

The Global and the Local: Fruitful tensions in medical ethics

Introduction

It is often argued that the use of the “Georgetown principles” [6] in bioethics is at best suitable in a North American context but is foreign to European ways of thinking. This is said to be both because of the nature of the principles¹ and because these supposedly universal principles stand in the way of the context sensitivity which is crucial in fruitful moral reasoning. For that, the contention is, we need more contextual analyses which takes the specific local features into account. In this paper I will discuss the relationship between global and local perspectives in medical ethics in light of this alleged tension between principled thinking and contextual thinking in moral discourse. I will argue that this is a fruitful tension and that some common ways of criticizing principled thinking in medical ethics is based on a confusion about the nature of moral thought. An ethics from a European perspective should neither lose its critical perspective by overemphasizing contextual thought nor risk the charge of cultural insensitivity by a thoughtless application of principles. It should strive for being at the same time enlightened by global principles and sensitive to local context and live with the creative tension that this inevitably implies.

Principles vs. context

The critique of the use of moral principles in bioethics has been under attack, for example by writers who represent “an anthropological turn in bioethics” [13]. It seems to me that this criticism tends to conflate two different contentions that is very important to keep separate. The former (A) is that bioethics needs to be much more attentive to different cultural contexts. The second (B) is that moral principles are particularly damaging for the attempt to be more sensitive towards cultural differences. Now it is very important to note that both these statements are ambiguous and it depends on how they are understood whether they can be defended or not. The former can be understood as (A₁) that bioethics needs to take peoples’ attitudes and concerns as well as actual social policies more into account in the analysis of situations under moral scrutiny. Put in this way, I take the statement to be in full accordance with a crucial aspect of fruitful bioethical analyses and indeed describing one of its main requirements. It can also, however, be understood as involving a more normative claim, namely (A₂) that bioethics should be guided by the “substantive moral commitments within shared settings” [4, p. 109] which ought not to be subjected to critical analysis. Understood in this way, I take the statement to be in opposition to a fruitful bioethical analysis and indeed undermining the requirement of free critical thinking.

Contention (B) about the use of principles in bioethics can also be understood in at least two very different ways. According to the first

¹ This has been convincingly rejected by M. Häyry [7].

(B1), moral principles are seen as a predefined set of moral convictions, neatly packed as “the four principles”, which form a universal core of morality while in fact they reflect “American values” which are rigidly and insensitively applied to quite distinct cultural contexts [13, pp. 110–111]. It is possible that this description is true of some writings in bioethics and, if it is, those writings would obviously not harbor fruitful and sensible analysis. To that extent I can agree with the criticism which would be directed towards a particular use of moral principles in bioethics. I do not think, however, that (B1) is a fair description of most thinking in bioethics and certainly not of sensible use of moral principles. According to the second way of understanding the critique of principled moral thinking, (B2), moral principles as such are opposed to cultural sensitivity and stand in the way of addressing “the practical moral challenges and policy issues that arise in multiethnic, pluralistic settings” [13, p. 109]. If we understand the critique of the use of principles in bioethics in this stronger way, it is no longer aimed at particular, almost caricature versions of principlism but at all principled moral thinking. This, I believe, is narrow contextualism which is just as limited a perspective as the rigid principlism criticized in (B1).

A common mistake of rigid principlism and narrow contextualism is that each in their own way imply attempts to alleviate the creative tension between the sense for local context and the appeal to general principles in a too simple way. Rigid principlism does so by neglecting the need for situational analyses while narrow contextualism does so by neglecting the need for moral thinking. But more importantly, both positions misunderstand the nature of moral principles and their use in moral reasoning. Rigid principlism regards principles as given, as a set of values that can exist independently of context and can be “applied” to each and every “case” without a careful scrutiny of the cultural situation. Narrow contextualism correctly rejects this procedure but wrongly assumes that this is an exhaustive description of moral princi-

ples and that biomedical analysis will get better without them.

Moral principles and moral thinking

It is a bad assumption in bioethical discourse that a list of the four Georgetown principles is all there is to say about principles in bioethics. I do not say this because I find that a bad list. To the contrary, I think that it indicates a few of the most important values that need to be respected in the field of bioethics. I take it to be the major task of medical ethics to clarify basic moral interests of patients and research participants and critically analyze the factors which threaten them. These basic interests I summarize in terms of human welfare, agency and co-existence. By the interest in welfare I mean those things that relate to survival, health and flourishing of human beings. Under the interest in human agency, I place issues relating to self-determination, dignity and integrity of human beings. And under the interest in fair co-existence, issues of justice and solidarity amongst human beings seem to fit.

The “problem” with the four Georgetown principles is therefore not which principles are put forth but rather how they are often thoughtlessly applied and simplistically identified with certain types of North American interpretation of the underlying values. Moral principles are not fixed rules but general guides for moral reflection which indicate which values are generally of importance for free human beings. This reference to values is crucial because without it there is a tendency to legalism which ignores the human interests at stake in the situation. By the same token, these values and interests must always be interpreted in light of the self-understanding of the people concerned and cannot be described without it. In this way, principles need to have a contextual reference and without it they are mere value indicators waiting to be filled in and interpreted in a contextualized analysis and reasoning. This is what bioethical thinking is largely about. Another way to put it is to say that moral principles always have a “situation index” [15, p. 134]

and without it they have mere *prima facie* status. If moral discourse is to guide actions and decisions, there is not much help in discussing decontextualized principles, but exceptions to them in morally complex situations or specification of these principles in light of contextual restraints ([10], see also [3]). This is the stuff of moral reasoning and it can only be done after the scrutiny of the situation each time.

In sensible moral thought, moral principles are not rigidly applied; they inform moral reasoning, help identify relevant features of situations and enlighten decisions. Seen in this light, "principles are not instructions to avoid examining particulars, but rather are instructions about what to look for" [8, p. 404]. An obvious critique of this position from the contextualist point of view is that the interpretative framework itself is skewed towards dominance of principles which is bound to distort the local contexts which are foreign to principled thinking and thus instruct us to look in wrong directions. I find two things of main importance to respond to this point. One is, as I mentioned above, that the values the principles receive their significance from, must always be interpreted in light of the cultural context under scrutiny. The other is that even though the values tend to be culturally different they relate to underlying human interests which are generalizable in the sense that they are shared by human beings, even though they take on different cultural manifestations.²

An example of autonomy

I will try to explain what I mean by the example of what I called the interests in human agency which is often expressed in terms of the controversial principle of autonomy. Many contextualists are particularly bothered by this principle because not only is it interpreted in terms of North American style individualism but is also given a certain primacy among the competing principles. But

such criticism, which is aimed at a particular manifestation or cultural interpretation of the principle, is often taken to the extreme of rejecting the principle of autonomy altogether which is a much more controversial position. The issue of autonomy is a complex philosophical matter and its identification with individual choice based on informed deliberation is only one expression of it which should not be taken as a universal model, even though it has been prominent in mainstream biomedical discussion. It could even be argued that this particular mode of respecting autonomy can undermine agency which is the underlying interest of the principle.

I will mention two examples of this in the field of medical ethics where the ideal of maximizing individual deliberation is of questionable value. First, in clinical situations the principle of autonomy tends to be interpreted in terms of respecting individual preferences by informing patients about a variety of options for treatment. The role of the health care professionals should primarily be to provide the medical information upon which the patient can base his choices. It is even suggested that the professional should present the patient with his options in a "neutral" way, so as not to impose her values or preferences upon the patient and thus diminish his autonomy.³ The role of the patient becomes in effect one of a consumer whose wishes are the guiding ideas of the health care services.

I have argued elsewhere that this is a flawed model of the patient-professional relationship [1], and I will only mention two points here. From an institutional viewpoint this position is likely to lead to commercialization of medical services which could serve the interests of the affluent but may in the long run reduce quality and access of the general public to health services. In this way this manifestation of individual autonomy can increase injustice in health care and

² See for example a good discussion of cultural relativism in J. Rachels [11].

³ This has been referred to as the "engineering model" in medicine, and the "nurse-technician" R. Veatch [14] and S. Smith [12].

threaten solidarity and thereby also undermine the conditions of human agency. From a more individual viewpoint of the patient, this position harbors a danger of abandonment, anxiety and loss of trust which in effect reduce his standing as an agent and indeed have consequences that patients do not want.

In the field of medical research the vehicle of this atomistic view of individual autonomy is a formalistic understanding of informed consent. According to the ideal of maximizing individual deliberation, participants are expected to read intricate descriptions of procedures that often overwhelm their cognitive capacities. As a consequence, informed consent tends to become a mere formal procedure which is institutionally effective but contributes little to genuine understanding of the research. In this way, the moral purposes behind informed consent – not to manipulate, coerce or deceive participants – are not well served and in some cases even lost by overflow of information. The moral purposes of informed consent could often be attained with simpler and more effective means than detailed forms, but routine rules over common sense in this context, misleadingly justified in the name of individual autonomy.

But these misguided attempts to respect autonomy in medicine and research should not lead to the rejection of the principle of autonomy across the board. This principle should serve as a constant reminder of the importance of not subjecting patients or research participants to procedures that they do not want, not placing them in circumstances that violate their dignity and generally not treating them as mere patients rather than free agents. The most common reason for these misguided ways of implementing individual autonomy is that they are monological rather than dialogical. The image that is presented of the autonomous subject is of individuals who by themselves are deliberating information that has been provided by professionals who otherwise leave them alone so as not to influence their decisions. But this is a distorting image and certainly not conducive to strengthening the conditions for human agency.

If we want to aim for strengthening human agency and respect for persons, the task is to clarify and implement the appropriate dialogical conditions between patients/research participants and health care professionals [5]. This is not only important in order to provide conditions for a more meaningful discourse about autonomy but also to relate it to the cultural context of health care. In a properly conducted dialogue the professional meets the other in his or her situation and is bound to take the cultural context into account [2]. There is no reason to let the particular cultural context shaped by “American and Canadian jurisprudence of truth telling, information disclosure and individual informed consent” [13, p. 105] to be the prevailing paradigm of how autonomy is respected in the professional-patient relationship. The interest in human agency implies that people are not coerced or deceived and this often implies providing them with information. But every thinking physician knows that disclosure of information is always a matter of contextual judgment: how to tell, when, to whom, to what extent etc. and not a legalistic “duty to disclose” [13, p. 107]. It does not mean that people are “told the truth” no matter what, even against their will and cultural traditions.

Respect for tradition?

If I am right about the cultural sensitivity of the respect for persons, decisions not to inform patients in a culture where family decisions are prominent could even be defended in the name of autonomy. This is a delicate issue which is difficult to discuss in general terms because it requires knowledge of the cultural context and of the peoples’ wishes in the relevant setting. It does not mean, however, that we are to respect all local ways of decision making. In particular, it is important that respect for tradition and differences does not override the basic interests of non-consenting individuals and other weakest members of society.⁴ In this discussion it is

⁴ There is a good discussion in R. Macklin [9].

necessary to complement an interpretation of the cultural context by a critical analysis of the socio-economic conditions and cultural power relations that undermine human agency and basic capacities for choice. This implies that we need to take context into account in a different and more critical way than is often suggested in contextual thought.

Here we face an interesting tension that must not be cheaply released. I do agree that bioethics needs “to better recognize the role of culture and religion in shaping modes of moral deliberation” [13, p. 99]. This cultural sensitivity should, however, not be taken to mean that culturally accepted norms have primacy over moral reasoning and critical analysis of any cultural context, including our own.⁵ I refer here simply to the inherent movement of moral reasoning [4]. Even though the norms for reflection are often found in actual practice, the reasoning about their validity must not be limited by the normative implications of that practice. Free moral thinking inevitably implies that the reasons for the normative claims made must stand to scrutiny. It may be sufficient for some schools of social science to find out what is in fact accepted but critical thinking also enquires why it is accepted and whether it is *worthy* of recognition. It is always an additional question, however, how practices which violate basic human interests of individuals are dealt with, and that task clearly requires cultural sensitivity and careful deliberation.

⁵ One of the most important tasks in the field of bioethics is to criticize the culturally motivated standards of medical progress which breed serious injustices against cultures in need of basic health care. Priorities in mainstream bioethics reflect these global injustices which are much more serious than the alleged lack of cultural insensitivity in ethical reasoning.

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Literatur

1. Árnason V (1994) Towards Authentic Conversations. Authenticity in the Patient–Professional Relationship. *Theoretical Medicine* 15:227–242
2. Árnason V (2000) Gadamerian dialogue in the patient–professional interaction. *Medicine, Health Care and Philosophy* 3:17–23
3. Árnason V (2000) Diskurs im Kontext. In Edelstein W, Nunner-Winkler G (Hrsg) *Moral im sozialen Kontext*. Suhrkamp, Frankfurt, S 149–172
4. Árnason V (2005) Sensible Discussion in Bioethics. Reflections on Interdisciplinary Research. *Cambridge Quarterly of Health Care Ethics* 14:322–328
5. Árnason V (2005) *Dialog und Menschenwürde*. Ethik im Gesundheitswesen. Lit-Verlag, Münster
6. Beauchamp T, Childress JF (1979 and later editions) *Principles of Biomedical Ethics*. Oxford University Press, Oxford
7. Häyry M (2003) European values in bioethics: Why, what, and how to be used? *Theoretical Medicine* 24: 199–214
8. Kymlicka W (2002) *Contemporary Political Philosophy*. An Introduction. Oxford University Press, Oxford, p 404
9. Macklin R (1999) *Against Relativism*. Cultural Relativity and the Search for Universals in Medicine. Oxford University Press, Oxford
10. O’Neill O (1996) *Towards Justice and Virtue*. A Constructive Account of Practical Reasoning. Cambridge University Press, Cambridge
11. Rachels J (1986 and later editions) *The Elements of Moral Philosophy*, Ch 2. McGraw-Hill, New York
12. Smith S (1981) Three Models of the Nurse–Patient Relationship. In: Mappes TA, Zembathy JS (eds) *Biomedical ethics*. McGraw-Hill, New York, pp 120–126
13. Turner L (2003) Bioethics in a Multicultural World: Medicine and Morality in Pluralistic Setting. *Health Care Analysis* 11:99–117
14. Veatch R (1981) Models for Ethical Medicine in a Revolutionary Age and Smith S (1981) Three Models of the Nurse–Patient Relationship. In: Mappes TA, Zembathy JS (eds) *Biomedical ethics*. McGraw-Hill, New York, pp 56–59
15. Wellmer A (1986) *Ethik und Dialog*. Suhrkamp, Frankfurt, p. 134