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

Some conclusions

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

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

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

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Abstract

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

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

Introduction

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

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

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

Teaching Goal – Internal or External?

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

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

Medical Ethics or Health Care Ethics?

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

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

Historical Insights

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

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

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

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

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

Methodological Approaches

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

1) Principle-based approach

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

2) Procedure-based approach

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

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

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

3) Narrative approach

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

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

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

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

Conclusion

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

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

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

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Abstract

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

Introduction

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