Harvard-CUHK Joint Online Symposium (December 2025)

Mapping the Horizons of Global Bioethics for Education, Research, and Practice: Reflections for the Future

Global Bioethics in Practice — High Point Summary of the June Symposium

Guiding question: How do global perspectives and engagement shape relevance, impact, and learning in clinical bioethics?

Situational Snapshot

Global bioethics in practice is not merely the application of rules, but a lived navigation of high-stakes environments. Clinicians must traverse the tension between systems designed to "save lives" and the human need for a good death; between legal rights and family solidarity; and between diverse spiritual traditions. Practice is where these global forces and local realities converge.

Summary of High Points Extracted from the June Symposium

To answer the guiding question, the symposium identified three distinct areas where our clinical practice needs to evolve:

1. Shaping the Ethos of Care: Learning from Universal Virtues
   Focus: Moving from technical competence to internal resilience

   - **Universal virtues (Kindfulness)**. Practice is grounded not just in procedures, but in virtues like "**Kindfulness**" (mindfulness + compassion). This shifts the goal of clinicians from solely saving lives to accompanying suffering.
   - **Inclusive impact (One human family)**. This spiritual grounding shapes impact by driving **interfaith collaboration**. Bioethics in practice must break down religious silos to serve "**one human family**," ensuring that spiritual care is relevant to every patient, regardless of their specific faith or lack thereof.

2. Shaping Systemic Impact: Overcoming Structural Barriers
   Focus: Moving from individual decisions to structural barriers.

   - **System vs ethics**. Sometimes, hospital systems are physically and culturally designed with a **"save life" ethos** that may block the possibility of a good death. The structure itself limits the impact of ethical care. To restore ethical impact, we need structural tools like Advance Care Planning (ACP) **to create a sanctioned space for these conversations**, bridging the gap between rigid systems and human values.

3. Shaping Cultural Relevance: Navigating Law, Family, and Hybridity
   Focus: Moving from static stereotypes to dynamic navigation.

   - **Balancing law and family**. Clinicians operate in the gap between **individual-rights laws** (global/Western) and **family-centered decision-making** (local). They must find a **balance** that honors legal autonomy without severing the family bonds that define the patient's world.
   - **Dynamic traditions**. Finally, relevance requires treating traditions like Confucianism not as static history, but as **living, transitional partners** in dialogue. Clinicians engage with "**real, hybrid patients**" (who are both modern and traditional), requiring bioethics that is flexible, transcultural, and responsive to complexity.

Headline Insight

Global perspectives shift clinical bioethics from **rule-application** to **contextual navigation**: demanding **internal virtues** to sustain care, **structural reform** to enable good deaths, and **cultural agility** to bridge the gap between legal rights and family values.

Potential Questions to Spark Dialogue

1. On the "Ethos" of Practice (Virtues & Learning) *Focus: Moving from technical competence to internal resilience*	• In a clinical culture that is often obsessed with curing and efficiency, how do we practically train young professionals to value **presence and accompaniment** as legitimate medical outcomes? • If we move beyond teaching just "decision-making logic," how do we equip clinicians with the **internal spiritual resilience** needed to sustain compassion at the bedside? • How can we move spiritual care from being a "service for specific believers" to a **universal standard of care** that addresses the suffering of every patient, regardless of their faith or lack thereof?
2. On the "System" of Practice (Structure & Impact) *Focus: Moving from individual decisions to structural barriers*	• If our hospital systems are physically and procedurally designed to "save lives" at all costs, what **specific structural changes** (space, workflow, policy, documentation) are needed to make a **good death** a real possibility, not just an ideal? • Can we truly have an **ethical impact** on end-of-life care without physically redesigning our hospitals to create **space for dying well**? • How can structural tools like **Advance Care Planning** be introduced in cultures where **discussing death is taboo**, without it feeling like an imposition of Western values or a loss of hope?
3. On the "Culture" of Practice (Relevance & Navigation) *Focus: Moving from static stereotypes to dynamic navigation*	• We often face a deadlock between Western legal frameworks (which prioritize individual rights) and local social realities (which prioritize family decision-making). How can clinicians **honor the law without destroying the family trust** that supports the patient? • Patients today are rarely purely "traditional" or purely "modern" — they are hybrids. How must our clinical approach evolve to serve these **real, fluid identities** rather than relying on static cultural stereotypes?
4. Synthesis Question (Closing) *Focus: The future direction of the field*	• Instead of choosing between a **single universal standard** and **local bridge-building**, what balance do we actually need? In which areas of practice do we require **global minimum standards**, and where should we prioritize **context-sensitive bridge-building**?