

## **CROSS-CULTURAL BIOETHICS CURRICULUM DEVELOPMENT: AN EXAMPLE**

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**Abstract:** In this paper, we discuss a novel project in bioethics education for medical students. Columbia University's (CU) graduate Bioethics faculty was invited to develop a curriculum in close consultation and partnership with a top-ranked medical faculty in the Hong Kong SAR, the Chinese University of Hong Kong (CUHK). The intent was to provide an innovative curriculum to meet global standards for bioethics education, while attending to specifically local ethical norms and challenges. This paper does not describe the entire project and partnership; it does describe some of our approaches to accommodating an initially American-style curriculum to a Hong Kong medical school and its students.

**Keywords:** Education; Ethics Curriculum; China-Hong Kong SAR; Cross-Cultural; Bioethics

### **Brief Introduction:**

Ethics education in medical school is considered an important element in producing professional and principled physicians who may then become more effective, caring physicians over the course of their careers and suffer less from moral distress and 'burnout'. Ethics curricula in medical schools vary in scope and modes of delivery, but a common global trend is towards increasingly formalized curricula, which may incorporate previous practices of 'educating by example' or existing coursework in professional norms and ethics, while adding breadth and depth in ethical topics addressed and modern methods of curricular delivery.

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***The CU-CUHK Partnership:***

The medical ecosystem of the Hong Kong SAR is a sophisticated one, including a public healthcare system serving most Hong Kong residents, the Hong Kong Hospital Authority (HA). The HA formulates and oversees ethics policy and maintains ethics panels empowered to consider issues in clinical ethics and healthcare delivery. In addition, Hong Kong Medical Council (MCHK) requires evidence of robust ethics education as part of the regular re-accreditation process of the two Hong Kong medical schools.

At the inception of the CU-CUHK partnership, commitment to ethics education was already firmly embedded in the CUHK medical faculty curriculum. A core of faculty was devoted to teaching professionalism in the clinical years. Final year students attended a one term medical ethics course combining lecture, small group discussion and assessment by student video work product and classroom administered essay exams. In addition, shortly before the CU-CUHK partnership, an ethics Grand Rounds for medical students had been incorporated into the clinical years' curriculum for Year 5 students. Each meeting is devoted to an ethics case run by faculty with extensive discussion. Student attendance at several Grand Rounds is a required component of the medical curriculum.

In 2015, the medical faculty chose to expand on these efforts by partnering with Columbia bioethics. The goal of this partnership was to ensure the rapid implementation of a next generation ethics curriculum to meet and exceed MCHK standards, and most importantly to prepare a new generation of Hong Kong physicians for the challenges of 21<sup>st</sup> medical care.

***Groundwork:***

When we were asked to partner with Chinese University of Hong Kong to develop this de novo bioethics curriculum for every year of their six-year undergraduate medical program, we were initially challenged to understand more fully the process of medical education in Hong Kong. Our faculty has had experience teaching medical students, post-graduates, nurses, lawyers, and other interested professionals topics including clinical ethics, research ethics, public health ethics, and philosophy and history of bioethics. We drew upon that experience to develop a curriculum that integrated with what we understood about the medical culture in Hong Kong and the mission of the medical school.

A weakness in our process was the absence of extensive on-site research and wide discussions with members of the CUHK medical faculty. This was simply a function of the short lead time between the engaging with CUHK on this project and its initial implementation. We went forward with an awareness that implementing this new curriculum would require dynamic assessment of its effectiveness and relevance.

We acted on that awareness in designing student work. For example, all Year 1 students complete an assignment titled “Health and Illness: Beliefs and Biases” early in their bioethics studies. In this activity, students are tasked to examine their own lives, families, religions, and cultural outlooks to identify the experiences and factors that have shaped their beliefs and biases about health and illness. Working through this exercise not only benefited the students but foregrounded for the CU faculty some issues which raised student anxieties and uncertainties. These included concerns about encountering mentally ill patients, accepting the use of Traditional Chinese Medicine (TCM) by patients, and privacy versus openness in discussing aging and dying. We used student work to prioritize and deepen some planned elements of the curriculum.

We were advantaged by having one of our own graduates as an onsite manager, lecturer, troubleshooter, and observer for the first years of this curriculum. In fact, our initial graduate to take on this role had studied Chinese culture in University and had good knowledge of written and spoken Mandarin and was familiar with Hong Kong, its culture and recent history.

This enabled changes and feedback that was subject to a rapid response and thus course’s relevance grew faster than might have been otherwise. The year by year implementation plan was a further advantage. One year of the new curriculum was introduced each academic year, so that in the first year of teaching, only Year 1 students participated in the new curriculum, in the second year of teaching both Year 1 and 2 students participated; by the sixth year of teaching all Years’ 1-6 students will be embedded in the CU-CUHK program. This design permits close attention to delivery of the curriculum, student outcomes, and manageable opportunities for revision and incorporation of feedback from students and teaching staff.

This paper is short description of some of the approaches and strategies we used to develop this flexible and organic product. We used current literature and nationally recognized recommended standards (generally from the United States and the United Kingdom) to develop baseline themes and issues that

we felt every medical school should address.<sup>1,2</sup> We had some specific local structural (not thematic) considerations to account for in our planning.

1. Age of student: The Hong Kong educational system follows the British educational system. This means that medical students most commonly arrive straight from high school and are age eighteen or nineteen, with some exceptions. They will spend six years in medical school. The first three are primarily classroom based and include required, but limited, humanities education, so the students background education in critical thinking skills comes primarily from their high school experience. We carefully considered students' young age and lack of life experience when designing the modules for the first three years.
2. Language abilities of the students: The Hong Kong admission criteria for medical school is primarily exam based. Students generally come from two different educational streams. One is the public-school system which teaches in both Cantonese and English but whose students are generally stronger in Cantonese. The second is from an essentially private school system where education is conducted in English and whose students may not be completely fluent in Cantonese. Mandarin fluency varies among students and is it not the primary language of education, medicine or private life for the vast majority of students. English is the language of medical school instruction.
3. Lack of qualified Bioethics instructors: There is no bioethics training program or graduate program in bioethics in Hong Kong. This meant that there were no trained faculty to draw upon to implement our program. In the first three years, topics such as histology, microbiology, and other standards of early medical education are taught by PhD educated science lecturers who teach from a standard curriculum. This was the pool of instructors that we were drawing upon, and none had taught courses in the humanities before, much less bioethics. This required extra support and materials, as described below.

### ***Curriculum Development:***

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1 Wears, D, Kuczewski, MG. The Professionalism Movement: Can we pause? Am J Bioeth. 2004 Spring;4(2):1-10.

We had preliminary discussions with our CUHK colleagues on topics that would be of particular interest to the students. One of our recent Columbia Bioethics Masters graduates did an extensive literature search on best practices, while acknowledging a variety of views on the subject, and we presented an outline of a six-year bioethics education plan to the CUHK faculty.<sup>3,4,5</sup> Our initial curriculum was designed to be flexible and use unifying themes, such as the four principles, autonomy, beneficence, maleficence, and justice throughout the six years for the sake of continuity. In the first three years we planned to address the basics of clinical ethics, research ethics, public health ethics, and scientific integrity. In those years, students are primarily focused on classroom work (not clinical rotations), so our curriculum was organized as an online module system, with each module consisting of online reading and multimedia resources, written and multimedia assignments submitted online, a short, large group lecture to emphasize overall goals and learning objectives, followed by a small group meeting (20-40 students) of about 60 minutes to discuss the module theme using cases and prompt questions.<sup>6</sup>

For our model, our objective was to teach strategies and methods for analytically engaging with ethical dilemmas, not primarily the memorization of policies and law. We also placed an emphasis on encouraging student discussion as a method for building communication skills needed for ethical clinical practice. Given the cultural differences, this approach seemed more likely to produce ethically aware physicians than focusing on cultivating ‘virtuous’ physicians.<sup>7</sup> As you can see from Table 1, Year 4 is devoted to the local laws and policies and is placed AFTER attention to the development of critical thinking skills, grounding in basic bioethics, and awareness of fundamental issues in clinical, public health and research bioethics.

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2 Goldie J. Review of ethics curricula in undergraduate medical education. *Med Educ.* 2000 Feb;34(2):108-19.

3 Hafferty, F, Franks. R The hidden curriculum, ethics teaching and the structure of medical education. *Acad Med.* 1994 Nov;69(11):861-71.

4 Miyasaka, M, Akabayashi, A, Kai, I, Ohi, G. An international survey of medical ethics curricula in Asia. *J Med Ethics.* 1999 Dec;25(6):514-21.

5 Dubois JM, Burkemper J. Ethics education in U.S. medical schools: a study of syllabi. *Acad Med.* 2002 May;77(5):432-7.

6 Columbia University designed, supported and hosted the curriculum via Instructure’s Canvas learning platform, the standard Columbia University online instructional platform.

<b>Year</b>	<b>Mode of delivery</b>	<b>Topics</b>
Year 1	Online student preparation Short large lecture, small group tutorials	Ethical frameworks, clinical, public health, and research ethics
Year 2	Online student preparation Short large lecture, small group tutorials	Clinical, research, and public health ethics
Year 3	Online student preparation and in-class presentations Panel discussions, class meetings	Ethical and social frameworks, clinical and research ethics
Year 4	Online preparation Large lectures, panel discussions	Law and ethics, bedside ethics, stigma and ethics
Year 5	Online student preparation Lectures, small group tutorials	Clinical ethics in the context of specialty rotations, Ethics Grand Rounds
Year 6		Clinical ethics—biomedicine and TCM, aging and end-of- life, ethics and communication

Years 5 and 6 are devoted to ethical thinking and analysis on the wards. We use cases from the various specialty rotations that comprise the students' experience in these years. Students apply the principles, other ethical frameworks, and laws and policies they have learned in the first four years to the situations they are observing on the wards. We have also encouraged each specialty's lead faculty to use ethics modeling as a teaching modality and to support clinicians in leading classroom teaching for students themselves, rather than having outside 'ethics experts' come in. We feel this modeling has the most effective impact on students' images of themselves as future physicians. We offer support through teaching guides, reading material, and cases to the clinicians leading discussions.

### *A Topic Example:*

As described above, our modules in Years 1-3 covered a wide variety of bioethics issues. For each topic we prepared to introduce the general theory behind the topic and then used that general theory to address a local issue. In this way we could address some differences in standards and perspectives between the Hong Kong system and the American system. Here we use our Adolescent Consent module offered in the Second Year as an example of module design and development process.

The nuances of consent and capacity are considered fundamental to medical ethics education, so this topic was an essential element of the curriculum. We took into consideration the four aspects of capacity testing as described in the classic paper by Appelbaum and Grisso (in summary)—expressing a choice, understanding information, appreciating actions and consequences, and rational thought—the 'theory'.<sup>8</sup> In order to engage our young audience, we chose to use the case of the older chronically ill adolescent to capture the attention of students and encourage them to think critically about the nature of capacity. We anticipated that students would be particularly interested in this topic as they are so close to the age of majority themselves and so could use empathy and identification as sources of knowledge and understanding.

We selected readings from the media describing well-known recent cases in the United States, specifically the case of Cassandra, a 17-year-old woman diagnosed with Hodgkin's disease, a highly curable form of leukemia, who

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7 Eckles RE, Meslin EM, Gaffney M, Helft PR. Medical ethics education: where are we? Where should we be going? A review. *Acad Med.* 2005 Dec;80(12):1143-52.



was refused conventional chemotherapy and underwent forced chemotherapy. The second case was that of Dennis Lindberg, a 14-year-old Jehovah's Witness with leukemia who requested to forgo a life-saving blood transfusion and whose request was then honored by the courts. We opted for the case of Cassandra for a number of reasons. Her story was widely covered by the media thus many stake-holder's perspectives were easily via a simple Google search. Cassandra's personal opinion was available as an Op-Ed and thus as an important source document and patient voice.<sup>9</sup> We first had the students read a general overview about the case from US News and World Reports<sup>10</sup> and then do an online poll at home asking if Cassandra should be forced to accept chemotherapy. We then had the students read the Cassandra's Op-Ed and asked them to answer the same question and to consider what might or might not have changed their mind. These readings would open the discussion in class on the patient's voice. Did Cassandra make sense? Did she have consistent preference and values? Did she seem to have insight into her disease?

As a companion to the Cassandra narrative, we were also fortunate to have a journal article by Hong Kong physician Edwin Hui describing two cases of disagreement on treatment between child and parent in Hong Kong.<sup>11</sup> These 'real' cases helped us to ground the issue locally. The accounts and discussion presented in the Hui article explore the concept of Chinese familism and its role in decision-making. They also opened discussion on Hong Kong's heterogenous medical ecosystem in which patients may choose care of two very different methodologies—'traditional' Chinese medicine (TCM) and the biomedical model. Our students are trained in the biomedical model only, but they will certainly treat patients who have sought care or are seeking care in parallel from a TCM doctor. These cases open the door for a discussion on how to encourage patients to be open about where they are seeking care in order to serve them effectively. In the accounts offered by Hui, the ill teen disagrees either openly or quietly with their family regarding their care. This is

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8 Appelbaum, P and Grisso, T Assessing Patients' Capacities to Consent to Treatment. Abilities. *N Engl J Med* 1988 319 (1635-1638).

9 C, C. (2015, January 8). Cassandra's chemo fight: 'This is my life and my body.' *Hartford Courant*. Retrieved from <http://www.courant.com/opinion/op-ed/hc-op-cassandra-my-body-my-life-0109-20150108-story.html> .

10 Leonard, K. (2015, January 22). Case sparks debate about teen decision making in health: A Connecticut teen is being given chemotherapy against her will. *U.S. News & World Report*. Retrieved from <http://www.usnews.com/news/articles/2015/01/22/case-sparks-debate-about-teen-decision-making-in-health>

11 Hui, E, Parental Refusal of Life-Saving Treatments for Adolescents: Chinese Familism in Medical Decision-Making Re-Visited. *Bioethics*, Vol. 22 Num. 5 2008 pp 286–295.



an important tension for students to recognize and address as familial decision-making is more common in Hong Kong than in the West.

In preparation of class, the students were required to turn some paragraphs answering these prompts:

1. How did Cassandra's perspective (her own voice) influence your opinion about how she should be treated?
2. Should Cassandra, Cassandra's mother, or the court have the final say on her treatment? Explain. Remember that the three basic elements of consent are:
  - o Appropriate information: Was good information given in a comprehensible way?
  - o Decision-making capacity: Is the person able to appreciate and process that information?
  - o Voluntariness: Is the person being coerced or convinced unduly in any way (by the medical community, friends, parents, etc.)?
3. What should happen once Cassandra turns 18 and is no longer a minor, and subject to protection of the State?

To promote active classroom discussion, we provided a video for tutorial leaders to review, alerting them to potential issues that may come up in the classroom and to good prompt questions to get students discussing the elements of capacity. We also provided tutorial leaders with extra resources reviewing the rights of minors and decision-making in Hong Kong and a general primer on capacity and decision-making so they would adequately prepared for student questions.

This module is well-liked by students. Tutorial leaders report enthusiastic engagement and active discussions. Students finish the module with a thorough understanding of the basic requirements of capacity and they have started to consider the gray areas that can occur when patients are not of age or when patients make decisions that do not conform with medical recommendations. These critical thinking skills continue to be encouraged and refined during all six years of their medical education.

**Conclusion:**

The experience of working with a world class institution such as Chinese University of Hong Kong to implement a comprehensive and best practice bioethics curriculum into its medical school has been both profoundly gratifying and educational. We provide this short account of one aspect of this collaboration as an example of successfully merging an American bioethics standard with Hong Kong priorities and concerns. Teaching techniques that proved successful in American classrooms were successful in Hong Kong classrooms as well as long as we remained flexible and responsive to content and emphasis. We have many examples of locally important topics that were brought to our attention via the curriculum ,and then integrated as a case or learning touchpoint the next year. For others considering this type of project, we must emphasize that listening to students, their responses, and their concerns was essential to refining the curriculum to keep interest and comprehension of material high.