中国科学院教材建设专家委员会规划教材

全国高等医药院校规划教材

医学伦理学

第2版

李 勇 陈亚新 王大建 主编

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内容简介

本教材吸收国内外医学伦理学教材的优点，结合我国医学实践和教学特点，由国内一批长期从事医学伦理学教学和研究的杰出中青年专家和教授共同编著完成。本教材在第1版的基础上，听取了广大教师和学生的建议，总结了8年教材使用中显现的优势与不足，对教材的内容进行了全面修改，在继承第1版教材适合教学的优点同时，在各章后增加了案例思考题，使教学内容更加贴近实践，逻辑结构更加严密，更加适用于多层次的教学与阅读。本教材在全面介绍医学伦理学的基本理论与发展的同时，在医学科研伦理、卫生管理伦理、器官移植伦理、基因伦理、生殖伦理、多元文化视野中的生命伦理学等章节进行了部分学术创新。

本书不仅适用于医学本科生教学，对广大在职医务人员、其他专业关注生命伦理的研究者和学生也是一部实用的参考书和读本。

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Foreword: Creating bioethics

Concern with matters ethical has long been a part of the practice of medicine. Across the centuries and around the globe, those who attend to illness have, for the most part, recognized their responsibility to the sick: their duty to provide care in time of need and to act in the best interest of their patients. Concern with matters bioethical is a more recent development. Some scholars locate the birth of bioethics in the 1960s (Jonsen, 1998), others see the beginnings of bioethics in the response to atrocities the abuses in medical experimentation that occurred during World War 2 (Rothman, 1991). In either case, bioethics is a newcomer to the professions of science and medicine: in the early 1960s bioethics did not exist as a separate area of inquiry. Today bioethics is an established part of medicine and medical science. Centers of bioethics are commonplace in medical schools, bioethics has a large and growing number of professional journals, bioethicists are in invited to serve on government commissions, and graduate programs and professorships in bioethics are proliferating.

This volume is testimony to the success of bioethics. While bioethics got its start as a new and distinct profession in the United States, it is now a global enterprise, an obligatory part of medical training, medical research, and medical care. Ethics review of research involving human subjects is now mandatory, regardless of where in the world that research takes place. Medical decision making and interactions between caregivers and their clients are now informed-to a greater or lesser degree-by bioethical ideas about care, respect, harm, and benefit. In short, medical systems and medical cultures-in China, as in North America and the countries of Europe, Africa, South America, Asia and the Asian-Pacific-must take seriously the ideas of bioethics.

The appearance of bioethics raises interesting and important sociological questions. Why did bioethics emerge when it did? How are bioethical ideas implemented in different medical organizations and cultures? It is true that medicine has always had to adapt to changes within the profession and developments external to medicine. As the field of medicine has grown and as its knowledge has expanded, new technologies and new medical specialties altered the patterned relationships between caregivers and their clients. These relationships have also been influenced by changes in society: in the United States, the proliferation of malpractice suits and the emergence of the new profession of bioethics are the most significant of these new and external challenges to medicine. But notice that the changes wrought by bioethics are unique. Unlike changes initiated elsewhere, bioethics is a direct assault on the expertise and authority of physicians and researchers. Yes, in the United States, the specter of malpractice has altered the way health care is delivered-forcing doctors to be more vigilant and defensive-but the challenge here is to be more medical, to be competent, and to be informed about the latest developments in medicine. Bioethics, on the other hand, alters the essence of the relationship between doctors and patients by introducing a third party to monitor the morality of the exchange. With bioethics, the trust that characterized the relationship between professionals and clients is increasingly rationalized and segmented. It is one thing for a physician or researcher to call on a specialist colleague for advice about neurology, cardiology, or research design, it is quite another for that same professional to call on an expert for advice about the morally correct thing to do.

Given its unique status as a new field that calls into question the moral authority of medicine, it is important to understand how bioethics came to be, how it emerged and established itself as a required part of medical care. From the sociological point of view it is most illuminating to consider the different ways bioethics emerged in different societies and cultures. Although some bioethicists consider the ideas of the field to be sufficiently abstract as to be universally applicable (Beauchamp, Macklin), there is increasing recognition that the form and implementation of bioethics varies according to the cultural soil where it takes root. It is instructive, then, to begin with a look at the social and cultural conditions that gave rise to bioethics in the United States. After setting the stage with that analysis we can consider the transplantation of American bioethics to other countries.

The social and cultural sources of bioethics in the United States

It is no surprise that many histories of bioethics have been written by bioethicists themselves. Histories of bioethics by bioethicists offer valuable and detail-rich accounts of early meetings and efforts to create-and to carve out a niche for-the discipline, but they are often subject to distortion by efforts to secure one's place as a pioneer and founder of bioethics (see, e. g. , Jonsen 1998) or by the desire to offer a favorable view of the enterprise (see, e. g. , Andre 2002).

Conventional histories of bioethics-some written by bioethicists and some by non-bioethicists-claim that the field emerged in response to technological advances in medicine. Indeed, this is the view promulgated in the founding statements of the first centers for bioethics. According to its literature, The Hastings Center, established in 1969, was created to "fill the need for sustained, professional investigation of the ethical impact of the biological revolution," including "advances made in organ transplantation, human experimentation, prenatal diagnosis . . . the prolongation of human life. . . " (Hastings Center, 1973; see also, Callahan, 1981). According to this view, bioethics was established to find a way to live with new technology, to find answers to questions that were unimaginable a few decades ago: When is someone "dead enough" to allow the harvesting of organs? What conditions justify creating a human clone? Should there be an upper age limit for in vitro fertilization?

Others see bioethics emerging from the "rights movements" of the early 1960s. Challenges to established patterns of discrimination in various institutions spilled over into medicine, leading to systematic scrutiny of the actions of doctors and hospitals.

These histories give us a sense of the state of affairs in medicine and medical science around the time when bioethics emerged, but they fail to explore the way bioethics was received, how it has developed, or its influence on the way medicine is practiced and medical research gets done. These aspects of bioethics have been examined by social scientists.

In the late 1980s and the 1990s social scientists began to recognize the presence of bioethics in medicine and began to do research with an explicit focus on bioethics. Sociologists and anthropologists went into to medical settings with the stated intent of seeing how ethical problems were handled. Zussman (1992) examined decision-making in intensive care units, Bosk (1992) watched genetic counselors at work, Jeanne Guillemin and Lynda Holmstrom (1986), Renée Anspach (1993), and Jessica Mesman (2002) looked at interactions in neo-natal intensive care units. Chambliss (1996) studied nursing ethics and the moral dimensions of hospital life, looking at the many uses of ethics in organizations. In the mid 1990s and early 2000s social scientists, together with historians, began to explore the ethics of medical research: Lederer (1995) explored the history of human experimentation in America before the Second World War, Dresser (2001) examined the way patient advocacy influenced research ethics, Halpern (2004) offered an assessment of the "morality of risk" in medical experiments, Stern (2005) looked at the history of eugenics in the United States, and Fisher (2009) examined the outsourcing of clinical research to the private sector.

In 2008, Renée Fox and Judith Swazey published their "team of two" observations about the emergence and development of bioethics. Their "scholarly autobiography" describes their work in and around bioethics and allows them to identify the social and cultural contexts associated with the beginnings of the field and to call attention to the continued "cultural myopia" of American bioethics.

Fox and Swazey (2008, 230) are interested in what happens when "bioethics circles the globe;"

they call for "detailed studies of in-depth of what are considered to be matters of bioethical concern in a cross-section of societies, how they manifest themselves in different socio-cultural settings, and how they are experienced and responded to by individuals in various statuses and roles, and by social groups and institutions confronted with these issues." This volume is a step in that direction, describing the way bioethics has manifested itself in Chinese society. I expect that we will see more volumes like this, where bioethics scholars describe how in their societies bioethical issues emerge and are defined and responded to. Particularly interesting will be conversations about, and analysis of, the way bioethical ideas developed in the western cultural tradition are-(and are not) applied in other societies with different traditions. As a stimulus to thinking about the roots of ethical ideas in cultural traditions, I offer a brief summary of my thinking about the ways ethical concepts have moved from the west to other cultures.

Cultural traditions and ethical ideas

As bioethics has moved from the west to other societies, the question of "Whose ethics?" has become increasingly important. As I mentioned above, there are those who believe in a universal ethical standard and those who believe that ethical concepts can only be judged in terms of the society in which they appear. Macklin (1999; 2004) argues "against relativism," contending that while we should avoid "ethical absolutism," there are universal ethical standards that can and should be applied across cultures. To accept anything less, according to Macklin, is to apply a double standard. Beauchamp (2003) agrees, asserting that there is a "common morality," a morality committed to the "promotion of human flourishing" and against which the moral standards of particular societies can be judged.

Fox and Swazey (2008: 153—197) challenge the claims of universalists, calling on the work of two social scientists, Bourdieu and De Craemer. Bourdieu (2001) rejects universalism, noting the danger of "the imperialism of the universal," which occurs when a society universalizes "its own characteristics by tacitly establishing them in a universal model" (Bordieu 2001:3). Indeed, the principles that are often given the status of universals-autonomy, beneficence, nonmaleficence, and justice-are inextricably linked to western, individualistic notions of personhood.

Fox and Swazey (2009: 172—173) go on to point out that the western, individualistic conception of the person that informs American bioethics is not the one that prevails globally. Most of the world sees the person not as an isolated individual, but embedded in kinship, group, and community.

The universal v. relative debate is theoretically interesting, but it tells us little about what actually happens when international collaborators must move forward with research and make decisions about the application of ethical standards. In an earlier study (De Vries et al., 2010) examined how bioethical ideas have moved from the west to non-western societies. That research suggests that there are three ways that western bioethical ideas find their way into non-western societies:

1) the ideas may be "adopted wholesale", borrowed directly and put into practice.

2) the ideas may be taken from the west, but molded and altered to fit local culture.

3) western ethical ideas may be used to open a conversation about moral standards and stimulate the search for applicable ethical ideas that are drawn from local culture and reflect local traditions.

Let us examine each of these ideas briefly.

1. The wholesale adoption of Western bioethics: Bioethics as missionary work

Writing about "the past, present, and future of a Latin American bioethics," Del Pozo and Mainetti observe that the new medical technologies introduced in Latin America in the 1980s created a number of new ethical questions "for which neither classical medical ethics nor the omnipresent but increasingly questioned teachings of the Catholic Church provided acceptable responses" (2009: 272-273). They continue:

> In this context, the new bioethical paradigm was rapidly embraced by Latin America . . . Taking the path of least resistance, countries assimilated, to a large extent, North American bioethics. At a

fast pace, ethics committees, informed consent procedures, and legislation dealing with biomedical issues from organ transplantation to assisted reproduction flourished in the region (273, emphasis in the original).

The Latin American experience is typical. The export of new medicines, medical devices, and medical procedures to the developing world, together with the movement of clinical research from the research-rich to resource-poor countries, created a need for new types of ethical advice (Petryna 2005). Because the United States, Canada, and the countries of Western Europe had a head start in the development of medical technologies and the preparation of bioethical guidelines for implementing those technologies, it seemed only natural to import the bioethics along with the medicine and medical research. Western bioethics for western technologies.

The intent of the exporters and importers of ethics is noble-protection for those subjected to the new technologies-but wholesale adoption of ethical ideas and frameworks is not without problems.

Several researchers have noticed this lack of fit when it comes to gaining informed consent from individuals in the developing world (Dawson and Kass 2005; Ezeome and Marshall 2008; Hyder and Wali 2006; Molyneux et al. 2005). The Indian Council of Medical Research describes the problems associated with adopting the western idea of informed consent:

In the context of developing countries, obtaining informed consent has been considered many times as difficult/impractical/not meeting the purpose on various grounds such as incompetence to comprehend the meaning or relevance of the consent and culturally being dependent on the decision of the head of the family or village/community head(2006: 67).

Other researchers have confirmed this lack of fit between western ethical ideas and local conditions and cultures. Simpson describes the "growing disenchantment" that results from a "sense of mismatch between the ethical values that underpin the western biomedical tradition and the reality of local circumstances" (2009: 8). Chattopadhyay and De Vries go as far as suggesting that it is "... unethical to impose, either consciously or unconsciously, the dominant Western socio-cultural-moral construct to ethnic minorities in the West and the vast non-Western world" (2008: 108; emphasis in original).

The "wholesale adoption" or "missionary" approach to the transport of ethical ideas brings with it the danger of harm. Ethical ideas that are imposed rather than indigenous can limit useful research by demanding that western standards be met before research can begin. Furthermore, the imposition of ethical ideas can disrupt existing moral traditions, creating confusion and anomie. The presence of representatives from resource-rich countries-be they missionaries, bioethicists, or colonial administrators-in resource-poor countries, creates opportunities for "cultural brokers." These brokers translate between cultures, gaining status in their local communities by associating with the agents from the developed world.

2. *Molding western ethical ideas to fit local culture*

A second way that ethical ideas move between the west and the developing world is by adoption and reshaping. Western ethical concepts are imported, but then reframed or molded to fit local circumstances. This mode of transport is illustrated by Siddiqui's (2009) description of an introductory bioethics class for medical technology students at Karachi University in Pakistan. The topics covered in the course are typically western-informed consent, conflicts of interests, privacy and confidentiality, and patients' rights. However, Siddiqui points out that the instructors "decided to familiarize and educate students in basics of bioethics using practical examples and to highlight ethical issues keeping [the] cultural and social milieu of Pakistan in mind." He also notes that "students were also allowed to express their views in Urdu, as many were not fluent in English, and because we believe that ethics has no language barriers." The ideas are western, but they are translated into the Pakistani context.

A similar process is visible in a bioethics curriculum developed by the Middle East Research Ethics Training Initiative (MERETI)-a research ethics training program involved in the career development of individuals from the Middle East and funded by the Fogarty International Center (FIC) of the National

Institutes of Health. Members of MERETI formed a Workshop Development Team to create multi-day courses on research ethics targeted to investigators and members of research ethics committees (RECs). The course materials draw heavily upon western sources, but are tailored for those working in the Middle East:

Review of these materials reveals an emphasis on molding western ideas to a Middle Eastern context. Assigned readings, for example, include an article by Prof. Dr. G. I. Serour entitled "Islam and the Four Principles." This essay harmonizes the four principles of Beauchamp and Childress with the teachings of Islam, concluding: "…Islam is a religion which has given great importance to what are known today as the ethical principles of autonomy, beneficence, non-maleficence, and justice" (Serour 1994, p. 89). The effort in Serour's essay is not to develop ethical ideas from the Islamic tradition, but rather it is to show that the western ideas are supported by Islam.

Simpson (2009)-the anthropologist mentioned above who has looked at how the moral tradition of Sri Lanka is applied to the ethical questions of modern medicine-sees these efforts to mold western bioethical ideas to developing world cultures and values as "largely rhetorical." The work of translating western ethics into local idioms is a move in the right direction-a move toward recognizing the existence of moral traditions whose origins are not found in the western, Judeo-Christian society-but the act of molding or translating implies the priority of the imported ethical ideas.

3. *Deriving ethical ideas from local culture*

The final mode of transporting ethical ideas in the typology is more theoretical than empirical. While I have not seen this mode in practice, conversations going on in Pakistan lead me to believe it is the next logical step in the conversation about international ethical collaboration. This mode uses the knowledge of ethics developed in the West to encourage the ethicists of the developing world to generate their own culturally appropriate approaches to the ethical dilemmas that arise in their societies. Rather than importing ethical ideas wholesale, or modifying them to harmonize with existing moral traditions, this approach uses what ethicists in the west have learned about the process of articulating and applying moral ideas.

Unlike existing ethics training programs-funded by the Fogarty International Center, the Wellcome Trust, or the European Union-this approach is inductive. It begins with the solicitation of local moral ideas and uses the history of moral philosophy and [bio]ethics in the West as an example of how moral ideas developed and were implemented. This model turns the existing mode of ethical transport on its head, asking what we in the west might learn from ethicists in the developing world. Ethicists from the west remain helpful, but not as the providers of moral maxims or principles. Their work is to explain how they reasoned from their western traditions to bioethical guidelines.

Bioethicists in the developing world are aware of the need for this way of creating ethical guidelines, but they lack the power to implement the model. The Center of Biomedical Ethics and Culture in the Sindh Institute of Urology and Transplantation in Pakistan is one place where this approach is being developed. Shortly after the center was founded, its leaders organized a seminar "Foundations of Moral Thought: From the Greeks to Contemporary Bioethics," intended to "introduce participants to the ways in which historically, religious, secular, and cultural values have been linked in the evolution of human ethical thought, and how these continue to shape and modulate moral comprehension" (Centre of Biomedical Ethics and Culture 2005. p. 2).

The center director, Dr. Farhart Moazam, continues to press for a local bioethics: "It is necessary for us to evolve bioethics in a coherent way in this country, give it a form that resonates with our values. Otherwise bioethics in Pakistan will remain an academic exercise…irrelevant to the needs of our population" (quoted in Fox and Swazey 2009: 278). If this approach flourishes in the developing world, it will generate a dialog about moral ideas that will enrich ethics both at home and abroad.

Implications for bioethics in China

It is sociologically interesting and ethically important to examine the various incarnations of bioethics. In the United States, bioethics emerged as a challenge to medical authority; having established itself as a credible academic and clinical field, bioethics has found its way to other societies and cultures. The form bioethics takes in these new settings is partly dependent on content developed in the United States and partly dependent on the social and cultural context into which bioethics is imported. As bioethics develops in these new settings, the goal of the field-to ensure that health care and the life sciences are done in a way that respects persons and promotes justice-must be worked out in harmony with local traditions.

That bioethics must respond to social and cultural diversity does not mean simple capitulation to "things as they are." There is a critical element to bioethics: done well and done comparatively, bioethics offers an avenue to more humane medical care. Bioethics fails when it fails to look upon medicine and its relationship to medicine and culture with a critical eye. This is easy to see in the case of American bioethics. As American bioethicists have looked to ethical concepts in other countries, they have come to understand that slavish commitment to the principle of autonomy (often seen as culturally appropriate the individualistic society of the United States) has allowed caregivers to escape their responsibility as professionals, evading hard choices in treatment by leaving those choices-in the name of autonomy-to patients who are often frightened and confused.

Scholars who are creating bioethics in China can learn from the history of bioethics in the west and from earlier efforts to export western bioethics to other countries. The promotion of better medicine-more respectful and more fair-requires cooperation between caregivers, social scientists, policymakers, and an informed public together with a willingness to challenge the authority of medicine and culturally entrenched ideas that can be harmful to those bioethics seeks to protect.

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序言——构建生命伦理学

一直以来，对伦理问题的关注都是医学实践的一个重要组成部分。历经千余年，全世界关心人类疾苦的医务工作者大多都认识到了他们对于病人的责任：及时为需要的人提供医疗服务以及为病人谋福利。然而，关于生命伦理学问题却是近些年来才引起人们关注和讨论的新话题。在二十世纪六十年代，一些学者就集中讨论过关于生育的生命伦理问题(Jonsen, 1998)，也有人认为：生命伦理学开始于对第二次世界大战期间发生的滥用残酷医学实验的回应（Rothman，1991）。所以，不管是基于何种观点的认识，生命伦理学与那些古老的学科（例如科学和医学）相比，终究是一个新的领域，因为在二十世纪六十年代早期，生命伦理学甚至不是一个独立的学科。但是今天，生命伦理学业已成为医疗和医学科学中确定的、必不可少的一部分。生命伦理学研究中心在各个医学院广泛地建立；生命伦理学期刊的数量可观而且这一数量还在不断增长；生命伦理学家也被邀请供职于政府机关；越来越多的生命伦理学的研究生项目被开设，相应地，生命伦理学教授的数量也在增长。

本书的出版便是生命伦理学取得成功发展的有力证明。当生命伦理学在美国成为一个独立的新兴学科之后，今天它已成为全球的事业，它是医学训练、医学研究以及医疗保健领域的必修课。当今，不管医学研究在何处进行，用伦理学的观点去评价和规范这类与人类相关的研究已经成为必须。现在的医学决策和医患关系都或多或少地受到生命伦理学观念（诸如：关爱、尊重、利益、伤害）的影响。总之，中国的医疗体制和医疗文化必须认真考虑生命伦理学的观点（就像在北美、欧洲、南美、非洲以及亚太其他地区一样）。

生命伦理学的出现也引起了有趣的同时也是重要的社会学上的问题。为什么生命伦理学在那个时代出现？生命伦理学的理念如何在不同的医疗组织以及文化中应用？一个颠扑不破的事实是：医学总是要不断适应自身的发展和外部条件的变化。随着医学的发展和医学知识的增加，新的技术和新的医学特性已经改变了传统的医患关系的模式。当然这种关系的转变也与社会变迁有关。在美国，由于玩忽职守而引起的诉讼的增加和生命伦理学这一新的专业领域的出现，就是医学的外部环境最主要的变化，但需要注意的是，生命伦理学的发展而带来的影响是独特的。这一独特性表现在：生命伦理学对医生和专家的专业权威地位构成了挑战。是的，在美国，医生对犯玩忽职守错误的恐惧改变了医疗服务的提供方式，由于害怕失职医生们在提供服务时势必会更加的谨慎和保守。即便是这样，有一个问题仍然存在：医生对于病人来说他们永远更了解医学、更加专业、对医学的最新发展更为熟悉。而生命伦理学通过在医患关系中引入第三方道德监管的方法，改变了传统的医患关系模式。在生命伦理学中，医患关系的首要前提——信任，被以更为合理化和独立化的方式加以处理。对于一个医生或医学研究者来说，打电话询问他们的专业同僚询问有关神经学、心脏病学以及研究设计等专业问题是一回事；而对同样的专业人员来说，向道德专家询问哪些事情是道德上允许的，则是完全不同的情况。

生命伦理学地位特殊，它是一个对传统医学的道德权威进行拷问的新的领域，因此，了

解生命伦理学如何形成，如何出现以及它是如何成为医疗实践必不可少的一部分等问题是非常重要的。从社会学的观点看，颇具启发意义的一点是：考察不同的社会和文化中生命伦理学的形成路径。虽然有一些生命伦理学家（Beauchamp；Macklin）认为生命伦理学的抽象理念是完全自足的并且可以被普遍地接受，但是越来越多的人开始认识到由于文化土壤和根基的不同，生命伦理学的建构模式和应用方式也是多样的。所以，在开始的时候首先考察生命伦理学的诞生地——美国的文化和社会状况是很有启发意义的。

美国生命伦理学的社会和文化资源

现在许多生命伦理学史的著作都是由生命伦理学家完成的，这一点并不奇怪。生命伦理学家书写的生命伦理学史为我们提供了许多有价值的细节，包括：早期的会议和为了构建某种合适原则而进行的努力。但他们的努力时常走向歧途，因为生命伦理学家总是想确认某人在生命伦理学领域的先锋和奠基人的地位，同时他们总是想提出一种能够得到普遍认同的观点。

传统的生命伦理学史的著作（有些是生命伦理学家写的，有些是非生命伦理学家写的）声称：生命伦理学的出现是为了回应医学科学基础的发展。实际上，这个广为传播的观点是在第一个生命伦理研究中心成立宣言中提出的。从这个宣言的文本看，在 1969 年建立的 Hastings 中心是为了“满足考察生命技术革命所带来的伦理影响的专业研究的需要。”包括“器官移植的担保问题、人类试验、胚胎检查、生命延长技术……”（Hastings Center，1973；Callahan，1981）根据这种观点，生命伦理学的建立是为了更好地适应新技术的发展，寻找几十年前不曾出现过的新问题的答案。例如：什么时候摘取一个人的器官是合理的？什么情况下克隆人是合理的？人工授精是否应该有年龄上限？

一些其他学者把生命伦理学的出现视为是 20 世纪 60 年代“权利运动”的后果。各种社会机构都面临着建立消除歧视机制的挑战，而这也波及医学领域导致了对医生和医院行为的系统的审查。

这些历史性的描述为我们提供了在生命伦理学产生之时医疗领域和医学科学的发展状况；但是这些描述没能考察生命伦理学是如何被接受的，如何发展的，以及它对医疗实践和医学研究方式的影响，而关于生命伦理学的这些问题已经被社会学家所考察。

在 20 世纪 80 年代后期和 90 年代，社会科学家开始认识到生命伦理学在医学领域的重要性并开始了明确的以生命伦理学为主题的研究。社会学家和人类学家带着特定的目的深入医疗机构考察伦理问题是如何被处理的。Zussman（1992）研究了有关特护病房的决策问题；Bosk（1992）考察了基因法律顾问的工作情况；Jeanne Guillemin 和 Lynda Holmstrom（1986），Renée Anspach（1993），以及 Jessica Mesman（2002）考察了新生儿重症监护病房的问题；Chambliss（1996）研究了护理伦理和医院生活的道德问题，考察了伦理在组织中的作用。在二十世纪九十年代中期和二十一世纪初，社会科学家和历史学家开始探讨医学研究的伦理问题：Halpern（2004）提出了对医疗试验的道德风险的估计，Stern（2005）考察了美国优生学的发展历史，Fisher（2009）考察了临床研究外包给私人部门的问题。

在 2008 年 Renée Fox 和 Judith Swazey 出版了“两个人的团队”（team of two）这是一本关于生命伦理学产生和发展的报告。他们的“学术自传”描述了他们在生命伦理领域内的研究以及与之相关的研究，他们清楚地辨别了与生命伦理学发端相关的社会和文化语境，并发出了要警惕美国生命伦理学的“文化近视”的忠告。

Fox and Swazey 对生命伦理学风靡全球时到底发生了什么很感兴趣，他们对生命伦理学所关心的问题做了横截面式的深入细致的研究。例如，他们研究了生命伦理学如何在不同的社会文化结构中出现；处在不同地位、扮演不同角色的个人如何处理和回应生命伦理问题；社会团体和机构如何应对生命伦理问题。本书正是这样一种研究路径的继续，因为本书描述了生命伦理学如何在中国产生和发展的问题。我希望我们能够看到更多这样的研究，即属于不同文化共同体的生命伦理学者去描述生命伦理学问题是如何在他们所处的社会产生、讨论和解决的。这样一种对话也将是非常有趣的，即去讨论和分析在西方文化传统中发展起来的生命伦理学原则可以以怎样的方式适用于其他文化传统的社会（当然也可能是完全不适用）。为了促进对伦理观念的文化根基的思考，接下来我提供一些我对于“伦理观念是如何从西方移植到其他文化中的”这个问题的思考。

文化传统和伦理观念

随着生命伦理学从西方社会向其他社会的传播，“谁之伦理?”这个问题变得越来越重要了。就像我在上文中提到的那样，既有人认为存在一种普世的伦理标准，也有人认为任何的伦理观念只能够在其出现的社会文化背景下进行评价。Macklin (1999; 2004)提出了“反相对主义”，他主张：虽然避免“伦理绝对主义”是必要地，但是那种应该并且可能在不同文化中应用的普世的伦理标准也是存在的。根据 Macklin 的说法，我们应该接受一种双重的标准。Beauchamp (2003)同意这种观点，他声称：一种共同的道德是存在的，这种道德服务于“推进人类整体的繁荣”，而这样一种道德不能被任何特殊社会的道德标准所评价。

Fox and Swazey 参考了两位社会科学家 Bourdieu and De Craemer 的研究成果，向“道德普世主义”提出质疑。Bourdieu (2001)拒绝普世主义，他看到了当一个社会将自身的特征普世化后所带来的“普世主义——专制主义”的危险(Bordieu 2001)。确实，“自主”、“有利”、“不伤害”和“公正”这些原则常常被看作是普世的，而这些都毫无例外地与西方个人主义的人格观念相联系。

Fox and Swazey 继续指出，西方个人主义关于“人”观念宣判了以其为基础的西方生命伦理学不能在全球获得成功。“人”在世界上存在的许多其他文化中并不是一个孤立的个体，而是包含着血缘、群体和社会的意义。

普世主义和相对主义的争论虽然在理论上很有趣，但是它没能告诉我们随着伦理研究的进展，国际间的合作应该如何向前推进；它也没能告诉我们在具体问题中如何选取和应用伦理原则。早期的研究(De Vries et al., 2010)考察了生命伦理学从西方社会向非西方社会的传播，这个研究揭示了西方生命伦理学进入非西方社会的三种路径：

1) 西方生命伦理学的理念被完全地吸收和借鉴并在实践中直接应用。

2) 接受西方生命伦理学的基本理念，但对其进行塑造和改变以更好地适应本土文化的需要。

3) 利用西方的生命伦理学的理念来打开一个关于道德标准的对话空间，借此希望在本土的文化传统中找到能够即尊重传统又能指导实践的伦理原则。

让我们依次简单地看一看这些观点：

1. 完全地接受西方生命伦理学：传教士式的生命伦理学

在谈到“拉丁美洲生命伦理学过去、现在和未来”这个话题的时候，Del Pozo 和 Mainetti

发现，在二十世纪八十年代，随着新的医疗技术被引进到拉丁美洲，许多伦理问题被引发了，“这些问题既不是传统的医学伦理学问题也不是无所不在的问题，但是这些问题对天主教会所能提供的可接受的回答构成了越来越大的挑战。”

在这种情况下，拉丁美洲很快接受了新的生命伦理学范式。没有遇到什么阻力，拉丁美洲各国很快地很大程度地接受了北美的生命伦理学。很快地，伦理委员会、知情同意程序、关于器官移植和辅助生殖等生命伦理问题的立法，在拉丁美洲地区都蓬勃出现了。

拉丁美洲的经验是很典型的。为了世界的发展而进行的新药品、医疗器械和医疗程序的输出，以及临床研究从研究发达的国家向研究落后的国家的转移，这些因素的结合使得拉丁美洲产生了对新的伦理建议的需求（Petryna 2005）。因为美国、加拿大和西欧一些国家在医学技术的发展上起步较早，他们已经能够为这些新的医疗技术提供生命伦理学上的指导，所以在引进西方医学和医疗技术的同时引进西方的生命伦理学似乎是很自然的事情。

道德规范的输出者和引进者的目的都是好的，都是为了给可能受到新的医学技术影响的人提供保护。但是对伦理道德规范采取全盘接受的态度也不是没有问题的。

一些学者也已经注意到：取得个人的知情同意这一西方生命伦理原则在发展中国家是不适用的（Dawson and Kass 2005；Ezeome and Marshall 2008；Hyder and Wali 2006；Molyneux et al. 2005）。印度医学研究委员会这样描述了对于西方知情同意原则的接受问题：

在发展中国家，获得知情同意被多次认为是困难的、不切实际的。由于各种各样的理由知情同意原则在发展中国家无法达到它预想的目的。比如不能正确理解“同意”的意义，文化因素上的家长决定的传统等（2006）。

其他学者也确认了这种西方生命伦理学在本土文化中的不适用性。Simpson 描述了一种“成长的觉醒”，这种觉醒是来自于西方生物医学技术和本土实际情况之间的“不同的伦理价值的差异造成的错位感”（2009）。Chattopadhyay and De Vries 表达了同样的观点：不管是有意的还是无意的，将占主导地位的西方的社会－文化－道德结构强加于西方的少数族裔人士或是众多的非西方国家，都是不道德的（2008）。

“完全接受的”或是“传教士式”的方式对于伦理思想的传播是危险和有害的。强加于人的伦理思想比本土的伦理思想对有益的研究会产生更多的妨碍，因为强加的伦理思想会要求人们在开始研究之前就符合西方的伦理的要求。此外，强加的伦理思想会使业已存在的道德传统陷入混乱，同时产生新的问题和混乱。随着文化资源丰富国家的文化代表的出现（不管这种代表是传教士、生命伦理学家或是文化资源贫困国家的殖民管理者），文化经纪人也出现了。这些文化经纪人穿梭于不同的文化，做阐释的工作，他们通过做文化资源丰富国家的当地代理人而在当地的社会中获得一定的社会地位。

2. 塑造和改变西方生命伦理学的基本理念以更好地适应本土文化的需要

伦理思想从西方向发展中国家传播的第二条路径是吸收和重塑。这种路径认为西方的伦理思想无疑是重要的，但需要经过重塑来适应当地的实际情况。这种路径由 Siddiqui（2009）在巴基斯坦卡拉奇大学为医学生开设的生命伦理学导论课程中提出。这个课程中所涉及的话题都是典型的西方的，比如知情同意、利益冲突、隐私和保密和病人权利。但是 Siddiqui 指出：想要让学生了解生命伦理学基础的老师应该运用具体的案例和热点伦理问题的讨论，同时时刻不忘巴基斯坦特殊的文化和社会状况。他同时也说：由于很多学生的英

语不熟练，他们也可以用乌尔都语表达意见，因为我们相信伦理思想没有语言的障碍。思想是西方的，但这些思想可以被转换到巴基斯坦的语境中。

相似的情况在中东研究伦理训练计划(MERETI)(这是一个由国家卫生研究院的 Fogarty 国际基金资助的包含了中东个人事业发展规划的项目)中也可以看见。MERETI 的成员们组成了发展讲习班，开设关于研究伦理的为期几天的课程，主要招收研究者和研究伦理委员会的成员。在课程的材料的选取上，他们很注重借鉴西方的思想资源，但是会精心地选择那些适用于中东实际情况的著作。

通过回顾这些，我们可以发现中东地区在实践中是如何重塑西方伦理思想的。例如在指定的阅读中就收录了 Prof. Dr. G. I. Serour 的题为“伊斯兰教与生命伦理四原则”的文章。这篇文章力图融合比彻姆和丘卓斯的“生命伦理四原则”和伊斯兰教思想，他的结论是：今天的生命伦理四原则即自主、有利、不伤害和公正，从伊斯兰教的宗教观点看，也是非常重要的(Serour 1994)。Serour 的这篇文章并不是想在伊斯兰教的传统中发展出独立的生命伦理原则，而是想要证明西方的伦理思想是可以被伊斯兰教观点所支持的。

Simpson (2009)——一位上文中曾经提到的研究如何把斯里兰卡的道德传统应用于现代的医学伦理问题的人类学家，在他看来这些想要融合西方生命伦理思想和发展中国家文化和价值的努力很大程度上都是空谈。把西方伦理思想准确地翻译成当地的语言才是正确的方向。这种方式认识到非西方的、犹太一基督社会的道德传统是存在的，但是想要融合和翻译的努力本身就暗示了他们想要引进的伦理思想的优越性。

3. 基于传统文化资源，发展生命伦理思想

从类型上看，最后一种传播伦理思想的模式更多的停留在理论层面而非实践。虽然在实践中我没有发现这种模式，但是巴基斯坦的例子让我相信这种模式是国际伦理对话合作的未来。这种模式运用西方的伦理学知识，鼓励发展中国家的伦理学家总结自己的、在文化上适宜的社会伦理问题的解决方案，而不是全盘接受西方的道德规则或是重塑西方道德原则使其能与传统共存。这种模式采用了西方伦理学家早已熟知的阐释和应用道德观念的方法。

不同于现存的由 Fogarty 国际基金、威康信托基金或是欧盟资助的伦理学培养项目，这种路径是一种归纳的路径。这种路径从对本土的道德理念的考察开始，然后从道德哲学史的角度把西方的生命伦理学作为道德观念是如何发展起来并加以实践为例。这个理论提出这样的问题：西方能从发展中国家的伦理学家身上学到什么？这完全倒转了现存的关于伦理传播的模型。西方的伦理学家仍然是有其作用的，但他们不再是道德格言和道德原则的提供者。他们应该做的是解释从西方的传统中如何推演出生命伦理学的指导原则。

发展中国家的伦理学家意识到用这种方法去创造能指导现实的伦理原则是必要的，但是他们缺少实践这一模式的力量。巴基斯坦信德学院的泌尿与移植生命伦理和文化研究中心是致力于发展这种模式的机构之一。这个中心成立后不久，其领导人就组织了“道德思想的基础：从古希腊到当代的生命伦理学”的研讨会，旨在介绍历史的、宗教的、世俗的、文化观念的因素是以怎样的方式影响了人类的道德观念的进化的，进而考察这些因素是如何调节人类的道德理解的(Centre of Biomedical Ethics and Culture 2005)。

中心的主任 Dr. Farhart Moazam，继续强调本土的生命伦理学的重要：“在我们的国家，以一种连贯的方式发展本土生命伦理学是很必要的，这将给我们带来更多价值观上的共

鸣。另外，巴基斯坦的生命伦理学也将继续学术上的、与人民实际需要无关的研究实践。如果在世界范围内这种研究方式能够被广泛应用，这将促进道德观念的对话，也将丰富本土的和国际的伦理思想”。

对中国生命伦理学的启示

去考察各种不同的生命伦理学，这不但在社会学上是有趣的而且在伦理学上也是很重要的。在美国，生命伦理学是作为一个对医学权威的挑战而出现的，今天它已经成为临床和学术研究当中的一个重要领域，同时也开始向其他的社会和文化传播。生命伦理学采用何种形式在新的环境中发展受到两个因素的影响，第一，受到美国业已发展成熟的生命伦理学内容的影响；第二，受到接受生命伦理学的社会的文化和社会背景的影响。生命伦理学要在新的环境中继续发展，它原本的目标（规范医疗和生命科学，使它们的发展体现对人的尊重和促进社会的公正）必须同当地的文化传统相适应。

生命伦理学要反映社会和文化的多样性，但这并不意味着简单的屈从于本土的现实。生命伦理学也包含着批判的维度：通过比较才能做的更好，生命伦理学为我们提供了一个更为人道的医疗保健道路。当生命伦理学不能够以批判的眼光去看待医学及他与医学和文化的关系时，生命伦理学就会出现错误，美国的生命伦理学就是最好的例子。当美国的生命伦理学家考察别国的伦理观念时，它们认识到，盲目地屈从于自主原则（通常被认为是与美国个人主义的社会文化相适应的）会导致允许救助人员逃避他们作为专业人员的责任，在“自主”的名义下，不顾病人的恐惧和迷惑，通过放弃选择从而逃避难以抉择的选择。

对于正在致力于构建中国生命伦理学的学者，他们可以从西方生命伦理学的发展历史中以及西方国家向其他国家输出其生命伦理学的早期努力中获得启发。更好的医疗、更多尊重、更加公平，这要求救助人员、社会科学家、政策制定者和知情的公众通力合作，同时需要他们有强烈的意愿去挑战医学权威，去挑战根深蒂固的、可能对生命伦理学所坚持的价值造成危害的文化权威思想。

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第 2 版前言

在高新生命科学技术高速发展的今天，面对我国新一轮医疗卫生体制改革回归公益性的发展方向，医学伦理学在我国的发展已经步入纵深发展阶段。我国医学伦理学的建设与发展已经不再仅仅局限于构建一个理论体系，翻译某一部西方医学伦理学或生命伦理学著作，引进某一西方医学伦理学的理念和思想，而是在多元文化的世界中，思考如何结合中华道德传统、文化特征、社会状况、发展阶段等因素，更好地将医学伦理学的理论服务于医学实践、维护人民健康和弘扬医学人文精神中，在全球生命伦理的大家庭有着自身的独特地位与文化特征。

距离本教材第 1 版，已经过去了八个春秋，为了更好地体现医学伦理学发展的理论成果和时代特性，承担医学伦理学教育的历史重担和责任，实现医学宗旨和医学与人文的融通。在第 1 版主编陈亚新、王大建的指导下，本书的第 2 版由李勇拟定大纲，汇集南京大学、东南大学、南京医科大学、天津医科大学、江苏大学、徐州医学院、江苏省中医院 7 所高校及医疗机构的编委们共同承担完成。

与国内同类教材相比，本书第 2 版编委有一个鲜明的特点，基本上都是由一批长期在医学伦理学理论研究和教学第一线的中青年学者组成，他们既有来自于医疗机构实务界的医务人员，又有来自于高等院校的教师；既有国家社会科学基金的主持者，又有积极参与国际组织伦理机构的行动者；既有医学背景知识的研究者，又有人文社会科学背景知识的学者。他们在杜治政、邱仁宗、孙慕义等医学伦理学前辈和先行者知识和精神的熏陶下，怀抱着医学伦理学研究的兴趣和热忱走在一起，继承前辈成果，总结教学经验，创新学术视域，共同为广大医学生及医学伦理学的爱好者编写一本适于教学、易于自学、内容丰富、开阔视野、富有人文气质与当代精神的医学伦理学读本。

本书在编写过程中，我们力求符合教学特点、规律与学术创新性的统一，让本书体现三个特性：其一，时代性。本书不仅坚持涵盖国家最新执业医师考试大纲的内容要求，而且将最新研究产生的理论成果吸纳其中，并与国家最新颁布的法律法规相适应。如医学人文精神、医学专业精神和医学整合理念的相关内容，2010 年颁布的《侵权责任法》中对医疗伦理责任的相关内容规定等。其二，实践性。本书坚持在教材编写内容中贴近生活、理论结合实际进行叙述，因而在每章的最后都附有案例思考题，以帮助加深理论的理解和应用，而且在部分章节内容更加注重实务操作性，如医学科研伦理中医院伦理委员会如何组织、运作和管理，如何进行伦理审查。其三，创新性。本书一方面坚持避免将教材写成学术专著，同时坚持在教材中进行局部学术创新，以拓宽学术视野。如基因伦理、器官移植伦理、生殖伦理等部分内容的创新，本书第十五章更是与国内外最新理论研究成果相结合，为拓宽新的理论视角提供参考。此外，为了方便讲授与自学，本书在每一章起始都提示了要点，以明确学习重点，书后还附录了较为详尽的医学伦理学的经典文献，除各章后的案例思考题外，还编撰了比较典型的综合案例，供阅读、讨论与思考。