TEACHING AND LEARNING ETHICS

How do bioethics teachers in Japan cope with ethical disagreement among healthcare university students in the classroom? A survey on educators in charge

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Objective: The purpose of this study was to demonstrate how educators involved in the teaching of bioethics to healthcare university students in Japan would cope with ethical disagreement in the classroom, and to identify factors influencing them.

Methods: A cross sectional survey was conducted using self administered questionnaires mailed to a sample of university faculty in charge of bioethics curriculum for university healthcare students.

Results: A total of 107 usable questionnaires were returned: a response rate of 61.5%. When facing ethical disagreement in the classroom, coping behaviour differed depending on the topic of discussion, was influenced by educators' individual clear ethical attitudes regarding the topic of discussion, and was independent of many respondents' individual and social backgrounds. Among educators, it was commonly recognised that the purpose of bioethics education was to raise the level of awareness of ethical problems, to provide information about and knowledge of those issues, to raise students' sensitivity to ethical problems, and to teach students methods of reasoning and logical argument. Yet, despite this, several respondents considered the purpose of bioethics education to be to influence students about normative ethical judgments. There was no clear relationship, however, between ways of coping with ethical disagreement and educators' sense of the purpose of bioethics education.

Conclusions: This descriptive study suggests that educators involved in bioethics education for healthcare university students in Japan coped in various ways with ethical disagreement. Further research concerning ethical disagreement in educational settings is needed to provide better bioethics education for healthcare students.

The importance of bioethics education in medicine, nursing, and health care has long been recognised. Bioethics education for healthcare university students has been examined and discussed internationally and, regardless of nation, a certain consensus has been reached about the purpose, pedagogy, subjects of study, and the issue of who should teach bioethics.^{1–10} However, there are also issues that have been neither sufficiently scrutinised nor extensively discussed yet. One of these is the question of how bioethics educators cope with ethical disagreement among students when teaching bioethics.

This problem is, in our opinion, extremely important in the field of bioethics because there are many bioethical areas where ethical opinions have not yet reached consensus—for example, direct donation of an organ from a brain dead patient; ways to approach a situation when opinions differ among proxies in the case of a patient who no longer has decision making power, and ethical decisions concerning abortion and voluntary euthanasia.^{11–15} Even if all facts about these issues were to be understood and recognised by students and teachers alike, ethical disagreement would inevitably prevail. The reason being, as Stevenson accurately points out, is that: "It is logically possible, at least, that two men should continue to disagree in attitudes even though they had all their beliefs in common, and even though neither had made any logical or inductive error, or omitted any relevant evidence."¹⁶

Despite this need to deal with ethical disagreement, however, a dearth of research persists on how bioethics educators cope with ethical disagreement in the classroom. No studies to date in the field of bioethics have examined this issue; nor have there been either discussions or surveys on

this issue in Japan. In order to reveal the current ways of coping with ethical disagreement, therefore, we conducted a cross sectional survey on educators involved in the teaching of bioethics to healthcare university students in Japan. This study's primary objective was to learn how educators cope with ethical disagreement inside the classroom and to clarify the factors that influence the way they cope. We hypothesise that educators' individual and social backgrounds, their understanding of the purpose of bioethics education, and their individual ethical attitudes toward the topic of discussion are related to how educators cope with ethical disagreement among students and, also, to how they deal with a student who asks for the solution to an ethical problem.

METHODS

Our sample consisted of faculty in charge of bioethics curriculum for healthcare students—that is, nursing, medicine, pharmacology, public health, social work, etc in both medical schools and nursing schools in Japan. Bioethics education was defined as any and all subjects related to ethical issues of health care—that is, ethics, philosophy, medical ethics, professional ethics, and bioethics. A cross sectional survey was conducted using a self administered questionnaire sent by ordinary post. At the time of this study, in 2003, there were a total of 80 medical schools and 103 nursing schools in Japan.

We developed an original questionnaire in Japanese and conducted a pilot study on a sample of nurses and graduate students in the field of bioethics at two universities (University of Miyazaki, 10 participants; Kyoto University three participants). The questionnaire was edited and revised

according to participants' comments regarding case content and questions. Questionnaires were posted to each school's dean or department chair, accompanied by a letter explaining the details of our research. Each school dean or department chair was asked to forward the questionnaire to the faculty in charge of the university's bioethics curriculum. A book token to the value of 1500 yen was also included for each respondent in token of our gratitude for those who responded to our questionnaire. One month later, we followed up by posting a reminder.

The questionnaire was written in Japanese and divided into four sections. Section 1 asked for participants' individual and social background; section 2 described a group discussion on informed consent and direct donation in which opinions among students were divided (table 1).

Questions that followed the cases in section 2 asked: 1) what one would answer if a student asked one's own ethical attitude regarding the case in question (select 1 out of 6 answer choices, including "others" in case A and 1 out of 7 answer choices, including "others" in case B [shown in table 4]); 2) how one would cope with ethical disagreement between students (select 1 out of 5 answer choices, including "others" [shown in table 5]), and 3) what one would do if a student asked for the "right answer" (select 1 out of 7 answer choices, including "others" [shown in table 5]). Section 3 asked educators to indicate the purpose of providing bioethics education to healthcare university students. A total of nine statements, including "others", were listed regarding the purpose of bioethics education, asking participants either to agree or to disagree. Section 4 consisted of the Robert Wendland case. This vignette asked how one would cope with disagreement among ethics committee members regarding the treatment plan of a conscious but incompetent patient if one were the committee chair.¹⁴ Participants responded in their own words. The results of section 4 will be presented in a separate report.

A statistical analysis was performed using a Yates-corrected χ^2 test; Fisher's exact test (for expected values of χ^2 test below 5); McNemar χ^2 test, and the independent t test. We divided the sample by age (20–50 years of age, above 50 years of age) and by specialty (medical, non-medical). When examining the differences in answers between case A and case B using the McNemar χ^2 test, we created two groups for each respective case: group 1 chose a specific answer choice and group 2 chose any other answer choice. A significant difference was a p value of 0.05 or less. A logistic

regression model analysis was used in order to substantiate the results of univariate analysis. Independent variables included respondents' age; sex; religion; primary field of specialty; years of teaching; participation in research ethics committees; participation in hospital ethics committees, and whether or not they supported a specific theory of ethics.

RESULTS

Number of respondents and response rate

Questionnaires were sent to the school dean or department chair at all 183 Japanese universities (medical schools, 80; four year nursing schools, 103). A total of nine questionnaires were returned unanswered from seven institutions because of "the absence of an applicable faculty member in charge of the bioethics curriculum"; from one institution because "all surveys are returned at the administration level for faculty have little time to spare", and from one institution that did not provide a reason. The remaining 174 questionnaires were delivered to faculty in charge of the university's bioethics curriculum. A total of 110 institutions returned questionnaires, but three institutions provided from two to eight anonymous responses and we could not determine which questionnaire was returned from those who were in charge of the university's bioethics curriculum. Therefore, a total of 107 (110–3 = 107) questionnaires were used for statistical analysis—the response rate was 61.5% (107/174).

Respondents' background

Respondents' individual and social backgrounds are shown in table 2.

Field of other specialty included religious studies, law, psychology, cultural anthropology, literature, and physiotherapy. More respondents in health care (nursing, medicine, physiotherapy) than in non-health care (philosophy and ethics, bioethics, religious studies, law, psychology, cultural anthropology, literature) were older than 50 years of age

Table 1 Two cases for small group discussion

Case A: The importance of informed consent in clinical research on people

You are discussing "the importance of informed consent in clinical research (*Declaration of Helsinki*, article 22: ethical validity)" with a group of students.¹⁷

Conclusion following discussion

Student group A: Completely agree with article 22 and assert that sufficient informed consent in clinical research is necessary regardless of circumstance.

Student group B: By explaining accurately the study's risks, subjects will become unnecessarily anxious and the number of people who agree to participate will decrease. Accordingly, although important, wouldn't it be better not to explain serious risks that occur only occasionally.

Case B: Regarding a brain dead patient's wish for direct donation

You are discussing "when a brain dead patient (donor) has expressed her wish to donate one of her organs to a relative and the relative has also consented, should one prioritise donation to the relative over other patients in need of an organ?"

Conclusion following discussion

Student group A: To specify the recipient in accordance with the donor's wish.

Student group B: To specify a recipient is unjust and impermissible.

Table 2 Characteristics and background of respondents; N (%)

Age distribution (years)	20–29	0 (0)
	30–39	3 (2.8)
	40–49	29 (27.1)
	50–59	40 (37.4)
	60–69	30 (28.0)
	70–79	1 (0.9)
Sex	No response	4 (3.7)
	Female	30 (28.0)
	Male	74 (69.2)
Faith/religion	No response	3 (2.8)
	No	79 (73.8)
	Yes	22 (20.6)
Primary field of specialty	No response	6 (5.6)
	Philosophy/ethics	24 (22.4)
	Bioethics	9 (8.4)
	Nursing	23 (21.5)
	Medicine	38 (35.5)
	Other	10 (9.3)
Period of involvement with bioethics education for students in health care	No response	3 (2.8)
	8.3 yrs (mean)	1–33 yrs (SD 7.0)
	No response	4 (3.7)
Ethics committee member (research)	Yes	60 (56.1)
	No	43 (40.2)
	No response	4 (3.7)
Ethics committee member (hospital)	Yes	26 (24.3)
	No	78 (72.9)
	No response	3 (2.8)
Ethical theory/position	Yes	34 (31.8)
	No	67 (62.6)
	No response	6 (5.6)

All numbers (%): n = 107

(81.9%: 50.0%, $p = 0.001$) and female (37.7%: 16.3%, $p = 0.027$). Non-healthcare respondents tended to support a specific ethics theory more often than respondents in health care (53.7%: 20.0%, $p = 0.001$) and years of teaching were longer as well (9.9 years: 7.0 years, $p = 0.045$). More respondents older than 50 years of age tended to participate in hospital ethics committees than younger ones (31%: 9.4%, $p = 0.024$). No statistically significant associations existed between religion and any other characteristics.

Respondents' understanding of the purpose of bioethics education

Respondents' understanding of the purpose of bioethics education for healthcare university students is shown in table 3.

The majority of respondents recognised the following objectives: to provide information regarding bioethical issues; to raise students' sensitivity to ethical problems, and to teach students appropriate methods of reasoning and logical argument. There were several respondents who, on the other hand, considered the purpose of bioethics education to be to influence students about normative ethical judgments and promote behaviour change. The majority of respondents did not consider raising a student's cultural level and level of sophistication to be an objective.

A relationship between respondents' understanding of the purpose of bioethics education and individual and social background was observed. Female respondents (93.3%) included raising students' sensitivity to ethical problems as a purpose more often than male respondents (73.0%) ($p = 0.042$). Respondents who had religious affiliations (36.4%) tended to include creating social consensus concerning ethical issues as a purpose more often than those who had no such affiliations (13.9%) ($p = 0.028$). In addition, those who perceived having students hold a certain ethical position as a purpose tended to have fewer years of teaching (4.8 years: 9.2 years, $p = 0.01$).

A logistic regression model analysis confirmed the results of univariate analysis above: female respondents tended to include raising students' sensitivity to ethical problems as a purpose ($p = 0.03$, $R = 0.169$); respondents who had religious affiliations tended to include creating social consensus concerning ethical issues as a purpose more often than those who did not have any such affiliations ($p = 0.01$, $R = 0.222$),

Table 3 Respondents' understanding of the purpose of bioethics education

Number of respondents who replied, "yes" to the following objectives; N (%)	
To raise students' sensitivity to ethical problems	84 (78.5)
To teach students appropriate methods of reasoning and logical argument	80 (74.8)
To provide information and knowledge regarding those issues	70 (65.4)
To influence students' ethical attitudes and promote behaviour change	35 (32.7)
To have students hold a certain ethical position	22 (20.6)
To create social consensus concerning ethical issues	21 (19.6)
To raise a student's cultural level and level of sophistication	14 (13.1)
It depends on the student year—that is, 1st year, 2nd year, etc)	6 (5.6)
Other	3 (2.8)

N=all numbers (%): n = 107

and respondents who had fewer years of teaching tended to include having students hold a certain ethical position ($p = 0.016$, $R = 0.198$).

Respondents' ethical attitudes toward each case

Respondents' ethical positions regarding case A and case B (table 1) are shown in table 4.

The majority of respondents were of the same opinion for case A whereas there was a wide range of opinions for case B. None of the respondents chose the option "not to answer such questions" when asked about their ethical attitudes toward cases A and B. Respondents who had "a clear ethical attitude" were defined as those who agreed with either student group A or B in case A or case B and who did not believe in brain death. In comparing respondents with a clear ethical attitude with those who did not, more respondents (74.7%) had a clear ethical attitude in case A than in case B (47.7%).

No significant relationships were observed between respondents' background and ethical attitudes in either case A or case B, except that more respondents younger than 50 years of age (28.1%) were prone to say: "I have not yet reached an ethical conclusion" in case B than older respondents (5.6%) ($p = 0.004$); a logistic regression model analysis confirmed the relation ($p = 0.004$, $R = 0.288$). No univariate analysis revealed statistically significant relation between respondents' background and their ethical attitudes in the two cases (whether the respondents had "a clear ethical attitude" or not).

Coping with ethical disagreement in the classroom

How educators would cope with ethical disagreement is shown in table 5.

In coping with the differences in ethical positions in the classroom, in both cases the commonest course of action is to "provide students with the teachers' own opinion as one of many possible positions". In case B, however, teachers were less likely to "maintain the position they consider ethically correct and refute an opposing position". Respondents who had a clear ethical attitude in case A (same opinion as student group A or B), when compared with respondents without a clear position, were more likely to "maintain the position that they considered ethically correct and refute an opposing position" (35.0%: 3.8%, $p = 0.004$).

Table 4 Ethical attitudes of respondents

Number of respondents who replied "yes" to the following answer choices N (%)	Case A	
	Case A	Case B
To answer that there is no one ethically right answer (conclusion) to this problem	4 (3.7)*	19 (17.8)
To answer that you have not yet reached an ethical conclusion	2 (1.9)+	14 (13.1)
To agree with student group A	79 (73.8)	22 (20.6)\$
To agree with student group B	1 (0.9)	23 (21.5)\$
To choose not to answer such questions	0	0
Other	20 (18.7)	23 (21.6)
To answer by saying that one does not believe in brain death	(Not applicable)	6 (5.6)‡
No response	1 (0.9)	0

N=all numbers (%): n = 107

*McNemar χ^2 test, $p = 0.001$

+McNemar χ^2 test, $p = 0.004$

‡Respondents who had "a clear ethical attitude" were defined as those who agreed with either student group A or B in case A or case B and who did not believe in brain death. McNemar χ^2 square test, $p < 0.001$

Table 5 Respondents coping with ethical disagreement in the classroom: selection of answer choices N (%)

Confirm each position and respective reasoning and then point out the logical limitations leading up to each conclusion

How would you cope with differences in ethical positions in the classroom?

	Case A	Case B
Upon doing so, say: "Neither position is ethically correct".	4 (3.7)	8 (7.5)
Upon doing so, say: "Please continue to think about this issue", and not mention which position is more justified.	17 (15.9)†	29 (27.1)
Upon doing so, provide one's own opinion as one of many possible positions.	44 (41.1)	53 (49.5)
Upon doing so, maintain the position that one considers ethically right and refute an opposing position.	29 (27.1)*	8 (7.5)
Other	12 (11.2)	9 (8.4)
No response	1 (0.9)	0

How would you cope with a student who asks for the "answer" to an ethical problem

	Case A	Case B
To respond by saying that there is no one ethically correct answer	5 (4.7)‡	13 (12.1)
To respond by saying that an answer (conclusion) to the problem has not yet been reached at this time	2 (1.9)	6 (5.6)
To respond by saying that you have not yet reached a conclusion regarding the problem	1 (0.9)	7 (6.5)
To respond with what you consider ethically right as one possible opinion	37 (34.6)	34 (31.8)
To respond with what you consider to be the ethically right answer as the "answer"	20 (18.7)§	10 (9.3)
To first explain that you have not yet reached an answer (conclusion) regarding the issue and then respond with one opinion—which you consider to be ethically right	27 (25.2)	25 (23.4)
Other	15 (14.0)	11 (10.3)
No response	0	1 (0.9)

†McNemar χ^2 test, $p=0.012$; *McNemar χ^2 test, $p<0.0001$;

‡McNemar χ^2 test, $p=0.039$; §McNemar χ^2 test, $p=0.031$

Concerning respondents' background and coping behaviour, more female respondents would not mention which position was more justified in case B (46.7%: 20.3%, $p=0.013$). As far as the respondents' understanding of the purpose of bioethics education is concerned, the respondents' perceptions that bioethics teachers should aim to have students hold a certain ethical position, or that influencing students' ethical attitudes and promoting behaviour change was a purpose of bioethics education, were statistically independent of respondents' coping behaviour both in case A and case B.

Coping with a student who asks for the right answer

In coping with students asking for the "answers", teachers, for case B, were less likely to respond with what they considered to be the ethically correct answer as the "answer".

Significantly more female respondents provided their own opinion as one of many possible positions (53.3%: 28.4%, $p=0.029$) and tended to answer that they had not yet reached a conclusion regarding the problem (16.7%: 3%, $p=0.02$) in case A; and more respondents older than 50 years of age (14.1%: 0%, $p=0.029$) and those who had longer teaching experience (8.6 yr: 3.2 yr, $p<0.0001$) responded with what they considered to be the ethically right answer as

the "answer" in case B. On the contrary, no significant relationships in case A and case B matched up with respondents' understanding of the purpose of bioethics education.

DISCUSSION

The two cases used in this study relate to informed consent in a clinical trial and direct donation by a brain dead donor. We chose these cases on the supposition that the majority of respondents would, in the first case, hold a clear and common ethical attitude regarding informed consent and would, in the second case, have varying opinions and no specific conclusion. Although our primary purpose was not to test the appropriateness of our supposition in this regard, the results seem to provide support for it. We identified two factors that account for the consistency of opinion on the issue of informed consent: (1) social consensus on the need to respect the research subject's decision, and (2) increased awareness of the *Declaration of Helsinki* and of the drafting of several ethical guidelines by governmental agencies.^{17, 18} However, there continue to be discussions and debates about the issue of direct donation in Japan. This topic has continued to be controversial since 2001, when two kidneys were directly donated to two family members in accordance with the wishes of a brain dead donor. Currently discussion concerning direct donation and its legality continues in Japan.^{15, 19, 20}

This study has the following limitations. First, the study's response rate was only slightly over 60%. The ethical positions and opinions of those who did not respond could very well diverge from the opinions reflected by our sample. Second, the study's sample was limited to faculty in charge of the university's bioethics curriculum and may not reflect the views of other bioethics teachers who are not in charge. The experiences and/or opinions of our respondents may not be the same as other bioethics educators running courses for healthcare university students. Therefore, our target sample should not be regarded as representative. In the early stage of research design, we had to give up surveying all of those who were involved in bioethics education for healthcare university students because of a lack of consistent and systematic methods to identify them in Japan. In addition, although we could conduct a survey on faculty in charge of the bioethics curriculum both in medical schools and in all the four year nursing schools, we could not include educators in charge of healthcare students who learn nursing in junior college nor educators in charge of those who study for other health related professions in other institutions. These factors limited the generalisability of our results.

Third, the study's questionnaire failed to include important questions such as whether the respondent was currently involved in face to face bioethics teaching; how often the respondent confronted ethical disagreement among his or her students in the classroom, and what kind of teaching methods the respondent tended to use. These questions are critical because our results are more meaningful if a considerable number of the respondents report that they engage in face to face education in the classroom or use teaching methods that offer opportunities for extensive classroom discussion or arguments. Although our current study did not yield any clue as to exactly how many respondents were involved in teaching activities and ethical arguments with their students, the age distribution of our respondents, and the current tendency of education methods employed in this field in Japan, suggest that a majority of our respondents involve themselves in small group discussions whenever there is an opportunity for ethical arguments.^{21–23}

Fourth, our study did not clearly define words used in a scenario presented in the questionnaire such as "sufficient",

“serious”, or “only occasionally”, increasing the likelihood that different respondents interpreted these words differently. More attention should have been paid to word choice in this case in order to obtain more reliable data from research subjects. Finally, we must emphasise that our findings do not reflect the attitudes of educators involved in the teaching of bioethics to students who are not in the field of health care.

Several findings deserve further consideration. First, findings showed that respondents from non-medical backgrounds maintained a particular ethical theory more often than respondents from medical backgrounds. Although our study cannot give a definite answer in this regard, we wish to note that a majority of the respondents from non-medical backgrounds consisted of teachers whose primary subjects included rather abstract and theoretical academic fields such as philosophy/ethics, religion, and law and that such teachers may tend to commit themselves to a certain idea or systematic normative thought. We surmise that the respondents from healthcare backgrounds, by contrast, might approach problems in a practical manner on a case by case basis. Given the specialty of respondents from a non-medical background, they may have had a better understanding of ethical theory than those from a healthcare background. As a result, it is possible that the respondents used their knowledge—for example, theory—to present and justify their ethical attitudes and sentiments.

Second, findings showed that female respondents were more likely than male respondents to include raising students’ sensitivities to ethical problems as a purpose of bioethics education for healthcare students. A possible reason may be that more than 70% of the female respondents had backgrounds in nursing and had been educated in nursing ethics to address the significance of ethical sensitivity.^{24 25} More female respondents than male respondents answered that they had not yet reached a conclusion (case A) and that they could not say what opinion was more valid than another (case B). These findings also suggest that female educators considered it more important to enhance students’ ethical sensitivity in each case than to reach a certain conclusion. Third, we also found that age had an impact on attitudes. Respondents under the age of 50 years tended to say they had not yet reached a conclusion; respondents who were 50 years old and over tended to rely on their own opinion as “the answer” to each problem (case B). Although only hypothetical, we believe that this may be a result of educators’ developed ethical thought and confidence—products of their life experiences, years of teaching experience, and long held perspectives on bioethical problems.

Fourth, the majority of our respondents identified the purposes of bioethical education as (1) to raise the level of awareness of ethical problems; (2) to provide information and knowledge of those issues; (3) to raise students’ sensitivities to ethical problems, and (4) to teach students methods of reasoning and logical argument. The results indicate that many teachers consider it very important for healthcare trainees to acquire the capacity to bring ethical deliberation to bear on complex healthcare issues. On the other hand, respondents who had religious affiliations were more likely than those who did not have a religious affiliation to include creating social consensus concerning ethical issues as a purpose of bioethical education. This finding suggests that those who commit themselves to a certain religious belief tend to hope to share that belief with others, including students in the class, and to develop social consensus in accordance with their religious norms. However, despite the fact that coping behaviours when facing ethical disagreements in the classroom were not related to the respondent’s understanding of the purpose of bioethics

education in the current study, the power difference between educators and students opens up the possibility that a certain normative decision could be presented to students in a manner that was authoritative and coercive. This issue is highly relevant to our final discussion point, which follows.

The finding that we think deserves our attention is that educators demonstrate different coping behaviours depending on their individual clear ethical attitudes when facing ethical disagreements in the classroom. This result may be attributed to a respondent’s commitment to a certain ethical position and a belief that healthcare workers should act in a certain way in certain conditions. It is necessary, therefore, to determine the nature and scale of the impact of educators’ ethical attitudes as well as their religious beliefs on their attitudes and behaviour in the classroom. This is because students in health care will need to address, in the future, a variety of important ethical decisions in research or in clinical practice, and how educators teach bioethics to students could ultimately have a significant impact on students’ ethical attitudes. What implications do our results—that when educators confront ethical disagreement, they may refute an opposing position in some instances while keeping quiet in other instances—have on both students and bioethics educators themselves?

At the university level and above, it is often up to the professor in charge to choose the themes on which to focus, the articles and textbooks to use, and the representative sociohistorical cases. Educators also decide how to hold class discussions, how to give lectures, and how to conduct tutorials. At the same time, the educator is in the position of assigning grades to each student—grades often considered very important to the student. This means that the educator has a great deal of discretion and freedom. Let us not overlook, however, that, regardless of cross cultural and national differences, the student is granted relatively little discretion and freedom to decide. This highlights our previous point about the power difference between educators and students.

Although there is no evidence offered by studies from around the world or from Japan that healthcare university students feel pressurised by their educators to project a particular ethical stance, when an educator who maintains “an authoritative role” opposes a student’s position with a “strong” rebuttal, the student might lose confidence and begin to hesitate to express his or her ethical stance. Students could also assume that they have to agree with their teacher in order to impress him or her. Additionally, there may be times when a student accepts his or her teacher’s opinion uncritically and perhaps never learns how to think in terms of ethics for him or herself. To avoid this, it is necessary to consider how an educator disagrees with his or her students’ ethical opinions. We believe that the proper method differs from that of a relentless and unforgiving scholar who opposes a theory in a philosophy or bioethics journal. As long as the educator can fail the student, it is extremely difficult to develop a perfectly equal relationship between educator and student. For precisely this reason, it is necessary to pay attention to how an educator expresses his or her ethical attitudes and how he or she criticises a student’s position in order to avoid exerting “authoritative verbal and/or non-verbal pressure”.¹¹

On the basis of our findings, we surmise that it is often difficult to predict what type of attitude an educator has towards his or her students. In instances like case A, which deal with gaining social consensus, it is likely that an educator will refute a student if the student’s opinion goes against the social norm. It is also likely that differences exist among educators as to which problems have reached social consensus and which issues remain controversial. Students

may be unaware which issues have reached social consensus and which problems remain controversial. Accordingly, we believe that educators should avoid the possibility of “biased education”—selecting materials that reinforce their own views on an ethical problem and should provide students with as much information as possible on the current debate regarding an issue. It is necessary for an educator to express his or her ethical position only once he or she has provided his or her students with a summary of what has not yet reached social consensus and where deep rooted disagreements exist.

Here is where an educator's integrity may become an issue. Educators may experience psychological conflict between being a good educator and living according to their own ethical ideals. Likewise, questions arise as to what bioethics educators should do if their own ethical positions conflict with local law or widely accepted ethical guidelines when teaching bioethics to health-care students. Is it all right to refer to one's beliefs as ethical in the classroom even if they are illegal? For instance, would it be all right for a teacher to tell his or her students that voluntary active euthanasia is justifiable even when it is currently forbidden legally? This could possibly lead a student, when he or she becomes a professional, to committing the crime of practising euthanasia. We need to consider what type of behaviour could harm a student and how much freedom, autonomy, and discretion educators should be allowed. Although we cannot reach a conclusion about this normative inquiry immediately, we must carefully keep on considering what kind of role we expect of a bioethics educator and what the goals of bioethics in healthcare education are. We leave these questions for further discussion.

In conclusion, this study found that the way in which bioethics educators dealt with ethical disagreement in the classroom at Japanese healthcare universities depended largely on their own ethical position, despite their holding similar educational goals. We found that the relationship between educator and student involved many complicated problems, just as the relationship between physician and patient does. The way an educator teaches in the classroom is an important issue, and one that is of fundamental importance to the ethics of bioethics education. Our findings may not be limited to Japan. Possibly a large scale survey or a more detailed qualitative study could provide a more accurate description and deeper insight into this area. We, as bioethics educators, need to begin a normative discussion on these issues based on an accurate understanding of the current situation.

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