Pluralism and Politics in Global Bioethics Education

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Formal training in bioethics, a routine part of medical curricula in the USA, potentially has relevance for medical education outside of Europe and North America, but having evolved out of Western philosophical traditions and technologically sophisticated care, it cannot be simply exported to other societies. Bioethics in a global context must highlight ethical pluralism: the co-existence of alternative and competing ethical frameworks, calibrated to different civilizational traditions and socio-political conditions. This article suggests three ways to conceptualize ethical pluralism without compromising the practical goals of bioethics education. It discusses philosophical debates over universalism and relativism, criticizes the notion of "culturally sensitive" ethics, and explores how global economic and political inequities transform bioethical decision-making. "Making pluralism an explicit theme of bioethics education will correct some blind spots of conventional American bioethics as well as equip physicians outside of the West to negotiate clinical and policy conflicts in locally persuasive terms."

Key words: Medical ethics; graduate medical education; cultural diversity; pluralism; cultural anthropology

Most of the 124 medical schools in the USA now provide formal bioethics training. In this country, bioethics has largely replaced other disciplines in teaching about the behavioral and humanistic components of health care. Students who might once have taken courses in medical humanities or community health now spend their precious non-clinical time learning the principles of autonomy and beneficence, guidelines about informed consent and surrogate decision-making, and ways to balance professional and personal conflicts of interest. Does this model of bioethics training have a legitimate place in medical education elsewhere in the world, especially outside of Western Europe and North America (henceforth, Euroamerica)? As a discourse and a set of interrelated institutions (academic journals, consultants, institutional review boards, national commissions, etc.), bioethics arose in the United States about 40 years ago, and it remains fundamentally shaped by the political and cultural preoccupations of the USA. Can conventional bioethics, necessarily reflecting American values, adequately equip medical students to face the dilemmas of clinical medicine in China or Tanzania? If not, how can medical faculty in such settings devise better and more effective types of bioethics education?

Universal Ethics in a Plural World

These questions concern the practical details of medical curricula, but they also immerse us in philosophical and sociological debates. In this article, I will sketch out some of these debates, their different possible resolutions, and their implications for bioethics pedagogy outside of Euroamerica. The chief philosophical debate involves the claim of universal ethics and the corresponding relativist critique. Some bioethicists argue that there are fundamental ethical principles that ought to be applied across national and cultural boundaries. From this standpoint, universal principles comprise the core moral sensibility possessed by all human beings. Ruth Macklin offers two candidates for the status of ethical universals in medicine: humanness (compassion for the pain and suffering of others) and humanity (recognition of the equal worth and basic autonomy of every human). She employs these principles as objective standards to evaluate different societies as morally progressive or regressive. Critics of the universalist approach find it flawed on two counts. First, supposed ethical universals like Macklin's actually stem from the European Enlightenment, especially the concepts of moral agency and individual autonomy discussed by Emmanuel Kant in the 18th Century and later developed into the political philosophy of liberalism by John Stuart Mill (among many others). Non-western civilizations have different, but equally encompassing ethical systems. To brand as morally regressive Confucian ethics, with its emphasis on harmony and communal obligation, or the eco-centered ethics of Cameroun Nso' people, with its concern to cultivate and share spiritual potency, is a simple exercise in ethnocentrism. It takes Western ethical thinking, a product of particular historical and social contexts, and endows it with a timeless, universal validity.

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Second, the whole enterprise of applied ethics misconstrues the relation between abstract principles and the ways people actually resolve ethical dilemmas in everyday medical practice. The oft-cited universal principles of American bioethics—autonomy, beneficence, non-maleficence, and justice—are so general and open to diverse interpretation that no one can straightforwardly apply them to actual dilemmas. People necessarily make ethical decisions based not only on principles, but also on rule of thumb, short-term consequences, institutional routine, cultural notions of selfhood, religious ideals, etc. Moreover, high-order principles fail to capture the dynamic aspect of moral life: how people come to label issues as moral problems in the first place and how moral standards change over time. By contrast, critics of universalism scrutinize expert claims to abstract ethical knowledge and compare them to the everyday experience of moral distress in particular local settings. According to this approach, moral justification occurs from the bottom up; that is, it starts with consensual (and often implicit) agreements and practices which people may then rationalize and clarify via a language of principles and rules. (Intriguingly, the authors of the foremost “principalist” text now argue that common morality is the source of bioethics: “A society’s moral views are not justified by an a historical examination of the logic of moral discourse or by some theory of rationality, but rather by an embedded moral tradition and a set of procedures that permit new developments.”) The ideal Japanese bioethics curriculum should explicitly advocate Euroamerican principles, especially mutual respect, as universals which offer a superior guide to ethical action.

Like Tanida, Ruth Macklin places universal principles at the center of her model of bioethics. However, her more nuanced approach to the conflict between Western and non-Western ethics suggests a different agenda for bioethics education. For Macklin, ethical universals are not exceptionless rules, equally obligatory in all contexts. They are instead high-order imperatives with varying content, and they will generate different codes of conduct in each society. In Euroamerican civilization, for example, respect for persons typically comes linked to the high cultural value of individual privacy. Consequently, Western bioethics sets strict rules about violating bodily integrity, breaching the zone of personal space, and circulating personal medical information beyond the physician. The guidelines in Western bioethics about protecting patient confidentiality therefore have two sources: a high-order principle (respect for persons) and a middle-level, culturally specific notion of privacy. Macklin explains that the Confucian tradition also endorses respect for persons, but simply elaborates it according to a different middle-level notion. In societies influenced by the Confucian tradition, the principle of respect for persons is based not on individual autonomy, but rather on the contribution of each individual to the cohesion and welfare of society. Therefore, safeguarding personal privacy is not an ethical mandate for clinical practice in China. Indeed, medical exams are often conducted in quasi-public spaces and people’s medical information is sometimes posted at their workplace. Such practices do not contravene the universal ethical mandate to respect persons, however much they differ from the middle-level mandates that have inevitably seeped into American bioethics.

Her example suggests a specific goal for international bioet-
hics education: to train students to separate high-order ethical universals from the codes of conduct rooted in a particular national or cultural tradition. Keeping these two separate is more than a philosopher’s game. It would allow medical students to compare them explicitly and critically, and hence not fall into either the knee-jerk acceptance of local ethical viewpoints or the over-eager adoption of Western bioethics. Students will learn to scrutinize local ethical beliefs in light of supra-local concepts—a difficult task, because such beliefs are usually submerged within a culture’s background understandings of health, illness, and healing. Students will thus learn to disentangle the universalizable principles from the locally bounded notions within their own inherited ethical traditions. Yet students will also learn to analyze imported Western bioethics according to the same rubric. In many parts of the world, physicians embrace Western medicine wholesale as a modernizing force, not just for the sake of better health care but also to combat an outmoded or corrupt political order. Acknowledging that Western bioethics (such as the primacy of autonomy) contains complex mixtures of general and culturally specific mandates injects a dose of realism into the appeal of Western medicine. Physicians who wish to introduce bioethics into non-Euroamerican societies will better calibrate them to the values of their surrounding society and the local constraints of practice.

Pitfalls of “Culturally Sensitive” Bioethics
Bioethics education outside the USA should thus focus directly on the challenge of ethical pluralism. If the supporters of ethical universalism can endorse this goal, we should expect its critics to endorse it even more strongly. We shall see, however, that they also can become side-tracked by the appeal of seamless ethical systems. Critics of universalism do not seek out the high-order principles lying behind the world’s diversity of moral systems. They assume that ethics, like any other type of cultural evaluation (beauty in art, skill in sport), is culturally and historically embedded, hence not generalizable across social boundaries. Let us examine the non-universalist perspective with reference to Chinese civilization, which has inspired several in-depth studies of alternative bioethical thinking. Chinese ethics privileges the alliances and interpersonal connections (guanxi) that people forge in their immediate social surroundings. Complex ties of reciprocity, influence, and gift-giving link together these networks of persons, families, co-workers, and compatriots. Ethical obligations address not the autonomous individual or the pursuit of justice and human welfare in abstract terms, but rather the duties incumbent on individuals in their particular social roles. Striving to meet one’s responsibilities, and, thereby, to perfect one’s “social self” through relationships with others, is the core mandate of Chinese ethics.

Medical ethics in China fits into this larger framework. The practice of medicine involves ordered and interconnected relationships: professional to patient, nurse to doctor, doctor to society, etc. The ethical practitioner strives to exhibit the relevant virtues (inter alia, kindness, self-sacrifice, alertness, honesty) in each social context. Fulfilling one’s duties is both the highest principle and the most grounded application of Chinese bioethics. Obviously, this approach does not resemble the “applied moral philosophy” of American bioethics, because in the Chinese case, cultural and social variables are not separated from abstract ethical principles. For example, the Chinese find artificial insemination ethically troublesome, not because of a general opposition to commodifying bodily substances, but because this procedure does not help parents fulfill their obligation to extend the ancestral line. Similarly, withdrawing life support for elderly patients in persistent vegetative states poses ethical problems not in terms of beneficences or surrogate decision-making, but because of the respect owed to senior family members.

The Chinese case raises a more general question: If each civilization has its own distinctive ethical system, should bioethics educators even attempt to transcend local traditions? Perhaps they should instead tailor their curriculum to fit locally dominant values; that is, to teach a “culturally sensitive” bioethics. For several reasons, I think this is precisely the wrong response to the fact of ethical pluralism. Teachers of bioethics should avoid the temptation to organize their courses according to a single, all-encompassing conceptual framework (Confucian ethics in China, West-African ethics in Nigeria, or, for that matter, Enlightenment ethics in Euroamerican societies). First of all, if a society is complex enough to support formal scientific medical education, then it undoubtedly contains competing ethical values. To return to the Chinese case: contemporary medical ethics in China actually departs radically from the thumbnail sketch of interpersonal obligations presented above. Due to half a century of Marxist and Maoist influence, doctors now consider their ethical duty to treat nurses as well as practitioners of traditional Chinese medicine as equal comrades, not subordinates. Moreover, many of the “ethical heroes” singled out in Chinese medicine are women. Clearly, the communist rhetoric about an egalitarian society functions as a counter-principle to older class and gender hierarchies. More recent political upheavals (the aftermath of the Cultural Revolution and ongoing market reforms) have undercut the Confucian code and the very ideal of family unity. Health-care professionals now face stark ethical choices but without recourse to a single, broadly legitimate ethical system.

Bioethics education in China, therefore, should not base itself on a unified, internally consistent “Chinese ethics,” for this is only a nostalgic fiction. Medical students instead need an introduction to the competing ethical principles and arguments which they will actually encounter in practice. In
this complex society, a literal battleground of philosophies and political ideologies, bioethics should not wall itself off from wider conflicts. It should instead provide students with the widest possible range of ethical idioms (Confucian, communist, liberal, among others) and alert them to the strengths and weaknesses of each. Of course, the situation in China is not unique. The ethical systems of most societies in the world are equally complex and contradictory, and they should not be reduced to a single civilizational tradition. It makes sense in most societies, therefore, to focus explicitly on ethical pluralism and how it infiltrates everyday moral idioms among all the parties involved in health care (patients, families, policy makers, and clinicians).

Making ethical pluralism a central topic for bioethics education outside the USA has yet another advantage. It will help global health professionals to avoid repeating the problematic history of American bioethics. In its origins in the 1960s and 1970s, American bioethics was a critical enterprise: a response to specific medical abuses that was fueled by moral outrage and the wider struggle for civil and political rights. Conventional histories of bioethics explain how, against the longstanding paternalism of American medicine, it pressed new claims for patient autonomy. Against medicine's preference for reductionist explanations of sickness, bioethicists issued new calls for fairness in the distribution of medical risks and benefits. In response to notorious cases of researchers exploiting vulnerable populations (e.g., the decades-long denial of treatment for African Americans in the Tuskegee syphilis study), they devised specific procedures for obtaining participants' informed consent.

However, this heroic narrative diverges from the ambivalent but more accurate account supplied by many of the field's founders and long-time observers. American bioethics may have begun with a strong critical edge: a vehicle of broader rights claims and a struggle to limit professional sovereignty and end medical abuses. But as it entered institutional medicine—as schools hired ethics faculty and as ethical review boards became a routine feature of research—the field changed significantly. Bioethics started to support many standard medical practices and to represent medicine's favored benevolent self-image to the public. Forty years after its founding, bioethics has come to encompass and blunt stronger critiques of American medicine, and this theme dominates the ongoing ferment in the field. Critics claim that the mainstream approach in American bioethics (elucidating abstract principles along with the rules to balance them in particular cases) fits all too well with medicine's reigning positivism and its preference to parcel off ethical problems as a separate domain to be handled by its own credentialed experts. Making ethics a matter of interpersonal (or bedside) decisions fits with the individualist explanations of suffering with American medicine. Devising formal methods of balancing competing ethical goods is a familiar and acceptable strategy for academic physicians: a decision-tree for ethics like those for diagnosis or treatment. In short, making "applied principles" the template for bioethics was the price of acceptance into the medical curriculum, but it robbed the field of its critical edge.

Medical educators in other countries should not make the same mistake. They should not strive to make bioethics conform perfectly to the dominant structure of medical practice or local beliefs about health and illness. By definition, any totalizing conceptual platform (such as "Chinese ethics" or "West African ethics") does not stand at a critical distance from the surrounding society. It threatens to become simply another avenue of hegemonic control, to the detriment of patient care. Hegemony simply means a form of political control that operates invisibly, i.e., not through open violence or coercion, but instead through religious orthodoxy, common-sense notions of the good and the true, and codes of professional conduct. Teaching bioethics through the prism of single civilizational tradition will sap the ability of medical students to challenge existing standards of care, because the tool and the object of criticism resemble each other too closely. Just as American critics fault American bioethics for excluding other bases of ethical judgments (e.g., the common good or the emotion of care), the global bioethics community should fault single-minded approaches (no matter how culturally appropriate) for their tendency to repeat received truths and, hence, narrow the range of debate.

The Ethics of Scarcity

Taking pluralism seriously thus emerges again as a fundamental requirement of bioethics education, wherever it is offered. I have justified its importance from two directions: the modified universalism of Ruth Macklin and the critique of totalizing ethical systems advanced by several social scientists. Let me now argue for ethical pluralism from a third direction: the imbalance of wealth and power between Western centers of scientific medicine and the poorer societies where the majority of world's population lives. In developing societies, the imbalance creates a distinctive profile of morbidity and mortality and, hence, a particular ethical landscape for medical practice.

Diseases of poverty dominate the medical needs of most people in the developing world. Infectious disease, malnutrition, unregulated industrial pollution, and blocked access to even the most basic medical services are the leading causes of preventable sickness and death. In most countries of Asia, Africa, and Latin America, health expenditures have fallen dramatically over the past 20 years, partially because of the global recession of the 1980s but also from the "Structural Adjustment Policy" of the International Monetary Fund and the World Bank which enforces fiscal austerity by slashing
bystander. As governmental spending has fallen, public health worsens and poverty deepens, and this combination increases the burden of morbidity (epidemiologists and social scientists have exhaustively documented the multiple links between economic policies and health status). The global inequities of wealth are thus pathogenic in a double sense. They not only create the pre-conditions for disease (inadequate housing, hygiene, and nutrition), but they also limit the foreign exchange available in developing countries to purchase basic Western pharmaceuticals and medical supplies. Against this backdrop, much of conventional bioethics seems frankly irrelevant. In the USA, the field arose in response to innovations in dialysis, transplants artificial organs, and assisted reproduction, and it continues to concentrate on cutting-edge technologies. However, the technologies which provide such intense and detailed debates in wealthy societies are largely unavailable to three-quarters of the world’s population and inappropriate to their needs. Disease of poverty demand a different ethical calculus. The topmost value in this calculus is not autonomy, community or care (some of the leading contenders in American bioethics), but rather distributive justice and the equitable access to minimal levels of preventive and curative services. The widest satisfaction of basic needs becomes the standard to evaluate clinical, policy, and public health decisions. In poor countries, the targets of ethical concern are not technological advances which outrip legal precedent and prior moral constraints (as in the USA), but rather the preventable suffering created by global economic and political hierarchies. Some have labeled this an “ethics of scarcity,” and it creates two sorts of obligations: to alter these hierarchies (and thereby to reduce the social sources of suffering) and to foster self-help and mutual aid in particular communities affected by disease of poverty.

The ethics of scarcity should become a central pillar of bioethics education in developing societies. Indeed, physicians need it precisely because treating the diseases of poverty in the context of scarce medical resources challenges some of the deepest ideals of professional medicine. Kenyan physicians currently face an ethical crisis of this sort, as the human immunodeficiency virus (HIV) pandemic overwhelms their practices. As one neurologist at the University of Nairobi hospital puts it, “... the essence of the principle of [doctoring] is to save lives. So it comes to it that lives are no longer being saved.... Before you got worried when one of your patients died, but now it seems to be usual thing.” The HIV pandemic demoralizes physicians as it erodes their confidence in their own therapeutic skills. It also threatens their professional self-image as teachers of the next generation. A single disease now dominates the clinical landscape and makes it difficult to train students in anything other than terminal care. Of course, an ethics of scarcity is not demanded by the clinical entity of acquired immunodeficiency syndrome (AIDS), but rather the way that social forces magnify its effect. In general, the poorest and most stigmatized populations suffer disproportionately from the global resurgence of infectious diseases. In Kenya as in other poor societies, AIDS multiplies the problems already created by poverty and social dislocation. Moreover, most patients in Kenya cannot afford the pharmaceutical cocktails which bring such dramatic benefits to seropositive individuals in wealthier societies. The epidemiology of the disease, its typical course, and the disability it creates thus reflect the subordinate position of Kenya in the global political economy. Such socio-medical realities demand an ethical response, as illustrated by current debates over clinical trials for AIDS drugs in poor populations which will never benefit from treatments eventually developed in American or European laboratories.

To trace how large-scale inequities both magnify patients’ suffering and undercut physicians’ sense of competence is a core task of bioethics education outside of Euroamerica, and it complements some of the familiar approaches of mainstream bioethics. To begin with, an ethics of scarcity overlaps with utilitarianism insofar as it obligates physicians to maximize the health status of the greatest number of people. However, it does not conceive of health status as a context-free goal, of the same order of abstraction as happiness or pleasure. At a general level, a middle-aged father with advanced renal disease in a Swedish hospital suffers no less than a middle-aged father fighting cholera at his home in a Peruvian shantytown. It could even be more cost-effective to cure the Swede, given the infrastructure already in place to offer him dialysis and the difficulties of delivering care to the Peruvian, let alone the systematic changes needed to prevent another cholera outbreak one year hence. However, because cholera disproportionality affects the poor, an ethics of scarcity would give the Peruvian case priority.

Moreover, this approach preserves the concept of distributive justice from mainstream bioethics, but re-orient it to the regional and international level. Consequently, barriers to healthcare services do not provoke a discussion of rationing, simply because the services and treatments in question are not fundamentally scarce. From a global perspective, the scarcity is as political achievement, not a fact of nature, and it results directly from decisions made in wealthy societies and supported by various elites in the developing world. In wealthy societies, the ethical concern over scarcity leads to rationing and corollary strategies to preserve both the efficient use of resources and the equal worth of persons in need. In developing societies, the ethical debate addresses instead the social origins of scarcity and the responsibility to combat them, and hence it extends bioethics beyond the bedside and health policy domains into the realm of political advocacy and action.
The ethics of scarcity must equip students for the distinctive dilemmas of work in poor societies, and for this task it draws from the vast clinical experience of mainstream bioethics. For example, American bioethics courses typically teach about the difficulties of disclosing bad news. They train students in the proper demeanor and listening skills, and they prepare them to assess the ethical risks of non-disclosure. Pediatricians in Tanzania face related dilemmas when children test positive for HIV. Should they reveal the diagnosis to parents, given the possibility of retribution and family disruption as well as the lack of affordable treatments for pediatric AIDS? What forms of pre- and post-test counseling should they provide? Should information be given only to parents or also to other members of the extended family? Whatever the answers, they must take account of the social forces buffeting such families, such as migrant labor that takes fathers away for months at a time and the dominant profile of childhood mortality that makes AIDS only one among many likely causes of death. Ethical dilemmas of disclosure thus involve not only competing principles (autonomy vs. beneficence) and competing guides to action (truth-telling vs. protection of a fragile family equilibrium). They involve more than the civilizational and religious roots of ethical decision-making in East Africa. They also demand detailed, even ethnographic knowledge of how poverty affects people's ethical decision-making. Pervasive poverty may constrain ethical action in a narrow range of modest, short-term goals, but it may also unleash creative desires to justice and dignity. In this example, the bioethics of scarcity would attend to the range of ethical arguments that poor Tanzanian parents find convincing and that will advance their own version of the good.

Conclusion

To craft effective bioethics education outside Euroamerica, we must acknowledge the singular relation of bioethics to its society of origin. American bioethics embodies a particular, if broad, intellectual tradition (European moral philosophy) as well as several value commitments characteristic of the contemporary United States (privacy, contractual social relations, etc.). Physicians and philosophers elaborated the discipline in order to manage new technologically intensive therapies in ways that the American public could accept and that preserved the humane self-image of the profession. Outside of Euroamerica, the general intellectual landscape, the social position of the medical professional, and the face of everyday medical practice differ considerably. The aims and approach of bioethics education must also shift in order keep the discipline locally relevant and clinically useful.

First and foremost, bioethics education should acknowledge the diverse conceptual frameworks that are available to articulate ethical dilemmas. Of course, the particular mix of frameworks depends on the society in question. Certain developed societies (e.g., Japan or Israel) enjoy both technologically sophisticated medical care and codified, canonical traditions of ethical thought which differ substantially from those in the USA and Western Europe. Teaching about ethical pluralism in such societies means presenting both Western bioethics and its civilizational alternatives and then exploring how they overlap or contradict (a project already begun in the case of reproductive ethics in Israel and Japan). In developing societies, the ethics of scarcity becomes a key response to the worsening global inequities and the resulting burden of illness. However, this approach cannot be presented as a totalizing system, since it both depends upon and elaborates certain aspects of American bioethics. Finally, in societies such as China, both clinical medicine and public health are highly politicized. To make pluralism a focal point of bioethics is to highlight, not suppress, competing ideologies of health and sickness and therefore to show the relevance of wider political debates for medical education.

Most importantly, teaching about ethical pluralism does not mean abandoning the search for robust guides for practice. It is not the first step down the slippery slope to moral nihilism and clinical irrelevance. After all, profound disagreements arise even within a single, internally coherent, and culturally bound bioethical system. (Any casebook in American bioethics, for example, illustrates the infinite ways to balance the principles of autonomy and beneficence.) People's disagreements do not lead them to doubt each other's ethical sensibility or the general notion that careful thinking about ethical conflict will guard against blatantly unethical actions. The obvious global diversity in ethical systems can be approached in the same spirit. Teaching medical students about ethical pluralism will help them negotiate those situations where people seem locked in ultimate moral disagreements. Learning to move fluidly between local and universal ethics, and to appreciate the reliance of ethical decision-making upon other cultural values and political forces, has the potential to encourage dialogue in place of stubborn disagreement. "This is why bioethics education in a diverse world demands the self-conscious and explicit inquiry into ethical pluralism."

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