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ORIGINAL PAPER

What Does It Mean for a Case to be 'Local'?: the Importance of Local Relevance and Resonance for Bioethics Education in the Asia-Pacific Region

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Abstract

Contemporary bioethics education has been developed predominately within Euro-American contexts, and now, other global regions are increasingly joining the field, leading to a richer global understanding. Nevertheless, many standard bioethics curriculum materials retain a narrow geographic focus. The purpose of this article is to use local cases from the Asia-Pacific region as examples for exploring questions such as 'what makes a case or example truly local, and why?', 'what topics have we found to be best explained through local cases or examples?', and 'how does one identify a relevant local case?' Furthermore, we consider the global application of local cases to help extend the possible scope of the discussion, opening new avenues for the development of practical bioethics educational materials. We begin with a background description and discussion of why local cases enhance bioethics education, move to an overview of what is currently available and what is not for the region, and then outline a discussion of what it means to be local using example cases drawn from Hong Kong, Australia, Pakistan, and Malaysia. We are not creating a casebook but rather constructing by example a toolbox for designing active and dynamic learning cases using regional diversity as contextualised cases with generalised principles.

Keywords Teaching ethics · Hong Kong · Pakistan · Malaysia · Australia

Introduction

This paper was first conceptualised during the inaugural meeting of the Asia Pacific Bioethics Education Network (APBEN), Hong Kong, 2018. Medical educators from

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across the Asia-Pacific region shared their experiences of teaching bioethics to medical students and discussed the availability of teaching materials that fit their respective local contexts. The goal was to use local cases as examples for exploring questions such as 'what makes a case or example truly local, and why?', 'what topics have we found to be best explained through local cases or examples?', and 'how does one identify a relevant local case?' Furthermore, we hoped to broaden the category of what may be considered local examples to open new avenues for the creation of practical educational materials for bioethics. Whilst most of the cases described here are intended for use in bioethics education for medical students, the benefit of using local case materials can also apply to bioethics courses and discussions within other educational and professional contexts. We have not endeavoured to create a casebook but rather to construct by example the beginnings of a toolbox for designing active and dynamic learning cases by engaging regional diversity and keeping pace with a rapidly changing world. Our focus was on understanding how bioethical dilemmas and questions exist within local contexts, not only by considering cultural and social contexts but also by examining the systematic and structural elements that underlie local experiences of healthcare provision.

Locating Bioethics: in Theory and in Educational Practice

The question of locating bioethics within geographic, historical, and philosophical spaces appears frequently throughout broader theoretical debates, extending to discussions of whether a 'global bioethics' is possible or even desirable (Fox and Swazey 1984; Tai and Lin 2001; Holm and Williams-Jones 2006; Nie 2013). In the international community, there are continuing threads of disagreement about whether bioethics represents a static, unidirectional imposition from 'West', or whether it can be considered an ongoing collaborative endeavour that necessarily includes consideration of and respect for different social and cultural contexts. This debate has appeared in different forms over time in the bioethics and social science literature, not only questioning whether global and local bioethics are mutually hostile concepts but also theorising the appropriate size and shape of what constitutes global, regional, national, and local spheres (Tan Alora and Lumitao 2001; Akabayashi et al. 2008; Chattopadhyay and De Vries 2008; De Castro 2008; Hongladarom 2008; Tan 2017; Nie et al. 2018)

Fox and Swazey (1984), after an academic tour of China, outlined the concept of a Chinese 'Medical Morality' for an Anglo-American audience. They emphasised the narrow scope of North American bioethics, noting that ethical and moral frameworks in other cultural contexts should not be dismissed just because they are not identical to the parameters of what had been deemed 'bioethics' in the USA. Reactions were not all positive; for example, Gorovitz (1986) interpreted the article as an attack on moral philosophy. However, Fox and Swazey reinforced their argument by stating that "the regnant paradigm of bioethics… minimizes the role of social, cultural, and contextual factors, including social relationships and interaction, in shaping moral precepts, attitudes, and behaviour" (Fox and Swazey 2010, 278). These debates themselves have been described as America-focused, where China has been used mainly as a rhetorical tool to critique American bioethics (Nie 2013).

Authors focusing on the Asian context speculate whether global bioethics is an appropriate endeavour, including authors who describe the importance of prioritising local cultural contexts in the construction of new forms of bioethics. Tai and Lin (2001, 51) suggest that Asia must necessarily develop a bioethics responding to Asian cultural contexts since "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". Considerations of the importance of culture in bioethics have also been addressed specifically within the field of medical anthropology. Kleinman (1999, 70) calls for the primacy of "*what is locally at stake*" (italics in original). Nie and colleagues later demonstrate how one might apply this concept directly to topics within contexts of local relevance whilst also drawing lessons for global application; a crisis of physician-patient trust in China can point towards how a trust focused bioethics could be productively applied at multiple contextual levels (Nie et al. 2018). In this vision, global and local perspectives are not mutually exclusive, but rather mutually constitutive. As Chattopadhyay and De Vries (2008, 106) "There is an interesting irony here: in order to make bioethics global, it must be local".

An important question from the Asia-Pacific perspective is whether there can be an 'Asian' bioethics or if the vastness and diversity of the region preclude even this. De Castro (2008, vii) suggests that there are commonalities that make this level of analysis productive, and that Asian bioethics then might be defined as "Bioethics discourse on issues interesting to, and considered important by, people from the region". Since many of the topics of particular interest in Asia have been under-examined within Anglo-American bioethics tradition, the specification of Asian bioethics could be a driver to expand the field. Hongladarom (2008, 13) suggests that the term 'bioethics in Asia' would better represent the "*activities* that bioethicists are doing rather than something static which can be classified as Asian or otherwise" (italics in original); this might also help to de-emphasise problematic dichotomies, such as between Universalism and Particularism.

Outlining specific forms of bioethics for individual national contexts has been considered and attempted. Tan Alora and Lumitao (2001) and Tan Alora (2003) describe the possibility of a distinct Filipino bioethics based on local culture and everyday life, and this is proposed as an example of an 'authentically Non-Western' form of bioethics. Nie (2013) defines China as the relevant unit of analysis in his discussion of Medical Ethics, which is framed as a transcultural interpretation. But further consideration would suggest that the vast diversity of both China and the Philippines would complicate these projects. Stonington and Ratanakul (2006), in their examination of the use of mechanical ventilators in Thailand, suggest that though the creation of Thai bioethics is necessary to cope with the many sources of uncertainty and conflict in medicine, it is nevertheless important to realise that Thailand itself is not a place with a single ethics or a single cultural tradition. This suggests that to truly understand topics of local relevance, it may be necessary to go beyond forms of bioethics based on geo-political boundaries, regardless of whether they are drawn around entire regions or individual countries. Instead, the relevant local sphere could be defined based on its relationship with the bioethical question of interest.

The purpose of this paper is not to resolve these ongoing debates between the local and the global in bioethics; rather, we identify the ways in which an enhanced framework that includes both core ethics teaching and case-based learning framed

within the languages of local specificity can enhance the activity of teaching bioethics. Locally specific approaches are not necessarily incompatible with a value-based approach. The inclusion of local material merely accommodates the possibility that whilst core values may remain primarily consistent globally, the specific ways in which these values are conceptualised and applied follow local social and cultural realities (Baker 1998; Kleinman 1999; Hongladarom 2008; Nie et al. 2018). When using an expanded framework, local cases do not supplant core ethics teaching; rather, they provide an enhanced form of communicating the values by referencing the local realities in which people consider and make difficult decisions. By appealing to familiar situations within local contexts, ethics dilemmas and questions become more immediately accessible to students. We do not argue that ethics teaching without local examples is ineffective; rather, we argue that local examples can often improve ethics teaching by enhancing student engagement, attention, and understanding. The personal and emotional engagement provided by local examples can also lead to improved learning retention and students' ability to more rapidly connect ethics classroom material to experiences in real-world clinical settings.

What Does It Mean for a Case to be 'Local'?: Categories and Examples

Moving beyond the theoretical question of locating bioethics, our specific interest in examining *local* cases emerged from the identification of a practical need within bioethics education in the region. Future medical professionals need to understand and negotiate the sorts of complex ethical dilemmas that they will face in their future practice, and if the teaching materials available do not reflect the local real-world conditions, this education will not be provided. Although the need for bioethics training is global, specific teaching and clinical training activities are necessarily embedded in local contexts. There are common experiences that are shared across humanity, including birth, illness, and death, but there are differences in the ways that these experiences are interpreted, understood, and embodied across cultural and social contexts. In attempting to universalise examples, the very details that make a situation meaningful may be lost, leading to a discussion that fails to address why people find these core human events to be so meaningful in the first place.

Within the existing case-based materials available for teaching, there are areas where rich resources are available, but there are also specific lacunae. Due to the demographic pressures associated with ageing in Asia overall, teaching case materials on end-of-life and other ageing-related topics situated in multiple cultural contexts are widely available. Materials that address broad philosophical issues such as autonomy and the philosophical traditions of world religions are also widespread, though these pieces often tend to be more theoretical than case-based. In other areas, case-based materials may be available, but in a less systematic fashion, with topics and locations found in ways more piecemeal and variable. The most fully realised example is the two-volume Singapore case book, including 'Making Difficult Decisions with Patients and Families' (Centre for Biomedical Ethics 2014) and 'Caring for Older People in an Ageing Society' (Centre for Biomedical Ethics 2017). This resource addresses topics of regional importance, including the role of Traditional Chinese Medicine (TCM), the role of foreign domestic workers within families and home care, and cultural values

regarding respect for elders, as well as Singapore-specific examples of more universal dilemmas, including conflicts between stakeholders, decision-making, and end-of-life care. A similar effort has been made in Hong Kong, with a specific focus on ageing in the local context (Yuen and Au 2017). Cross-cultural comparisons are well-represented on some issues of bioethical importance, but this varies greatly based on the topic of interest. There also exist some topics which have been examined in cross-cultural scope, including stem cell science (Chekar and Heitmeyer 2017) and artificial nutrition and hydration (Ngan et al. 2019), but the range of topics treated in this comparative fashion is limited. Finally, it can be difficult to find materials that present cases in full context, without a flattening of the importance of the local in service of the 'universal'.

The greatest lack of materials is in the category of bioethical cases described alongside a serious consideration of local systems and cultures. Whilst there exist anthropological studies of cases of importance to bioethics (for example, Stonington and Ratanakul 2006; Nie et al. 2018), these cases are often intended mainly to illustrate theoretical points rather than primarily as teaching resources. Discussions of national or regional healthcare systems are typically described at the macro level, and they are rarely presented as the main topic for teaching cases. Dramatic cases of rapid technological progress are often described after being stripped of the local regulatory, political, and social features that made the cases possible in the first place. For example, there has been much discussion of the recent, unexpected news of germline gene editing in southern China (Cyranoski and Ledford 2018); how an experimental technique facing such widespread disapproval could have nevertheless happened at the margins of the global regulatory system is only fully intelligible by understanding the broader context of China's political, economic, technological, and regulatory landscape.

There is also a broad lack of cases chosen precisely for time-sensitive salience; rather, case reports are often designed with aspirations of permanent applicability, sometimes by obscuring or removing the most pressing immediate problems and controversies. Whilst topics such as end-of-life or confidentiality are often used for cases because they are considered to be of enduring interest, the very specifics that may stand out the most to doctors and medical students as they encounter patients may have to do with the particular times in which they live, including health system circumstances, specific epidemics and disease outbreaks, cultural changes, or economic situations improving or worsening. To relegate these significant issues to the background does a disservice to future medical professionals, who must understand not only the topics considered most enduring and universal but also the specific conflicts and controversies of their own here and now.

Collaborators agreed that the inclusion of local content was engaging for students, and it communicates the importance of bioethics by situating ethical dilemmas within familiar and locally resonant contexts. In our teaching experiences, we found that an over-reliance on cases produced elsewhere, lacking local resonance, often distanced the students from the immediacy of the learning process, failing to promote ongoing attention or engage student interest. The presented cases were selected by collaborators primarily for their local resonance and based on use or planned use in the classroom. The cases provided were then divided into three main categories, each of which addresses an important aspect of the 'local' that is relevant to the teaching of bioethics. The selection of these categories was based on discussion amongst the individual

collaborators, with a focus on their perspectives on the primary bioethics issues common at each relevant locality or country, and subgroupings were based on the identification of common structural themes. The issues were prioritised for inclusion based on having been deemed relevant for medical practice in each country of reference, but existing bioethics teaching materials were determined not to be adequately representative of the local situation, necessitating the creation of new educational materials to fully address the topic.

Cases with a Focus on Justice: Based on Local Healthcare, Economic, and Social Systems

Distributive justice refers primarily to the fair distribution of healthcare resources and services, and there is also an increasing focus on justice in fair distribution of the social determinants of health (Daniels 2001). The first category includes dilemmas of distributional justice that are inherently embedded in local health and social systems, and they highlight the ways in which the structural underpinnings of social and medical systems have important impact on bioethics within both public health and clinical medicine.

These examples demonstrate the concern from the authors that mainstream bioethics has largely been focused on issues of personal autonomy regarding new developments in biotechnology, rather than the problems of social justice arising from the growing (health) gap between the world's rich and poor communities (Farmer and Campos 2004). Yet, at the same time, they reinforce how the issue of distributive justice becomes strongly contextualised to the environment and setting in which it occurs. For example, in developed areas such as Hong Kong and Australia with high standards of living, the malady of distributive injustice still exists, but in ways that differ from low-income settings. Though it is often overlooked, learning about the situations of the haves versus the have nots is also relevant to the future practice of medical students who plan to work in higher-income countries (Daniels et al. 1999). The ethical dilemmas considered in these cases directly reflect health and medicine, as it exists within local social, economic, and political contexts and constraints.

Case 1: 'Inequality, Health, and Justice Through Photos', Hong Kong[1]

This case is defined as a 'public health case study'. The cost of living in Hong Kong is extremely high (Economist Intelligence Unit 2019), and there is an increasing population of individuals who live in illegally subdivided buildings, which are often called 'cage homes', because they often consist of a bed-sized area enclosed in wire mesh. The physical reality of these living situations not only poses direct health risks but also serves as a symbolic reminder of how economic vulnerability more broadly poses systematic health risks. The Chinese University of Hong Kong (CUHK) programme in bioethics for undergraduate medical students begins in the early years with a principle-based approach to teaching ethics, and the scope is broadened in subsequent years to introduce additional ethical schools of thought and approaches as well as to extend into multiple topical areas of bioethics including clinical, public health, research, and legal

[1] Case contributed by Sara M. Bergstresser.

ethics. This discussion is used in the second year in a small class tutorial setting. This case takes the principle of justice as a starting point and extends into broader questions of policy and public health ethics. Students are divided into groups of 5–6 individuals, and each group receives a printout of one photo, with each group receiving a different photo. The photos are taken primarily from the work of Benny Lam, a Hong Kong photographer who reveals the conditions of the underprivileged in Hong Kong (Lam 2016). For example, a particularly dramatic photo shows a living space so small that food must be prepared in the bathroom.[2]

As the students consider their assigned photos, the following set of questions guides them in discussion: For each of the following images, think about 1) If one of the people pictured in this image, or a person who lives in the environment pictured in this image, were to come to you at the hospital, what do you think would be their most likely health problems?; 2) How might these problems be related to their social or environmental living conditions?; and 3) What would your advice to the patient be, and what could you suggest to help alleviate their health problems? Once the students have had time to consider their responses, each group is invited to present their answers to the questions to the whole class. We briefly discuss the students' reactions to this situation, making sure to emphasise that many individuals must live this way due to economic disadvantage and that students should not confuse it with an expression of laziness on the part of the inhabitants. Students can then consider the issue as a full group and consider what can be done at the policy or societal level to address these concerns and how they relate to the principle of justice. This example allows the students to explore the specific ways in which the unjust distribution of the social determinants of disease leads to health disparities within the Hong Kong population. Though these social determinants are often related to income inequalities worldwide, the particular manifestations of inequality and their relationships to illness are embedded in the local context; the 'cage home' phenomenon is a salient manifestation of injustice in Hong Kong. In this case, using the local context allows us to teach the students to identify the forms of unjust resource distribution and social determinants of illness that will be of specific relevance to their future patient populations.

Though economic inequality is a topic of importance for any setting, this case is particularly relevant to Hong Kong because the population density, housing shortage, and cost of housing are some of the most severe globally, and this is an issue of constant discussion in the city, and it is unlikely to disappear in the future. Economic stratification is particularly high, indicated by one of the highest Gini coefficients in the world, of 0.539 (Census and Statistics Department 2017). Gini index measures 'the extent to which the distribution of income … among individuals or households within an economy deviates from a perfectly equal distribution' (OECD 2006). Usually, a Gini coefficient below 0.3 indicates an equitable income distribution, 0.4–0.5 means income is inequitable, and 0.5 or above indicates considerable disparity. The high Gini coefficient of Hong Kong reflects a highly skewed wealth distribution in the city. The disparity in quality of life becomes even starker in a situation of severely limited living space. The 'cage home' example is also valuable because it is not widely known or publicised locally, and since students typically come from middle-class

[2] This photo and other examples are available at: https://www.nationalgeographic.com/photography/proof/2017/07/hong-kong-living-trapped-lam-photos/

backgrounds, many do not know the reality of the living circumstances of some of their future patients. Since medical students in Hong Kong are drawn almost entirely from the local population, and most go on to practise locally, it is particularly relevant for their future careers.

The nature of the images is also useful to capture their attention. The original teaching material for the module on justice focused on questions of the allocation of healthcare itself as a matter of justice. The material was drawn from bioethics teaching materials that originated in the USA, where there is no guaranteed healthcare access at the national level, which is an aberration amongst highly developed countries and areas. Hong Kong has a public healthcare system, so the idea of a lack of access to healthcare for citizens is not particularly relevant for them, and the students have trouble conceptualising a system that does not provide this basic level of access. Whilst justice and healthcare allocation are relevant to the Hong Kong experience, since there is a two-tier public/private system, it is not the only health-related justice concern present in Hong Kong. As noted above, the social determinants of disease are also important drivers of health disparities in the city, which is a result of the broader pattern of systematically unjust distribution of social resources and goods.

Before this exercise was introduced, students were often unable to recognise that access to health is restricted by social circumstances outside one's control, such as affordability, language barriers, and doctor's bias, which could lead to patient dishonesty and poor health outcomes. After this exercise, students expressed surprise at the situation of many of their fellow Hong Kong residents, and they acknowledged the limits of what they could do as an individual doctor to alleviate the situations of hypothetical patients. Healthcare systems are not perfect, and students were encouraged to think about the ways in which policymakers can be mindful of unjust resource distribution and its connection to ill health, and how a knowledge of policy and public health can help to inform clinical decision-making and patient advocacy. In multiple tutorial sessions, there emerged spontaneous acknowledgment that remedies must be made at the systematic or policy level and that doctors and patients are both clear stakeholders in these broader social processes.

Case 2: 'Resource Allocation in Healthcare', Sydney, Australia[3]

The case explores four different aspects of debate: the cost of modern healthcare, the allocation of healthcare resources, end-of-life care and the appropriateness of patient treatment goals, and the potential coercion of families by government and institutions to cover the costs of their family's healthcare. The ethical issues pertaining to this section are discussed from the perspective of the local environment in Australia, and whilst the four areas raised for discussion can be applied to any country and any healthcare environment in the world, this example reinforces the perspective that the social justice is strongly contextualised to the environment and setting in which it occurs. From the Australian viewpoint, this becomes an even greater paradox due to significant inequality within the country, with Indigenous Australians having poorer health, significantly greater infant mortality, shorter life expectancy, and lower levels of education and employment, not only within Australia but also within the developed world

[3] Case contributed by Stuart Lane.

(Australians Together 2019). The issue of health resource allocation is a hugely evolving issue within Australia with ongoing discussions focusing on many areas including the ageing population, the economic burden of chronic disease, and trying to achieve equity for Indigenous Australians (Armstrong et al. 2007; Macri 2016). The modern healthcare provided in Australia is highly advanced, technological, and expensive. Coupled with the increasing expectations of society to provide as much healthcare as possible for everybody, with no restrictions, the inability to meet everybody's healthcare needs, wishes, or demands has become a national talking point.

This case was used as part of a discussion exercise in a large group seminar setting for final year post-graduate students in the Sydney Medical Program as part of the Personal and Professional development teaching theme. The students are usually high academic achievers from mostly economically stable backgrounds within Australia. Approximately 20% of the cohort are international students from North America or Asia. They would not usually have much exposure to difficult ethical decision-making, an awareness of the cost of healthcare, or an awareness of the future working environment. The case was one that the contributor (SL) personally looked after for part of the patient's admission and discussed extensively with other colleagues in the hospital. It portrayed many of the ethical debates being brought into the medical programme, which are also of relevance to this paper.

The clinical case is introduced, which is a 25-year-old patient admitted to the ICU with a subarachnoid haemorrhage. The first part of the case looks at the cost of their treatment. The large group (150 students) breaks up into smaller groups of 10 students to discuss the cost implications. The case is then slightly amended to make it otherwise exactly the same; however, the patient now has a poor prognosis. The small groups then discuss the implications of resource allocation and then report back to the main group. The case is amended again to make it an elderly patient with a very poor prognosis, and the issue of end-of-life care and appropriate treatment goals are discussed. After the small groups reporting back to the main group, the case is finally amended to make it an elderly overseas tourist with no travel insurance and a poor prognosis. The issue of hospitals getting local relatives to sign-up for their care and be responsible for the cost is raised. At the end of the session, the students are asked for solutions to the problems they have described and how society should address these potential solutions. They are asked to consider the ethical principles they are applying when making their arguments.

The case was very readily available for use, as it is discussed in the national environment every week. The whole issue revolves around social justice, which is still a strong motivator for Australian society. However, as chronic ill health now impacts more and more people, autonomy is becoming a more important ethical principle for society, as they are personally affected. Australia is a very wealthy country, and the ethical dilemmas that appear in healthcare reflect this. Whilst it can be argued that many of the issues Australians argue about are 'first-world' problems, the issues are real and are hotly debated by the population. Governments win and lose elections on the issues of healthcare, and whilst buying investment properties and the price of coffee can be passed off as 'idle discussion', the wish for most people to live longer and better, and to have a right to do that is a strong driving force in the country. This is an issue for every state in Australia and is a constant source of political motivation between the federal and local state governments. Healthcare is a local state issue, however, and federal

elections are fought on this major state issue, due to the complex nature of how the funding is allocated. To simplify the situation, providing the public with healthcare is a state government requirement; however, the federal government provides the state government with the money to achieve it. This leads to an ongoing political debate between the federal and state governments as to where the fault for healthcare deficiencies lie, each blaming the other for the lack of available money. As a recent article suggested, the founding fathers of Australia gave the state responsibilities but forgot about the money (Colebatch 2010).

The student response to the case exercise was very positive, as they found the discussion both revealing and engaging. They were shocked at the cost of healthcare, and there were significantly different views around the allocation of resources and the approach to end-of-life care. The students were appalled at the response of the government and the hospitals as to how they had patient's families sign to ensure the cost of payment for healthcare. These dubious practices have come to the forefront with recent reports suggesting Australian hospitals are pressuring families to elect to use their private health insurance (Kruger 2019a, b), and worse still, patients admitted with mental health issues are being classified as private patients when they are unable to even consent to treatment. The case of overseas nationals having to ensure their families' payment treatment has not yet made national headlines, but it is only a matter of time before it does, as the practice is widespread. The student participants were strong advocates for the overseas national to receive the same standard of care that they would expect for their own citizens, and more significantly that she receive ongoing follow-up care in Australia even though it could not be provided long-term in her local country.

Discussions of local cases always have a significant impact on students, as they closely reflect their future working environment and address issues and questions that they will have to negotiate in their careers. However, they also demonstrate how the students themselves may frame and contextualise social justice from a local perspective and within a familiar environment. The examples used in this teaching session were based around the 'local' context of the availability to provide high-level and expensive hospital care, and this is where the students' discussions were focused. Their explorations were around what would have been acceptable social justice from a truly 'personally local' perspective, not the 'contextualised local' perspective of the overseas national. The case demonstrates that social justice as a bioethical principle is commonly learned and furthermore reinforced in the personally familiar and personally experienced environment, therefore making understanding and learning of social justice extremely contextualised. 'Local' cases may be familiar and helpful to assist student learning; however, they need to highlight what 'local' really means to the students. It is not only that it happens locally to them but also that they identify with the familiar healthcare context in which it occurs.

These two cases demonstrate how different ways of understanding justice can be brought to the fore for students by using local examples and contexts and by comparing their own local situations to those found in other countries. Even when the broad socioeconomic situations may be similar, there are still important systematic differences relevant to the teaching of bioethics. For example, though Hong Kong and the USA are both high-income countries, the healthcare systems differ markedly between the two, with important distinctions in forms of distributional injustice and how

resources are allocated. An understanding of how uninsured individuals in the USA cannot access healthcare proved to be of theoretical relevance to students in Hong Kong, but it did not provide a relevant guiding example to identify the forms of injustice that occur in their own city. Similarly, where both Hong Kong and Australian students learn that unjust distribution of social resources is related to health determinants, the practical clinical presentations of individuals and manifestations of disease within marginalised groups will be quite different in each place. In Australia, individuals from marginalised Indigenous groups may suffer not only from poverty but also from living in rural locations far from healthcare access; in Hong Kong, marginalised individuals are most likely migrants from foreign countries and mainland China, and they may suffer from living in hyper-dense urban environments, which are detrimental because of overcrowding and pollution rather than lack of healthcare access. The ability to recognise how injustice impacts these specific local populations will be important for the students in future clinical practice.

Cases with a Focus on 'Local Competence': at the Intersection of Health Systems and Cultural Norms and Practices

The second category also relates to local health and social systems, specifically addressing dilemmas that are produced at the intersection of these systems and local cultural norms and practices. This draws upon the concept of cultural competence and its importance for clinical bioethics. Cultural competence refers to the ability to provide care accommodating patients' diverse cultural practices and religious beliefs (Betancourt et al. 2003). Culturally competent healthcare improves health outcomes and patient satisfaction, enhances quality of care, reduces distrust in the patient-provider relationship, and helps to eliminate racial and ethnic health disparities (Betancourt et al. 2003; Mygind et al. 2008; Paez et al. 2009; Ngan et al. 2019). Paasche-Orlow describes how the moral underpinnings of cultural competence and Western medical ethics are conceptually compatible and that 'culturally competent care will advance will advance patient autonomy and justice' (Paasche-Orlow 2004, 347).

In these cases, there is often a marked contrast between the theoretical ideals described in general bioethics texts and the actual local realities in which the students will work. Whilst we begin with the concept of cultural competence, we also go beyond this concept to include the need for competence in the details and consequences of the structural features of local healthcare systems and clinical settings; therefore, this category has expanded beyond the area of culture to be termed 'local competence'.

Case 3: 'Sounds of Silence', Pakistan[4]

This is a video-based case, which was developed by the Centre of Biomedical Ethics and Culture (CBEC) at SIUT in Karachi, Pakistan, and highlights local cultural perspectives. The 9-min case is freely available for use for teaching purposes. The topics addressed include respect for persons, the question of when informed consent is truly informed, issues of patient autonomy in a male-dominated society, right to

[4] Case contributed by Kulsoom Ghias.

privacy, empathy, and doctor-patient communications (Centre of Biomedical Ethics and Culture 2019).

The opening scene of the video shows three doctors, an older male attending and two younger doctors, presumably trainees, one male and one female, working in a clinical setting. It starts with the female doctor questioning why consent for a procedure should be taken from a patient's husband, rather than from the patient herself. The senior male doctor replies: 'Isn't it the same thing?' In the second scenario, a different patient is led into the clinic by her husband for a consultation. The husband describes the condition, answering questions about where his wife's pain is located and her prior treatment history. When the patient is examined in front of everyone, she is visibly reluctant but does not say anything. The husband asks questions about her treatment plan. At this point, the senior doctor leaves and the junior doctors discuss whether the patient should sign the consent form herself, but in the end, they decide that the husband can sign it for her. The patient does not say a word throughout the entire clinical encounter.

In a later scene taking place the next day, the younger female doctor tells an older female colleague about her unease with the silent patient the previous day, describing how the patient was not involved in the conversation at all and how the husband made all of the decisions for her and signed the consent form. The older female colleague confirms that it can be disturbing at times, but states 'this is what actually happens'. She shares a similar experience of her own when she asked a woman with an ovarian carcinoma what she wanted to know about her own disease, and the patient said 'please, tell my husband everything'. The younger doctor, still unsettled, argues that this situation is not about something trivial like what to cook for dinner, 'it's about a part of her body that has to be taken out', and that the patient should be part of the discussion. The older doctor replies that in their culture, women often have little say over their lives and that you can try to ask for their opinions, but she does not think it would make any difference. In the end, the younger doctor says that she is not convinced and that it just 'doesn't feel right'.

This case has been used at Aga Khan University (AKU) in post-graduate medical training in Pakistan and Afghanistan. Trainees, who are almost entirely indigenous and largely go on to practise locally following graduation, are required to attend bioethics sessions as part of their core curriculum in which respect of person is stressed. Trainees watch the video and are then encouraged to reflect on their thoughts and feelings. It resonates and is generalisable at the regional level, where there are similar male-dominated social, cultural, and religious norms that tend to marginalise a woman's right to information and making decisions about her own body. The classroom response to this case has always been positive even as a tension between theory and practice, that is a classroom-based emphasis on patient autonomy versus real-life examples of lack of respect of patient's wishes, is identified. Students are able to approach the case from multiple angles and identify the underlying ethical issues and engage in a rich discussion on patriarchal societal norms and female patient autonomy in this context. The discussion is supplemented by their own experiences and feelings of discomfort, similar to the female doctor in the scenario. Successful evaluation of this case requires the students to both consider elements of cultural competence and indicate an understanding of the reality of space and time limitations in local clinical settings. Students most often identify effective doctor-patient communication, which requires adequate time

and space that are not always available in busy and crowded clinics in the local context, as a way to resolve the ethical issues that arise in such circumstances.

Case 4: 'Patient Consultation in Public and Private Clinical Settings', Malaysia[5]

In Malaysia, bioethics education is included under the Personal and Professional Development theme in the Monash University undergraduate medical programme. It is taught and assessed as a formal module in the first four years of the programme and also applied within all clinical activities during the fifth (final) year. The contents are created by our Australian colleagues, and the principles of respect for autonomy, informed consent, beneficence, non-maleficence, justice, and confidentiality adopt much of what is practised in the Australian clinical context. In Malaysia, the majority of the students are local with about 10–15% international students. Most of the local students will go on to practise locally, though about 10% plan to work in Australia. Therefore, it is relevant for students to be aware of both healthcare systems and the practice of bioethics principles in both countries.

Malaysia operates a two-tier healthcare system that includes both public governmental and private systems. Within the population of about 32.6 million (Department of Statistics Malaysia 2019), about 75% of the people seek medical attention at public healthcare facilities due to the higher costs charged at private facilities. In addition, Malaysia has a multi-ethnic population with three main ethnic groups—Bumiputera (69.3%), Chinese (22.8%), Indian (6.9%), and others (1.0%). Thus, cultural differences have a significant impact on the practice of bioethics in the Malaysian clinical settings. Students are taught principles such as respect for autonomy and informed consent. However, many patients, particularly those from the rural regions, are likely to attend the clinic accompanied by family members, rather than on their own, which tends to support collective rather than individual decision-making processes in the clinical setting. In this context, medical students need to understand the local socio-cultural stance that medical decisions are not always decided by the individual (when compared with the Australian setting), and decision-making may also involve their extended families, and sometimes the communities, especially in those staying in the rural regions or within the indigenous populations.

Additionally, in the local public health settings, a paucity of space with a high patient overload results in the sharing of one consultation room by two doctors and their respective patients. Doctors also tend to propose management plans to the patients, and patients do not typically disagree. Students find it quite difficult to reconcile the practice with the theory because they were taught that the therapeutic alliance is one that works on the principles of trust and confidentiality. In reflecting on their real-world observations of public clinics, they are faced with an ethical dilemma where confidentiality cannot be practised, as two different doctors are consulting their patients within the same space; respect for autonomy is also affected when doctors tend to be more paternalistic in their management approach.

These cases are taught to first-year undergraduate medical students who have minimal exposure to the clinical setting. However, these dilemmas are also seen and

[5] Case contributed by Wee-Ming Lau.

discussed in the clinical years when they have their placements in the public healthcare system. In the first year, students have two bioethics tutorials delivered as two 2.5-h sessions facilitated about 3 weeks apart in the first semester. Students participate in bioethics tutorials in groups of 20–25. They are subdivided into smaller discussion subgroups of 5 and are encouraged to reflect upon their recent visit to an urban community clinic. Not all students may have visited the polyclinic, so a good mix of those who had completed the visit with those who have not done so is essential. The session starts by asking students to discuss amongst themselves the ethical principles that they would apply to the doctor-patient interactions that they observed during these consultations.

On the visit to the community clinic, the students go for two separate morning visits over a period of 12 weeks. They are required to interview a patient at the clinic and discuss the ethical principles as part of a case commentary assignment. Additionally, they have a 2-h discussion towards the end of the semester with their respective clinical tutors on the application of bioethics principles in a clinical setting.

This teaching approach was taken because graduates may be faced with similar ethical dilemmas, as most students will be practising locally on graduation. Students in the past have been disillusioned and asked the reason for studying ethical principles when these cannot be applied in the actual clinical settings that they experience. As one student asked, "why study ethics when it is not applicable to a real-life setting?" By introducing this topic to the first-year students, the potential shock at finding the wide contrast between the theoretical and the practical sides of bioethics may be considered and discussed within the group. Whilst disparities between the ideal situation and the resource-limited public hospital may still lead to feelings of disillusionment, in this way it may be presented as an element of concern within local bioethics and clinical practice, rather than as an inexplicable aberration when compared with the theoretical ideals produced from an Australian context. These cases are generalisable to bioethics education in many underdeveloped and developing countries where a paucity of healthcare facilities and space with low doctor-patient ratios does not allow the practice of 'real' bioethics principles learned in the medical schools, and it is important for students to reconcile with these dilemmas during their discussions in class.

Cases with a Focus on Social Changes and Locally Resonant Concerns

The third category includes cases that address timely or locally relevant concerns. In an attempt to be universal or timeless, teaching cases often neglect current or emerging topics of salience to particular geographies or times, but these issues may be the most visible and resonant topics for students themselves. These cases compliment the locally contextual cases described above by shifting the focus to how ethical issues are formulated and addressed in different settings. These cases also show how local ethical issues themselves can change over time and that flexibility is often needed in conveying changes in relevant values and perspectives to fit shifting circumstances.

Case 5: 'Doctors Plead Not Guilty to Manslaughter in a Hong Kong Beauty Clinic Death', Hong Kong[6]

This case provides a close look at the ethical issues involving the fast-growing yet inadequately regulated beauty industry in Hong Kong. The city government does not have a clear and specific regime for regulating the provision of aesthetic procedures. Whilst surgical and invasive aesthetic procedures are mainly served by the medical sector, procedures involving the use of medical devices such as laser and intense pulsed light (IPL) devices are provided by both the medical and cosmetic sectors. Shifting economic factors impacts the multibillion-dollar beauty industry in Hong Kong, which is expected to grow even further in the coming years. A research study conducted by a healthcare fund revealed that in 2015, there were 786,000 'medical aesthetic' consumers in Hong Kong and the industry was worth HK$4.2 billion (South China Morning Post 2017). Whilst more people are willing to pay large sums for the promise of enhanced appearance and the slowing of visible ageing for personal, work, or social reasons, there is little regulation of the services provided by beauty clinics in Hong Kong. This case has local significance within policy, economic, and sociopolitical dimensions.

This case was used in a tutorial discussion for third-year undergraduate medical students. The topic fits into the ethics teaching framework, as a case where multiple principles are involved and questions of enhancement and public policy are also at stake. Students were first asked to consider the question of whether it is ethically permissible for doctors to provide a cosmetic enhancement service to a patient based on consumer demand, and they were asked to contextualise their answers by referencing the existing Hong Kong regulatory and social landscape. In terms of health policy, Hong Kong has a unique history. Because it was part of the British empire from 1841 to 1997, the healthcare, law, political, and educational systems are very different from those in mainland China. Therefore, a case drawn from mainland China would not reflect the local policy. In Hong Kong, the existing legislation governing private healthcare facilities is mainly focused on private hospitals and non-profit medical clinics. There is a lack of regulation governing high-risk medical services and processing health products for advanced therapies, but means of improvement are ongoing discussions in local spheres. In addition, medical advertisements are generally prohibited in Hong Kong because they may mislead patients in choosing the most suitable treatment; this is because patients and the general public do not usually possess professional knowledge to determine the accuracy of the advertisement. On the other hand, beauty clinics do advertise, and it is an important topic of discussion about whether regulating these advertisements would serve to protect the general public.

The specific news event is then introduced for discussion: in 2012, four women contracted a rare deadly 'superbug' infection and became seriously ill after receiving a beauty treatment involving blood transfusions at the beauty salon. One of the victims, a 46-year-old woman, died of septic shock in this incident. The beauty treatment was advertised as improving skin and the immune system, but it was a technique typically used to treat cancer patients, which was neither medically recommended nor specifically approved for cosmetic use. In addition to one death, three other women reportedly

[6] Case contributed by Isabel S.S. Hwang and Olivia M.Y. Ngan.

experienced fever, dizziness, and diarrhoea. Though the doctors involved entered pleas of not guilty to manslaughter charges in court, one of the doctors and the technician involved were later found guilty of manslaughter in a 2017 decision, and no verdict was reached on the second doctor, with a retrial ordered (Lau 2017; Siu 2018).

In November 2018, whilst these discussions were being conducted, another related case in the news involved a Hong Kong woman who had died after cosmetic injections of Botox (Leung and Zhang 2018), and so the timeliness of the topic was particularly clear to the students. Students discussed the case within the context of medical involvement in cosmetic services. Students were asked to discuss and debate who should be considered most at fault for the case: the medical doctor who performed the procedure, the owner of the beauty clinic who was also a physician, or the lab technician who failed to provide clean cell samples for the injection. Finally, students were asked to reference the potential harms involved and to consider the appropriate role of Hong Kong health authorities in regulating the emerging industry (Cheng and Ng 2014). Student response was lively, and there was a significant debate surrounding the responsibility of each of the individual health providers versus the local regulatory body. Identifying with local actors in local cases may also facilitate the development of empathy, which is necessary for future physicians.

Two main ethical questions emerged from the broader class discussion, including whether human enhancement via plastic surgery satisfies the core purpose of medicine, and where best to locate the boundary between ‘treatment’ and ‘enhancement’. Referencing the principles of non-maleficence and beneficence, students discussed the ways in which cosmetic surgery does or does not fit within the core priorities of medicine, and they were encouraged to reconsider previous assumptions by considering the boundary between reconstructive and cosmetic procedures. Many students prioritised the role of autonomy in modern healthcare, arguing that it is ethically permissible to proceed with cosmetic procedures as long as patients are well-informed of the risks and benefits. Other students argued that health must be conceptualised beyond the physical to include the mental and psychological spectrum, and they considered whether ethical permissibility is enhanced if consumers find cosmetic surgery helpful in augmenting psychological well-being. Finally, students were able to identify competing ethical questions and values in the case, including the need not only to balance benefit and harm but also to consider patient autonomy, broader regulatory policy, and the complexity of physician responsibility to patients within economically lucrative professional landscapes.

Case 6: ‘Research Ethics and Questionable Publication Practices’, Pakistan[7]

This case was created with the explicit goal of addressing a real-world conflict specifically within the local context. At AKU, a local bioethics casebook is in development, predicated on the rationale that even cases available from the region may not be sufficiently context-specific. The case is drawn from an actual event that took place in the contributor’s department (KG), resulting in a de-identified, real-life case with some embellishments. As a result, it is extremely contextual and specific to practices that are condoned or not necessarily viewed as unethical ‘in the

[7] Case contributed by Kulsoom Ghias.

grand scheme of things' but where there is a need to consider these practices within ethical scope.

> Dr M is eager to apply for his department's Outstanding Researcher award, which is accompanied by a significant grant for future research. Dr M works on the replication mechanism of an obscure bacteria and research funding is difficult to obtain in this field. To be eligible for the Outstanding Researcher award, Dr M has to show productivity in the form of publications. Dr M submits his most recent manuscript to a well-known peer-reviewed and indexed bacteriology journal. Given the specialized nature of the work, the editor asks Dr M to provide names of potential peer reviewers who are not co-investigators or collaborators. Dr M knows of at least two other research groups in the world that have the relevant expertise to review his manuscript but is reluctant to provide their names for fear of the competition. Instead, he provides the names of his former PhD supervisor (who is at a different institution), and a new member of his own research group, Ms P (who is now at the same institution as Dr M, but not an author on the current manuscript). For Ms P, he provides her former institutional email address, which is still active. Dr M does not disclose his relationship to either of the proposed reviewers and instead assures the editor that 'neither of the two proposed reviewers is a co-investigator or collaborator on the current manuscript'. The editor sends out the blinded manuscript to the two reviewers who have been alerted by Dr M to expect the offer to review his article. Both reviewers provide minor comments and suggest that the article be accepted for publication. The manuscript is published shortly after and Dr M receives the Outstanding Researcher award.

This case has not yet been used in the classroom, but it is intended for use in Pakistan at all levels (undergraduate, graduate, post-graduate, continuing professional education) by students, teachers, and facilitators as a research ethics resource. Issues of research ethics tend to be complex and multi-layered, so a researcher who plagiarises also often indulges in other questionable research practices and research misconduct. The case draws upon the case author's experiences teaching a PhD course on Ethics in Healthcare; for the research ethics component, she used real-life cases reported in the popular and scientific press but found herself posing questions such as 'what if this happened at AKU or in Pakistan?' and introducing angles that did not exist in the cases to begin with but were more plausible in the relevant setting. The best examples are consistently real-life cases as reported by students or residents of AKU themselves or else issues that have been highlighted at an institutional level. Essentially, this makes the cases very local context-specific, and whilst they may not be generalisable, this case and others like it fulfil a need that is not met by commonly available cases. This case met the need for smaller, single-issue cases, so that each aspect can be given due consideration individually, which is sometimes lost in more complex cases. It also shows that a real-world issue can be successfully transformed into a formal case, but it may necessitate multiple forms of de-identification to preserve confidentiality.

Discussion

Identifying a role for local cases depends on the specific topic in bioethics to be taught and the significance of the local context to the relevant issues at stake. Many general cases illustrating broad bioethical issues or common features of global biomedicine may be appropriate to and applicable in many settings. On the other hand, identifying areas where the use of local cases adds information and interest to the educational process can be extremely valuable. For this reason, we would broadly define teaching cases that lack local relevance to include any case that does not adequately capture relevant contexts present within the geographic scope of interest. This provides an applied definition of 'local' itself, which allows for flexibility, diversity, and change over time, which may then be incorporated into responsive and locally relevant medical education. In addition, local competence not only applies to the content of a case, but it is also important for the classroom presentation and discussion format, since educational systems and student expectations differ by location and culture.

In some situations, an appropriate regional context may constitute a sufficiently local paradigm. Other cases may instead be best localised to a national level. Cases from neighbouring countries may still have significant differences that render them of little use; for example, a case from India will often not adequately capture local debates in Pakistan, and a case based in majority Buddhist Thailand will not capture the complex mix of religious backgrounds present within the population of Malaysia. Some sub-national regions may also have their own local concerns that do not exist at the national level, which may be based on rural/urban divides, different population demographics or environmental features, differential access to healthcare, divergent epidemiological profiles and risk factors, and so on. Finally, urban areas often have very specific ethical issues, including factors related to infrastructure, health systems, lifestyle, epidemic disease, migration trends, and age demographics, as well as unique histories, cultures, and populations. For example, a case based in mainland China will often have cultural relevance to Hong Kong, but it will not always capture the specific policy or cultural issues present in Hong Kong and its unique public health system.

At the practical level, our experiences teaching bioethics in medical education across the region have led us to conclude that using locally contextual teaching tools enhances our ability to communicate depth of knowledge and that students often identify culturally alien or artificially universalised case examples as irrelevant to the common ethical dilemmas seen within their own local contexts. For example, in the context of teaching bioethics to undergraduate medical students in Hong Kong, students described standard case studies based on unfamiliar social, cultural, and political systems and events as difficult to understand, and they had difficulty connecting these cases to their own futures as Hong Kong medical professionals. The introduction of local cases, primarily inspired by current events and local news reports, prompted more lively tutorial discussions, with students more willing to express their own observations and opinions on topics of bioethical relevance. In Australia, the medical students are very focused on their local environment, and sessions with a focus on local cases were received well, with students requesting additional sessions of that type. Local context also allowed the Australian students to discover details of their health system that many had not previously realised. In Pakistan, even cases from the broader South Asian region were not always sufficiently context-specific for students, and cases drawn from

local contexts appear familiar to the students so that they might identify with the scenario, approach the case from multiple angles, and identify relevant ethical issues. In Malaysia, it was observed that the use of cases drawn from places with shared ethnicities and religions may still necessitate shifts in the application of principles due to differences in other local features such as culture, family upbringing, educational influence, and social media. These experiences suggest that success in cultivating lasting bioethical awareness amongst medical students is greatly enhanced by incorporating cases and examples that are relevant to the real-world realities of working in local medical systems.

The majority of students have always been receptive to bioethics teaching; however, there is always a group who do not see the relevance in it. Over the years, it has become evident that many of these students have significantly struggled with their future careers and have ended up in situations that they might have handled differently. The evidence is strong that students who demonstrate poor ethical decision-making at medical school continue to do so in the careers and commonly end up being reported to authorities for their behaviour (Papadakis et al. 2004; Dupras et al. 2012). Therefore, it is imperative that bioethics teaching continues.

Conclusion

In this paper, we examine the elements of what makes a local case and describe some techniques that may be used in identifying salient local issues. The three categories of cases outlined and described in this paper are intended to provide guidance for other educators in the region, so that they may identify and create teaching cases for their own local contexts. In addition, the examination of what makes a topic or dilemma local may be of interest to bioethicists studying culture, health systems, and global biomedicine, as they relate to ethical problems. Furthermore, the serious examination of ‘local’ features is not only useful for those working in the Asia-Pacific region, as every place has its own local context. We also emphasise the practical importance of incorporating materials that are of local relevance, which through familiarity and emotional connection will resonate with the students’ own experiences, observations, and future careers. It is a paradox of global bioethics that it becomes most relevant when it incorporates the realities and concerns of local worlds. In fact, presenting ‘standard’ bioethics cases to European, North American, or any medical students across the globe as though they were universal and not culturally inflected also limits these students’ ability to learn about the role of culture and local contexts in their own social and professional worlds.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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