moazam & Jafarey, 2010). Moazam and Jafarey state:

many Pakistanis, Muslim physicians and laypersons alike, believe that it [Western bioethics] is an incomplete guide for chartering realms that extend beyond the purely “scientific” In this view, when reflecting on morality and ethics, reason must take into account longstanding religious and cultural norms as well as an interpretation of Islamic law. (2005, p. 254)

Writing in the most recent edition of the *Bangladesh Journal of Bioethics*, the General Secretary of the

Bangladesh Bioethics Society, Shamima Parvin Lasker, asserts:

[f]ormulation of UNIVERSAL rules and regulation (guidelines) is needed which will not be limited to a specific tragedy or scandal or to the practice of researchers in one country, although their application will require adaptation to particular culture, health condition and economic setting. Research on this line is needed. (2013, p. 27; capitalization in original)

Beyond the more conventional debates concerning culture, nations also identify issues that arise as problems for them that might not have been thought necessary to address elsewhere. For example, a draft administrative recommendation on Chinese stem cell research states:

[t]he sources of human embryonic stem cell in China are mainly from cadaveric fetal tissue, frozen embryos or gametes remaining after In Vitro Fertilization (IVF). Such human embryonic stem cell research must be carried out under the principles of informed consent and confidentiality. There should be strict prohibitions against *causing pregnancy*, and abortion of donors or control methods, and timing of artificial abortion by any means. (Wang, Undated, emphasis added)

It is of interest that Article 1 of the final Chinese *Guidelines for the Moral Principles in Human Embryonic Stem Cell Research* states that the Guidelines are enacted to accord with the “ethical principles of life” (Ministry of Science and Technology, 2003). This appears to be a reference to Confucian values.

SOURCES THAT INFORM MEANING

The understanding of bioethics in the four countries is informed by centuries-old religious and cultural traditions and, in India, the claims of more recent activist movements. Each is a source of ethical concepts and deliberative mechanisms. Some Chinese bioethicists are applying Confucian perspectives to reinterpret Western principles. Pakistani and Bangladeshi bioethicists (as well as bioethicists from Iran, Saudi Arabia, and Turkey¹) have explored traditional Muslim sources and the teachings of Islam, comparing them with Western requirements for research ethics. Beyond discussion of Ayurveda in relation to codes of professional medical ethics, this review did not reveal writing applying other Indian² sources of belief or medical practice to research ethics or that compared these sources with Western bioethics (Pandya, 2000; Valiathan, 2008).³

Confucian Bioethics. There is not universal agreement that Confucianism provides the best source for a

distinctively Chinese medical ethics. Nie (2000) argues that Chinese medical ethics is a “combination of Maoism-Marxism-Leninism, Confucianism, Taoism, and Chinese Buddhism” (p. 247). He also states: “the assumption of a monolithic and unified Chinese culture in general, and a single medical ethics in particular, is a myth” (p. 250) that, in part, reflects the fact that the ruling ideology in China wants to promote the impression of a single moral system.

Nonetheless, Confucianism has been the main source used to explore bioethics from a Chinese perspective. Few Chinese scholars rely on Buddhism, Taoism (Li & Cong, 2008), or other perspectives for this purpose. Ruping Fan argues:

Confucian reflections can help to reverse a kind of cultural imperialism through which the attempt has been made to recast the moral discourse of Hong Kong and mainland China in terms of the moral assumptions of America and Western Europe. (2007, p. 513)

In Confucianism, the terms *lunli* (the principles) and *daode* (the practice) refer to an ethical system that prescribes the qualities people should possess and rules of conduct that should be observed to promote a harmonious society (Pang et al., 2003). *Lun* refers to human relationships and *li*, to standards or rules. *Lunli* is thus the rules governing relationships, which if followed, will create a harmonious, ordered society. *Dao* means the virtuous path and *de*, virtuous behaviour. Within this system, the concepts of *jen*, *yi*, and *li* provide guidance for determining an ethical course of action. *Jen* (sometimes referred to as *Ren*) encompasses altruism, compassion, good will, and humaneness. Its “focus is on what people can accomplish in relation to others” (Pang, 2003). For Confucius, *jen* prevailed if, as a value, it conflicted with others. *Yi* is the ability to recognize and do what is right and just, often interpreted as righteousness. As already noted, *li* are rules prescribing how people ought to behave.⁴ Another key concept, *chun-tze*, is the superior or ideal “man” (Nie, 2011; Tsai, 2005b). In the Analects Confucius says of the *chun-tze* that “he” acts according to virtue and integrity, is polite to all, respectful to his superiors, kind to the people, and just in his official functions. “The Chun-Tzu is ashamed when his actions do not match his words” (Confucius, 551–479 BC).

Daniel Fu-Chang Tsai and Qiu Renzong argue that the principles of autonomy, beneficence, nonmaleficence, and justice are discernible in Confucian ethics (Renzong, 2005; Tsai, 2005a). However, the Confucian concepts of *jen*, *yi*, and *chun-tze* have additional dimensions.

According to Tsai, the principle of autonomy can be found in the concept of *chun-tze* but has two dimensions—the autonomous person *and* the relational person. The autonomous “man” is self-determined, self-reliant, and constantly improving himself through moral cultivation. The relational “man” achieves humaneness (*jen*) through interaction with other individuals within the context of his social roles and responsibilities (Tsai, 2001). Individuals cannot reach the ideal of the superior “man” without being autonomous *and* fulfilling relationship-oriented responsibilities (Tsai, 2005a). Autonomy is, thus, both individual and relational (as it is in some Western feminist theories, though “relational” is likely to be interpreted somewhat differently).

In contrast, Ruping Fan contends that two different principles of autonomy are implicit in the cultural and ethical traditions of East Asian and Western countries:

the East Asian principle of autonomy contains the minimal substantive content of family-sovereignty, an objective conception of the good and harmonious dependence, while the Western principle of autonomy carries the minimal substantive content of self-sovereignty, a subjective conception of the good and individual independence. (1997, p. 319)

Fan considers autonomy to be entirely relational. The family, not the individual, has the final authority to make clinical decisions, as family members must rely on one another to take care of each other’s interests. For Fan, autonomy is best understood as the right of individuals to make choices harmoniously in cooperation with others (Fan, 1997). What is to occur if a dispute arises or duress is exercised is less clear.

Tsai believes the principles of beneficence and nonmaleficence can be compared with the Confucian principle of *jen*. *Jen* has two central dimensions or formulations: avoiding harm to others and “the love of gradation” (Tsai, 2005b, p. 637). A gradational pattern of love entails treating one’s family with respect and love, then progressing but with lesser degrees of precedence or urgency to treat the community, country, and all humanity similarly (Tsai, 2005a). As Tsai notes, however, Confucian precepts will require one to show unequal love and treatment to others according to one’s relationship with them (Tsai, 2005b, p. 639).

The principle of justice can be compared to the Confucian principle of *yi*, or doing what is right. *Yi* requires an examination of competing moral principles and applying them flexibly to the context. This may encompass the regulation of personal desires and limiting the pursuit of profit. Tsai (2005a) likens this to a focus on fair acquisition and distribution of resources.⁵ However,

Tai and Lin (2001) argue that Confucius saw justice as oughtness more than fairness. Confucius believed everyone was endowed with specific responsibilities by their station in life and meeting these responsibilities is what is meant by justice.

In Confucian ethics, dilemmas will arise due to competing demands from different relationships or when a person is asked to act contrary to a virtue s/he believes is important (Pang et al., 2003). Nurses in China describe conflicting loyalties to physicians, hospital administrators, and patients, which create difficulties for their identification of the correct course of action. An example may be withdrawing treatment from patients, as this may put their responsibility to patients in conflict with their responsibility to meet the resource constraints of the medical system (ibid.).

Ultimately, Chinese scholars have not derived or described an alternative paradigm for bioethics based on Confucian values in English-language journals. Instead, the work identified by this review focused on determining whether some Western bioethical principles are consistent with Confucianism and, if so, how they might be reinterpreted according to its values and principles.

Islamic Bioethics. While Islamic bioethics does not yet exist as a cohesive discipline, its features are beginning to be discussed in English-language journals by authors from Islamic countries. Since bioethical deliberation in Pakistan is inseparable from Islam, it draws on religious texts and legal rulings as the primary resource to guide ethical analyses. Ethical reasoning relies on Shari'ah Law and is based on four sources called *usul al fiqh* that have been agreed upon by the major schools of law in Sunni Islam (Moazam, 2011). They are the Qur'an, the Sunna, *ijma'*, and *qiyas*⁶ (Padela, 2007). The Qur'an contains the words of G-d. The Sunna relays the words of the Prophet (Moazam, 2011). *Ijma'* refers to the opinions of Islamic jurists formed after the death of the Prophet (Padela, 2007). The term *qiyas* means "to compare." In Islam, *qiyas* is reasoning by analogy or precedent utilized by Islamic jurists (Padela, 2007). Islamic bioethicists rely on the Qur'an, the Sunna, *ijma'*, and *qiyas* to determine their positions on ethical dilemmas in medicine and research. However, there is great diversity in the views of Muslim jurists. In effect, Shari'ah Law has been used to argue for different positions on the same ethical issue. Moazam (2011) provides an excellent example of this in relation to organ transplantation.

Several secondary principles within each of the Sunni schools can also be relied upon in ethical analyses. They include *maslahah*, the principle of public interest (Padela, 2007), according to which an act *may* be proper if it

confers benefit to the most people (Larijani & Anaraki, 2008). The principle of *isthisan* states that equity considerations may override *qiyas* (Padela, 2007). The principle of *darura* (necessity) permits the use of the forbidden in circumstances of necessity, and the principle of *la haradj* (no hardship) exempts people from religious deeds if performing them leads to extreme difficulty. The principle of *la darar wa la derar* (do no harm) prohibits causing a loss to another person (Larijani & Anaraki, 2008). Bangladeshi authors draw attention to the same principles:

Some of the rules of Islamic medical ethics are:

- (1) Necessity overrides prohibition that is if there are certain items which are Islamically prohibited, under dire necessity they can become permissible.
- (2) Accept the lesser of the two harms if both cannot be avoided.
- (3) Public interest overrides the individual interest.
- (4) Harm has to be removed at every cost if possible. (Talukder et al., 2010, p. 133)

Hossain (2012) notes, however, that pragmatic principles such as these will never take precedence over a clearly articulated principle originating in the Qur'an.

Islamic scholars have argued that autonomy, beneficence, nonmaleficence, and justice can easily be found in the Qur'an and the sayings of the Prophet (Aksoy and Elmali, 2002; Fadel, 2010). In 2004, CIOMS, in cooperation with the Islamic Organization for Medical Sciences (IOMS), published the *International Ethical Guidelines for Biomedical Research Involving Human Subjects—An Islamic View*, which analyzed the CIOMS guidelines for consistency with Islamic law (Alahmad & Dierickx, 2012). Most of the CIOMS guidelines are judged to be in accordance with Islamic principles and law, but not all. For example, Islamic law emphasizes the precedence of community interests over those of the individual (Aksoy & Elmali, 2002). The Islamic commentary on CIOMS Guideline 8, "Benefits and Risks of Study Participation," states that a risk to an individual is acceptable if the benefits to society are judged weightier. It is acceptable to "use the expected, significant benefits to society as a justification of the risks of interventions that do not hold out the prospect of direct diagnostic, therapeutic, or preventive benefit for the individual" (IOMS, 2006, p. 31).

Further work is needed to determine the extent to which public interest supersedes individual interest in the research context (Fadel, 2010). The IOMS document also states it is preferable to obtain the husband's consent when recruiting married women for research. A husband's consent is necessary when recruiting a pregnant

woman for research, where there is any potential risk to the fetus (*ibid.*). The husband's consent does not replace that of his wife in either case. The CIOMS guidelines recommend that the husband's opinion be obtained when possible.

Indian Sources of Bioethics. With India's vast diversity of languages, religions, and cultures, Subrata Chattopadhyay and Alfred Simon (2008) state that it is difficult to identify a representative Indian perspective on bioethics. Indian bioethicists have identified three sources—Indian philosophies (for example, Hinduism, Buddhism, Jainism), traditional systems of medicine (Ayurveda, Yoga, Unani, Siddha, Homeopathy), and perspectives of activist movements (women's rights, consumer rights)—that might be applied.

There is no particular belief or doctrine shared by Hindus that can be relied upon to distinguish Hinduism from other Indian religious or philosophical groups. Hinduism, Buddhism, Jainism, and streams within them have been influenced by each other, particularly in the realm of ethical thought. Indian philosophy can be divided into two stages: pre-systematic (before 200 AD) and systematic. In the pre-systematic stage, the *Vedic* literature (especially the *Upanishads*), Buddhist and Jaina canons, and epic tales consider the nature of reality and of knowledge, and life's goals and the attitudes and behaviors required to achieve them. In the systematic stage, the views of influential thinkers were systematized into schools of philosophy, which were divided into the six *Astika* systems based on the *Vedas* and the two main *Nastika* systems, Buddhism and Jainism, in which renunciation of the material world is the ultimate goal. A third *Nastika* system, the *Lokayata* system, reflects Indian materialism and rejects ideas involving the supernatural such as rebirth. The austerity inherent in other systems mentioned above is not found in this system (Bhelke & Gokhale, 2002).

Most concepts within Indian philosophy are complex, difficult to express concisely, and have no direct translation. A strong theme is that of *Brahman* or the constancy of the universe, unified and unchanging despite its seeming diversity. From *Brahman* comes all and all returns to it. The *Vedic* texts enlarge upon the relationship between *Dharma* (often interpreted as moral duties) and life's central goal—*Moksha* (liberation from the cycle of rebirth). *Dharma* is discussed at great length in *Dharmasastras*, an immense literature discussing duties and obligations. *Dharma* includes universal moral obligations like truthfulness, nonmaleficence, and compassion. It also includes social obligations dependent on cultural context such as family background, marital

status, caste-based social status, gender, and stage of life. Personhood is thus conceived of as relational. Speaking of Hinduism, Arti Dhand suggests that

in the social world, there is no such thing as “a person” per se. There are only different types of people, and we cannot consider people in isolation from their difference, or our ethical codes risk being so beset with exceptions that they become incoherent, or just plain irrelevant. (2002, p. 353)

Traditional systems of medicine like Ayurveda offer guidance on professional ethics, urging physicians to constantly endeavor to cure without causing harm (Pandya, 2000). Sanat Bhagwati states:

Indian philosophy advocates the development of the atman or soul, emphasising the relative insignificance of the body. The goal of Ayurveda is to keep the body healthy and preserve life so that it can be dedicated to austerity, meditation, discipline of the mind and liberation of the atman, the soul. (1997, p. 430)

Early Ayurvedic writing required a medical student to be chaste, truthful, and a vegetarian. The sick were not to be harmed, even in thought. Death was not to be discussed if mentioning it might do harm to the patient or others. Consolation should be offered to a patient close to death and treatment not commenced. The wife or goods of another were not to be coveted. The destitute were to be treated as if they were kin. Egotism should be renounced (Bhagwati, 1997). The other Indian traditional systems of medicine, namely, *Siddha* and *Unani*, similarly direct physicians to be spiritual, knowledgeable, truthful, patient, compassionate, and confident. Physicians are considered to have a moral obligation to attain new knowledge and skills in order to provide continually better treatment.

LOCAL IMPLEMENTATION OF WESTERN PRINCIPLES

The literature we reviewed is dominated by discussions of informed consent. Three themes were identified, which we discuss next under the headings “paternalism,” “family-based decision-making,” and “protective truth-telling.” Although discussed primarily in the context of medical decision-making, this may provide some insight into how consent processes function in research.

Paternalism. A paternalistic doctor-patient relationship was once the norm in all four countries examined in this paper. This type of relationship is characterized by patients' deep trust in doctors and the limited likelihood that patients will challenge their doctors' advice.

Although physician paternalism may still be the norm in India and Pakistan, this may no longer be the case for parts of China and in Bangladesh (Moazam, 2000; Chaturvedi, 2008).⁷

According to Moazam, Pakistani doctors are often held in high esteem because healers are seen as instruments of divine mercy (Moazam, 2000). They are perceived as having a connection with G-d in their role as a physician. Doctors are not viewed merely as experts providing a service to consumers, but are often placed in the roles of authority figure and family member by patients, who may address their physician as mother, father, elder brother, or elder sister (ibid.). Chattopadhyay and Simon (2008) assert that, in India, doctors are similarly held in high regard and often considered honorary family members.

EC Hui states that doctors in China

have social roles equivalent to that of parents and they are expected to treat patients with the benevolence of parental “hearts.” But since fathers (before the modern era, all physicians were male) also assume authoritative roles in the Chinese tradition, physicians are also expected to behave authoritatively. A combination of benevolence and authority provides the perfect soil for the development of paternalism. (2005, p. 223)

Given doctors’ high social status, many patients will simply accept their recommendations for medical treatment and participation in research (Hui, 2005).

However, badly constructed market-oriented reforms implemented by the Chinese government may be changing this view of doctors (Cong, 2004). The reforms reward doctors and hospitals for prescribing and selling medications and using high-technology diagnostic tests in clinical practice. As doctors’ base salary remains quite low, these reforms have generated conflicts of interest, leading doctors to overprescribe drugs and use more expensive tests. This has eroded patient trust (Cong, 2004; Fan, 2007; Zhang, 2011). A survey of 30 Chinese hospitals in April 2002 showed that 43.8% of patients do not trust medical professionals and only 25.9% of doctors felt that patients and physicians trust each other (Li & Cong, 2008). In addition,

[i]t is reported by Beijing Medical Association that in 2001 alone there were more than 500 cases of a patient/family member hitting a doctor. The most serious case was that of a patient who killed his doctor because the doctor could not cure his leukemia after the patient had expended all the money he had. (Cong, 2004, p. 167)

In Bangladesh, doctor-patient relations are quite poor. Acute health worker shortages in Bangladesh mean that

the doctor-patient ratio is very low (Talukder, 2011; Begum, 2001). Doctors reportedly complain of low salaries, lack of support staff and equipment, and high workload, causing them to work in more remunerative private practices and neglect their public patients (Talukder, 2011; Begum, 2001). Patient mistrust of doctors is thought to be a response to the image of doctors as corrupt and in pursuit of money. This is exacerbated by the short time that doctors generally spend with patients, their apparent lack of caring, and negligence (Talukder, 2011). This year the Bangladeshi “Health Rights Movement,” a forum of 92 organizations, called for government action to address rising corruption in the public health care system. In a Transparency International Bangladesh survey of 7,500 households nationwide, 40.2% of respondents reported suffering irregular and corrupt practices in public hospitals, compared to 33.2% in 2010 (UN Office for the Coordination of Humanitarian Affairs, 2013).

In 2008, the Bangladesh Medical and Dental Council, supported by the Centre for Medical Education in Bangladesh and the World Health Organization, developed a “Module on Teaching Health Ethics in Undergraduate Medical Education in Bangladesh” that notes:

[i]t has often been said that there has been a dramatic change of values from paternalism to autonomy in the physician-patient relationship. Traditionally, it was globally accepted that the physician knew best and should decide what should be done to patients, without informing them and without involving them in the decisions. Today, it is no longer valid that physicians make decisions without involving their patients and/or the patients’ relatives. The principle of patient autonomy prescribes that he/she should be the one to ultimately decide what should be done in the clinical encounter. There are, however, limits to patient autonomy and some of these are probably dependent on the specific cultural conditions in a country. (p. 13)

Family-based Decision-making. Empirical research in China, India, and Pakistan indicates that a consent process in which families or senior male members of families play a prominent or central role is common in clinical practice and may extend to the research context.

According to Confucian philosophy, the family is necessary for individual flourishing. People cannot lead a good life without establishing the three basic familial relationships (father and son, mother and daughter, husband and wife, elder brother/sister and younger brother/sister) and fulfilling the attached moral roles,

responsibilities, and rituals. It is seen as the responsibility of the family to take care of members who become sick. Family members are, therefore, deeply involved in the medical decision-making process along with doctors and patients so that patients do not bear the *burden* of independent decision-making (Pang, 1999).

Xiaoyang Chen and Ruiping Fan (2010) suggest that Confucianism assigns importance to harmonious family decision-making⁸ in which the views of each family member are considered and a compromise decision reached, informed throughout by virtue principles. Although family structures are beginning to change in China, traditionally families are understood to include at least three generations and bear the primary responsibility of caring for sick members. Doctors tend to give medical information to family members before patients. Discussions between doctors and families generally determine what information is given to patients, with families forming a bridge between patients and doctors. If there is disagreement between the patient and their family, a doctor should endeavor to stand with the party whose view is in the medical best interest of the patient and attempt to persuade the other party of this view (Chen & Fan, 2010).

Despite this emphasis on the family's role in medical decision-making, China appears to be in a transitional state, moving towards greater patient involvement in consent processes. Cong (2004) suggests that although families tend to adopt their doctor's plans, greater attention is being paid to patients, who are increasingly suing hospitals and doctors. Article 11 of a law promulgated in 2002 establishing the "Basic Standard for Medical Record Writing" states:

[i]t should be the patient himself who signs the informed consent form. Only when the patient is not competent, then his legally authorized representative should sign . . . If it is unsuitable to inform the patient because protectiveness medicine is being implemented, a family member should be informed and required to sign, and all these data should be recorded. (Cong, 2004, p. 172)

In Pakistan, religious beliefs and cultural norms emphasize the primacy of family *and* the privileged position of doctors. As such, family-centred decision-making is accompanied by a directive role assumed by the physician (Moazam, 2000). A patient may delegate family members to make treatment decisions or invite the doctor to decide. Sometimes families will insist on excluding the patient from decision-making (Jafarey & Farooqui, 2003). As families are hierarchical, and decision-making responsibility gendered, the oldest male will often play a key role in major decisions.

Empirical research, in which the views of patients, their attendants, parents, school teachers, and office workers were canvassed, found that 44% of those surveyed felt it was essential to include the family in medical decision-making. Sixty percent said that when the patient was a woman, it was essential to seek the father's or husband's permission first. Seventy-four percent said that a doctor must still gain the consent of female patients even if their family has already consented (Jafarey, 2006). Moazam asserts that a complete shift to individual rights is not feasible or desirable in Pakistan. As noted earlier, where families fund health care, they may face the unbearable decision between prioritizing the life of an individual or the survival of the family (Moazam, 2000).

In India, family decision-making is common in clinical and research practice. A literature review of pain relief and palliative care in low-income countries by S. K. Chaturvedi found the following:

[i]n a traditional and developing society, the family plays a significant role in each stage of diagnosis and management. In the Indian family scenario, a responsible family member (patriarch) is the decision-maker, who would discuss most treatment-related matters, and invariably there is collusion with the treating team. (2008, p. 613)

The head of the family (father, husband, or eldest son) tends to be the final authority on treatment decisions. It is not uncommon for a patient to leave decisions about medical care to the family, doctor, or spiritual advisor (Chattopadhyay & Simon, 2008). The review points out that family decision-making does not protect patients' privacy and confidentiality. With stigmatized illnesses such as cancer, this can have serious ramifications because patients will wait until they are extremely sick to seek care. Once families discover that a member has cancer, s/he may be isolated and disowned (Chaturvedi, 2008). A study of 50 men and 7 women in rural north India found a somewhat different decision-making pattern for medical research. In response to open-ended questions, 63.2% of participants said they would consult with others (family, friends, and/or neighbors) when deciding whether to participate in research. Yet 36.8% said that they would make the decision independently. Of the seven women interviewed, only one said that she would decide on her own. Four said that their husband or mother-in-law would decide on their behalf (DeCosta et al., 2004).

Protective Truth-telling. Doctors in China may not see full information disclosure as a patient's right. Instead, confidentiality entails refraining not only from disclosing patients' information but also from disclosing

medical information to vulnerable patients thought unlikely to benefit from it (Pang, 1999). Breaking bad news to a patient who may suffer an increased psychological burden is considered an insincere act (Pang, 1999). As a result, patients may receive limited information about their condition and treatment options, particularly when this concerns a terminal illness (Cong, 2004). Protective medicine can result in ethical conflicts for health professionals where a family requests the patient not be told about their condition but the doctor and/or nurse feels it is in the patient's psychological or medical interest to know. Chen and Fan (2010) argue that Confucian virtue principles suggest that health professionals should follow a family's directive to deceive the patient unless evidence is lacking of mutual regard between the patient and family and/or the family's wishes are "egregiously" in discord with the physician's professional judgment. Difficulties also arise when patients want to know their medical condition but medical professionals and family members prefer to withhold the information. Nie (2011) suggests that, in such cases, the Golden Rule in Confucianism should be relied upon to guide doctors' behavior: "Do not impose on others what you do not wish for yourself."

Evidence derived from empirical studies, however, indicates that most people in Hong Kong and Mainland China would prefer to be fully apprised about their conditions, even when the diagnosis is of a terminal illness (Nie, 2011). Nie believes it is also incorrect to claim that full information disclosure is culturally alien to China, as there was once such a tradition endorsed by the Confucian idea of *xin*.⁹ Although protective truth-telling is common practice today, it may ignore past traditions and the wishes of many Chinese patients (ibid.).

As in China, physicians in Pakistan use discretion when discussing a terminal illness with patients. They rarely tell a patient that s/he is dying or may do so in ambiguous terms. This is to protect the patient from additional distress (Moazam, 2000). The *Islamic Code of Medical Ethics* states that the patient has a "right" to know about his/her illness but also affirms that a doctor's "way of answering should be tailored to the particular patient in question." The doctor is advised to avoid "frightening nomenclature" (Moazam, 2000, p. 32). Qualitative research on doctors' perspectives on informed consent found Pakistani doctors believe that, while they have a duty to deliver at least basic information to their patients, the information provided should be "individualized" (Jafarey & Farooqui, 2003). They felt it was acceptable to use words like growth or mass instead of cancer and some preferred to exclude distressing facts and paint a more optimistic picture. The job of the doctor is to reassure and comfort the sick. Certain

doctors also said they limited the information they told patients in order to avoid scaring them away to doctors with a more reassuring approach. A concern voiced repeatedly was that, by providing "too honest" informed consent, they were imposing "foreign" values on patients by giving them "unwanted and unsolicited autonomy" (Jafarey & Farooqui, 2003, p. 95). Robyna Khan (2008) asserts that, in the research context, risks may be under-described because "[p]atients in clinical practice do not want to hear bad news and physicians tend to maintain the same smooth description as employed in clinical practice" (p. 82).

TRADITIONAL MEDICINE

Debates have arisen in China and India about whether research on traditional medicines should adhere to Western ethical principles and how the efficacy of these products should be measured. Scholars in China and India note that measures of drug efficacy can have dimensions beyond those assessed in most randomized-controlled trials. V. Sujatha and Leena Abraham (2009) refer to the "populist measure of efficacy," which refers to the lived experience of relief from symptoms. Wang et al. (2011) describe a "comprehensive judging system" for efficacy that includes subjective indicators such as participants' feelings. These authors suggest that Chinese medicine research should ensure research questions and methods are in accordance with the philosophies and theories of Chinese medicine (Wang et al., 2011). Gaining informed consent in such research includes an adequate explanation of the therapeutic mechanism of the drug being tested according to the theories of Chinese medicine (ibid.).

Discussion

Scholars from Bangladesh, China, India, and Pakistan would like a bioethics discourse that is more culturally relevant. It is, however, unclear whether they prefer the development of distinct bioethical paradigms or seek to enter into a dialogue with the potential to enrich and inform "international" frameworks. The literature suggests there may be support for the latter. Although there is some consistency with Western ideas, Islamic, Confucian, and Indian religious and philosophical traditions contain concepts that are not reflected in Western ethical principles. Scholarship based on Confucian ideas identifies concepts like familial autonomy, gradational love, and justice as oughtness. Scholarship from Islamic countries identifies further ideas such as *maslahah*, the principle of public interest.

Our review indicates that the desire by low-income countries to enjoy the fruits of knowledge-based

economies may lead to conformity with international research ethics standards in words rather than practice. Where Western principles are applied, they may take on a different meaning. For example, Islamic scholars believe that much of their learning is consistent with the “four principles,” but there are many ways in which these principles may be qualified. The Bangladeshi “Module on Teaching Health Ethics in Undergraduate Medical Education” both promotes the principle of patient autonomy and states that patient autonomy is subject to limits dependent on cultural conditions. Similarly, informed consent processes in research in Pakistan do not include a description of the more significant research risks. One ought not to have informed consent that is “too honest.” It might be argued that these practices are simply mistaken. However, it is equally possible that individuals believe they have been fulfilling the new standards required of them.

Asian scholarship on the application of Western principles has focused on the practice of informed consent, discussing decision-making norms in clinical medicine such as physician paternalism, family decision-making, patriarchy, and protective truth-telling. These factors move the locus of decision-making away from individuals, particularly women, and may impede individuals from being told pertinent information about research during the consent process. These issues would benefit from continued scholarship and exploration in teaching. Two key issues that emerge strongly are how the role of the family and the public interest are to be characterized and considered. For example, if the family is the sole provider of funding for health services and the sole provider of financial support and personal care subsequent to an intervention (whether or not this is related to clinical research), they become an integral part of the consent process. Family agreement when the patient does not consent may be potentially easier to resolve than situations in which the patient consents and the family does not agree. A simplistic response would place family negotiations beyond the purview of health or research ethics. Whether this is achievable or even desirable is another question.

It would be valuable to conduct more empirical research into how principles other than autonomy encoded in regulations in Asian countries are actually applied—both to health care delivery and to research, on which far less literature is available. Comparisons between Catholicism, Judaism, and the approaches described in this paper, and of these to secular research ethics, would no doubt be of value. Similarly, comparisons between other traditions and the different streams within Western ethical traditions, as they apply to medical research, should be undertaken. Patient-centered

practices derived from traditional medical practice may inform the development of similar practices in the West. An exploration of feminist ethics and how authors characterize ideas about interdependence, autonomy, and community in light of the ways in which these ideas have been considered over millennia in other traditions may prove enlightening. The results of such research will be of immense benefit to those seeking to offer meaningful instruction to future students and to the conduct of research.

This study has certain limitations. Only English language articles were reviewed, which excludes significant bodies of scholarship. Reliance on authors’ knowledge of local literature was a way of trying to address this limitation. Additionally, as it is difficult to canvass the gray literature in a comprehensive manner, it is possible that relevant articles were not identified by our review.

Ultimately, a commitment to conduct ethical research according to prevailing international, yet foreign, standards cannot be divorced from the influence of local context and culture. Without engaging in debate and building shared understandings of Chinese, Islamic, Bangladeshi, and Indian approaches to clinical and research ethics and what they entail in practice, there can be little confidence about what is communicated in discussion about the observance of ethical standards. As Widdows (2007) notes, the question is no longer “[w]hether or not we should advocate global bioethics,” but rather “[w]hat type of global ethics should we promote?” (p. 306). Standards of research ethics may need to give further consideration of issues such as how to address the role of family, with non-Western schools of thought providing resources to inform thinking so a truly *global* standard is created (Widdows, 2007). Positive engagement and inquiry may prove both instructive and rewarding.

Best Practices

Positive engagement between diverse cultures and philosophies will assist in the creation of a truly global bioethics.

Research Agenda

Empirical research should be carried out into how the principles encoded in international guidelines on the ethical conduct of research are applied in Asian countries. Comparisons between Asian and Islamic traditions and the different streams within Western ethical traditions, as they apply to medical research, should be undertaken.

Educational Implications

The results of cross-cultural research will be of immense benefit to those seeking to offer meaningful instruction to future students about the conduct of research internationally.

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Author Note

Please address correspondence to Bebe Loff, Michael Kirby Centre for Public Health and Human Rights, School of Public Health and Preventive Medicine, Monash University, Level 6 Alfred Centre, 99 Commercial Road, Melbourne, Australia. Phone: 613 99030587; E-MAIL: Bebe.Loff@monash.edu.

Authors' Biographical Sketches

Bridget Pratt is an Australian National Health and Medical Research Council Sidney Sax– Public Health Overseas Postdoctoral Fellow and a former PhD candidate at the Michael Kirby Centre for Public Health and Human Rights, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia.

Cassandra Van is a research officer at the Michael Kirby Centre for Public Health and Human Rights, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia.

Yali Cong is Professor of Medical Ethics at the Institute for Medical Humanities, Peking University Health Science Center, China. She is the Chair of the Peking University Institutional Review Board.

Harun Rashid is working at the State University of Bangladesh as Professor of Public Health and Research Management. He has served as the Director of Bangladesh Medical Research Council for 18 years.

Nandini Kumar was the Deputy Director General Sr. Grade of the Indian Council for Medical Research and is an Adjunct Visiting Professor at Kasturba Medical College, Manipal, India.

Aasim Ahmad is a nephrologist at the Kidney Centre Postgraduate Training Institute in Karachi and Director

Master of Bioethics (FIC/NIH funded) and Co-chair of the Bioethics Group, Aga Khan University, Karachi, Pakistan.

Ross Upshur is the Canada Research Chair in Primary Care Research and a professor in the Department of Family and Community Medicine and Dalla Lana School of Public Health, University of Toronto, Canada.

Bebe Loff is the Director of the Michael Kirby Centre for Public Health and Human Rights, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia.

BP wrote the first draft. BL refined this draft, and rewrote aspects of the paper in response to queries and comments. CV conducted the gray literature review. Other authors contributed culturally specific information and provided comments on drafts of the paper.

End Notes

1. The literature identified by our review that was written by Pakistani and Bangladeshi bioethicists in English on Islamic bioethics left certain concepts unclear. To gain a better understanding of these concepts, we relied on three additional articles written by authors from other Islamic countries: Turkey, Saudi Arabia, and Iran.
2. "Hinduism" is regarded by some as a late eighteenth-century creation of Christian missionaries, colonial scholars, and administrators, as there was at that point "no single name for India's overlapping religious traditions" (Mishra, 2009). This pluralist religious setting flourished before the establishment of the modern state of India, taking in the *Vedic* religion, the *Upanishads*, Buddhism and Jainism and, in India, "diluting the monotheistic core of Islam and Christianity" (ibid.). Some have gone so far as to argue that Hinduism is a European construction and does not reflect an Indian reality (Bloch, Keppens, & Hegde, 2010). The development of Hindu nationalism as a political movement may have been a spur to the consolidation of Hindu philosophies. As a result, in this section, we discuss Indian rather than Hindu sources of bioethics.
3. To the extent that literature beyond the parameters of this review was studied, certain themes that affect delivery of health care are evident. These include a circular rather than linear approach to life (with the achievement of a state of *moksha* or nirvana as the aim), not harming any sentient being, and the need to consider the individual within their family and environmental context. Writings raising bioethical issues focus on the beginning and end of life and transplantation.

4. Writing in 1924, Cai Yuan-pei proposed that there was concordance between the Chinese and Western ideas of righteousness and freedom, forgiveness and equality, and altruism for universal well-being (Chen, undated).
5. In a 1972 treatise on *yi*, Chung-ying Cheng states, “*Yi* is a principle of action independent of consideration of self-interest and material profit as well as that which preserves the autonomy of the self as an individual capable of fulfilling virtues. In this sense, *yi* is a universal of virtue which makes all virtues possible and therefore should be the foundation of all virtues” (pp. 273–274). *Yi* enables decisions to be made. The feeling of shame is a way in which one can become aware of *yi* (Cheng, 1972).
6. Not all regard *qiyas* as an acceptable source of Islamic law. For a discussion of this, see for example Muhammad Al-Mukhtar Al-Salami, “Al-Qiyas (Analogy) and Its Modern Applications,” Islamic Development Bank, Islamic Research and Training Institute, Eminent Scholars Lecture Series No. 15, retrieved from <http://uaelaws.files.wordpress.com/2012/05/al-qiyas-analogy-and-its-modern-application.pdf>.
7. Our own data from in-depth interviews with former Fogarty International Center bioethics trainees from Pakistan indicates that the norm of physician paternalism may also be changing in Pakistan. Doctors have been killed by patients’ families where patient outcomes were unexpectedly poor. Where Pakistani patients have a high socioeconomic status, physicians are now less likely to be primarily responsible for medical decision-making. However, where patients are not well-educated, doctors continue to make treatment decisions on their behalf. Shamim & Shamim (2010) also affirm this view.
8. Cheng and Fan (2010) point out that harmonious decision-making does not require that all people express the same view, nor should a person who expresses a contrary view be excluded from the discussion.
9. Cecilia Wee notes that *xin* is often interpreted as trust. She believes it is a narrower concept, more like making good on one’s word (Wee, 2011).

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