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Thai and American doctors on medical ethics: Religion, regulation, and moral reasoning across borders

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ABSTRACT

Recent scholarship argues that successful international medical collaboration depends crucially on improving cross-cultural understanding. To this end, this study analyzes recent writings on medical ethics by physicians in two countries actively participating in global medicine, Thailand and the United States. Articles (133; published 2004–2008) from *JAMA*, the *New England Journal of Medicine*, and the *Journal of the Medical Association of Thailand* are analyzed to inductively build a portrait of two discursive ethical cultures. Frameworks of moral reasoning are identified across and within the two groups, with a focus on what authority (religion, law, etc.) is invoked to define and evaluate ethical problems. How might similarities and differences in ethical paradigms reflect the countries' historical "semi-colonial" relationship, shed light on debates about Eastern vs. Western bioethics, and facilitate or hinder contemporary cross-national communication?

Findings demonstrate substantial overlap in Thai and American doctors' vocabulary, points of reference, and topics covered, though only Thai doctors emphasize national interests and identity. American authors display a striking homogeneity in styles of moral reasoning, embracing a secular, legalistic, deontological ethics that generally eschews discussion of religion, personal character, or national culture. Among Thai authors, there is a schism in ethical styles: while some hew closely to the secular, deontological model, others embrace a virtue ethics that liberally cites Buddhist principles and emphasizes the role of doctors' good character. These two approaches may represent opposing reactions—assimilation and resistance, respectively—to Western influence. The current findings undermine the stereotype of Western individualism versus Eastern collectivism. Implications for cross-national dialog are discussed.

Introduction

Why compare Thai and American approaches to medical ethics?

The past two decades have seen an explosion of global medical travel, commerce, and collaboration. But as healthcare providers, researchers, patients, medications and technologies, and medical ideologies cross borders with growing frequency, the potential for ethical misunderstanding (or even crisis) also grows. This study takes seriously the notion that avoiding global medical ethical impasses depends on effective cross-cultural dialog, which in turn depends on detailed, empirically-grounded understanding of other cultures' norms of ethical reasoning and discourse. Given a tradition of scholarship that often compares ethical cultures based on abstract first principles, or posits essential differences between "East" and "West", such detailed cross-cultural comparisons are all the more needed.

This article presents an empirical, inductive comparison of Thai and American physicians' recent writings on medical ethics, as published in major medical journals. As explained below, Thailand and the United States are not an arbitrary pairing of countries (even if this fact is more apparent to Thai than to American doctors). The countries' historical quasi-colonial relationship, their positions across the "East-West" divide, and their contemporary roles in a globalized medical economy enable their comparison to shed light on ethical issues of relevance both within and beyond their national borders.

Rather than examining a specific ethical issue, this study focuses on the approaches used to identify, appraise, and solve ethical problems in general. To what sources do authors in each country turn to decide (or defend) what is and is not ethical? How do they prioritize laws and regulations, religious precepts, personal

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character, and national identity in defining a morally "good doctor" and medically ethical behavior? Instead of treating "improved communication" as a well-intended but vaguely defined hope, this study aims to show concretely how discursive ethical norms might facilitate or undermine cross-cultural dialog.

Tensions in the Americanization of Thai medicine

In 1917, Thailand's Prince Mahidol Adulyadej (father of the current King of Thailand, and metaphorical "Father of Modern Medicine" in Thailand) began medical studies at Harvard University. His time there was fruitful: he received public health and medical degrees, met his future wife (a Thai national), and welcomed his son—the future king—in a Massachusetts hospital. In the 1920s, Mahidol cemented ties between his home and host countries by setting in motion programs, funded by American philanthropic foundations, for Thais to study medicine, nursing, and public health in the U.S., and for American medical experts to teach in Thailand's newly established professional schools (Foreign Correspondent's Club of Thailand, 1988; Handley, 2006). American sponsorship and influence continued long after Mahidol's 1929 death, to the extent that American agencies have been described as the source of "modern medicine" in Thailand (Lindbeck, 1984, p. 24). According to some scholars, the U.S. exported not merely technologies and scientific knowledge, but "the whole package of [the] American medical model", including American "professional attitudes" (Ratanakul, 1988, p. 302).

In standard histories of Thailand, one of the country's distinguishing features vis-à-vis its Southeast Asian neighbors is that it was "never colonized". But as contemporary historians argue, lack of official, political colonization did not prevent Thailand from being colonized economically and culturally by Western powers beginning in the mid-nineteenth century—a situation described as "indirect colonization" (Anderson, 1978, p. 199), "semicolonialism" (Jackson, 2010), or "crypto-colonialism" (Herzfeld, 2010). The challenges of contemporary Thai "post-Westernism" thus recall those found in many postcolonial settings: "[Thailand's] relationship with the West has entailed a paradoxical set of desires: how to catch up with the West without 'kissing the asses of the *farang* [Westerners]'; how to be like the West yet also to remain different" (Winichakul, 2010, p. 135).

Such tensions appear in the Thai response to twentieth-century American medical influence. Pinit Ratanakul (1988, p. 303), Thailand's preeminent bioethicist, repeatedly contrasts "the American cult of individualism and free market ideology" with Thailand's compassionate, holistic, just medical tradition, bemoaning the influence of the former on the latter. "This [American] ethics", he writes, has "changed the image of the physician from that of a healer with moral and religious sensitivities to that of a businessman engaged in an activity for his private benefit alone" (Ratanakul, 1988). Throughout his moral critiques, Ratanakul never disparages American material contributions, consistent with Winichakul's (2010) argument that a key Thai strategy for "com[ing] to terms with the West" is to present Thailand as *spiritually* superior, even if materially inferior, to the West.

The current project examines whether contemporary Thai physicians echo Ratanakul's critique of American ethical culture. More broadly, how do Thai doctors negotiate the "post-Western" dilemma? Do they utilize American or Western approaches to medical ethics—or explicitly *reject* such approaches, instead rooting Thai ethics in distinctly Thai sources?

East versus West

For decades, indeed, centuries, scholars have posited essential cultural differences between East and West (Nie, 2007). In the context of ethics, this difference has most commonly appeared as a contrast between a communitarian East and an individualistic West (e.g., Fan, 1997; Fox, 1990). In recent years, this dichotomization has come into question, perhaps most forcefully in the works of Nie (2007, p. 143, 2011), who argues that this "stereotype" serves only to obscure the complexity, contradiction, and mutability of ethical landscapes. Nie's (2011) "transcultural" approach to bioethics, in contrast, eschews stereotypes and the "fallacy of dichotomization", acknowledges the moral diversity within every culture, and encourages "continuous dialogue [and] reciprocal learning" (2011, pp. 7–12).

Most comparative analyses of Buddhist (or Thai) and Western ethics, or expositions of Buddhist ethics for Western audiences, have come from philosophical rather than sociological or anthropological traditions (e.g., Keown, 2005b; Ratanakul, 1988), and have not been ideally poised to challenge the "fallacy of dichotomization". These analyses typically center on first principles: in the case of Buddhism, often the Five Precepts or four *Brahmavihāras*; in the case of Western bioethics, typically The Belmont report (1979) principles of respect for persons, beneficence, and justice. The approach is often deductive; e.g., Keown (1995, p. xi), addressing Western readers, invokes Buddhist "theoretical principles" to derive the Buddhist view on bioethical issues such as euthanasia.

But such abstract, deductive, and often prescriptivist approaches reveal nothing about how actual people engage in moral reasoning in their daily lives (or what moral quandaries capture their attention). Moreover, attempts to deductively determine "the" Buddhist or Western view masque the diversity of beliefs within each culture, making it difficult to interrogate stereotypes or generate nuanced comparisons. The present study, taking seriously the goals of Nie's "transcultural bioethics", is intentionally inductive. It begins not from Buddhist scriptures or bioethical prescriptives, or from assumptions of between-country difference and within-country homogeneity, but from Thai and American doctors' own writings, to build a "bottom-up" portrait of how members of two complex professional medical cultures engage in ethical reasoning. This study contributes to the "Asian bioethics" debate by empirically testing assumptions of essential, incommensurable difference across the East–West divide (Nie, 2007). In the process, it spotlights an Asian country that has not often featured in discussions of Asian ethics.

Globalized medicine

Medical tourism is a growing business: over one million medical tourists now come to Thailand annually (Wilson, 2010, p. 120), and many other developing countries also participate in this expanding market. Healthcare providers and medical researchers, too, cross borders with growing frequency, to correct labor shortages or participate in the outsourcing of clinical trials. American researchers frequently helm such efforts: of 18 international trials (assessing techniques to prevent perinatal HIV transmission) reviewed by Lurie and Wolfe (1997), 12 were American-led, and nearly all were conducted in developing countries, including Thailand.

This medical globalization has not been ethically unproblematic; indeed, it has at times provoked outrage from both Western and non-Western (including Southeast Asian) critics (see, e.g., Angell, 1997; Mason, 2007; Treerutkuarkul, 2010). In this context, ethicists studying global medicine have asserted the need for universal ethical standards paired with respect for local beliefs and practices. A repeated metaphor is that ethical guidelines are like a constitution: consisting of broad principles which require interpretation to be applied in local cases (e.g., Benatar, 2002; Tangwa, 2004). Such interpretation depends crucially on cross-cultural understanding: participants in global medicine must recognize