Anthropology, Bioethics, and Medicine: A Provocative Trilogy

This article investigates the contributions anthropological perspectives can make to the field of bioethics. Four dimensions of an anthropological approach to bioethics are presented: the contextual nature of bioethical dilemmas; the cultural embeddedness of moral systems; the culturally pluralistic character of many bioethical problems; and the examination of the field of bioethics as a cultural phenomenon. The discussion explores how moral dilemmas and the means to resolve them are inextricably bound to their institutional, economic, and social contexts, how different cultural systems have different moral codes with different standards for behavior, and how bioethical conflicts often arise in culturally plural health care settings. In addition, it discusses the challenge offered to anthropologists to examine the values, cognitive framework, and social organization of bioethics. The article concludes with a discussion of ways that anthropological methods and knowledge can be applied in the bioethics arena. [bioethics, medical decision making, moral behavior, culture of biomedicine, United States]

The purpose of this article is to continue the dialogue on the relationship of anthropology and bioethics. The term "bioethics"—increasingly heard in hospital corridors, public policy debates, major medical journals, textbooks, and the media—has come to refer to inquiry into the ethical implications of scientific and technological developments in medicine. Although physicians and others have long pondered questions relating to ethics of medicine, the field of bioethics did not emerge until the late 1960s and early 1970s when the study of ethics—the philosophical inquiry into principles of morality and right and wrong conduct—began to be systematically applied to the domain of medical activity (Clouser 1974). Since then, bioethics has grown rapidly as a discipline. It has seen the emergence of a large literature on ethical issues in medicine, the establishment of centers, conferences, and professional organizations that address bioethical developments, the introduction of courses in medical ethics in many medical and

nursing schools, and the creation of hospital “ethics committees” to help patients, families, and staff make morally difficult decisions about their medical care (Fox 1990; Jonsen 1993; Marshall 1992).

Although scholars from different disciplines have been drawn quickly into the bioethics arena, social scientists, with a few notable exceptions, have been slow to turn their attention to the examination and analysis of bioethical questions. Lieban (1990) and Marshall (1992) suggest that while anthropologists traditionally have investigated the normative behavior and moral codes of the cultures they have studied (e.g., Hsu 1961; Kluckhohn and Strodtbeck 1961; Whiting et al. 1966), they have been less interested in bioethics for three reasons: the notion of cultural relativity has not had a place in the moral thinking of bioethics until very recently; the developments in Western biomedicine, which have triggered extensive bioethical debates, have not been the focus of anthropological research because of the discipline’s traditional emphasis on research in non-Western societies; and the different training and interests of anthropologists and ethicists have not fostered cross-fertilization between the two disciplines.

In recent years, however, interest in the intersection of anthropology and bioethics has been growing. Publications and conferences on the subject are appearing,1 and a number of social scientists (e.g., Clark 1990, 1991, 1992; Fabrega 1990; Fox 1990; Kunstadter 1980; Lieban 1990; Weisz 1990) have called for cultural analyses of ethical dilemmas in health care settings. Given these developments, it becomes pertinent to reexamine the relationship of anthropological and bioethics (for an earlier discussion, see Marshall 1992). In the discussion that follows, I consider the evolution of the field of bioethics, including its existing conceptual framework, as well as new theoretical movements in bioethics. I then examine four dimensions of an anthropological approach to bioethics: (1) the contextual nature of bioethical dilemmas; (2) the cultural embeddedness of moral systems; (3) the multicultural character of many bioethical problems; and (4) the challenge of examining the field of bioethics as a cultural phenomenon. The article concludes with a discussion of the methodological and theoretical contributions an anthropological approach can make in the evolving bioethics arena.

The Evolution of Bioethics

Technological and scientific advances in medicine and the biological sciences helped both to create the field of bioethics and to define its parameters. Its emergence as a distinct discipline in the United States was associated with several key events that took place in the 1960s and early 1970s. Among them were the selection of patients for chronic dialysis in Seattle, Washington, in 1962; the initiation of heart transplantation in South Africa in 1969; and the disclosure of the Tuskegee and Willowbrook experiments in 1972, in which African American men and mentally retarded children were used in life-threatening experiments without their knowledge (Jonsen 1991; Rothman 1991, 1993). These events stimulated public debate on such topics as how societal resources should be allocated to maintain life and what the parameters of informed consent should be for patients and participants in medical research. They also caught the attention of moral philosophers and moral theologians who began to apply formal analysis from their respective disciplines to ethical problems in medicine (Jonsen 1994).
From its beginning, the central preoccupations of the field of bioethics have been moral dilemmas in the practice of medicine and in scientific and clinical research. Some of the first efforts of the bioethics movement were directed toward protecting the rights and welfare of the subjects of research. The Belmont Report, produced by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1978, described how ethical principles could be applied to the ethics of research (Levine 1986; National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). In addition to human experimentation, bioethicists also became interested in the ethical issues surrounding organ donorship and transplantation, the conditions for prolonging or ending life, new reproductive technologies, genetic screening, and definitions of personhood. They began to address such questions as who is a person, when is a person dead, what is minimal acceptable quality of life, and when should medical treatment be withheld or withdrawn. Recently, bioethics has become progressively concerned with the economics of health care, in particular, questions relating to the allocation of scarce resources and cost containment (Fox 1990; see also Jonsen 1993; Rothman 1991). Debates on all of these issues have addressed the relationship between patients and health care practitioners, particularly physicians, in climates of changing health care technologies.

The Conceptual Foundations of Bioethics

Bioethics is a field whose origins lie in the branches of Western (primarily Anglo-American) philosophy and law that give primacy to the individual and emphasize individual rights, self-determination, and privacy. Its theoretical orientation and methods for approaching problems have been shaped by the moral philosophers, theologians, attorneys, physicians, and biologists who have dominated bioethics. The subjects they have studied and the ways in which they are discussed reflect U.S. preoccupations with the rights of individuals, fairness and equity in access to benefits, such topics as abortion and aging, and regulations and guidelines devised to resolve many of these problems (Jonsen 1993).

Fox suggests that three converging factors have shaped approaches and values in the field of bioethics:

American philosophy and philosophers have had the greatest molding influence on the field. It is principally American analytic philosophy—with its emphasis on theory, methodology, and technique, and its utilitarian, neo-Kantian, and “contractarian” outlooks—in which the majority of philosophers most active in bioethics were trained. Their philosophical positivism is reinforced by the principles and rules of “being scientific” that physicians and biologists have been educated and socialized to apply to their own professional work, and that they have brought to bioethics. In turn, the rationalism of American law, its emphasis on individual rights, and the ways in which it has been shaped by Western-American traditions of natural law, positivism, and utilitarianism overlap with and enhance key attributes of the philosophical and scientific thought in bioethics. [1990:208–209]

Grounded in these traditions, bioethics emphasizes logic, codified rules and techniques, and rigorous, precise, objective thinking. It seeks to develop rational guidelines for human conduct—rules or procedures of reasoning that can be used
to assess the morality of a given course of action (Clouser 1978). This aim is based on the premise that individuals are rational human beings who should engage in a process of moral reasoning, based on normative rules or principles, to arrive at decisions in situations of conflict or ambiguity. The emphasis here is on prescriptive behavior—how decisions ought to be made rather than how they are made.

The framework that has dominated much of bioethics has been the four-principles approach developed by Beauchamp and Childress (1979). At the heart of this moral code is the principle of respect for autonomy. Reflecting the deeply rooted American belief in individualism, as well as bioethics’ grounding in Western law and philosophy, autonomy has become a centerpiece of contemporary theories about how patients and physicians in health care settings should relate to one another. This principle holds that people who are able to make decisions for themselves have the right to determine their own course of action, even when they refuse medical treatment, and that others have the obligation to respect their decisions (Beauchamp and Childress 1979; President’s Commission 1983). Commitment to this principle over the last two decades reflects changes in notions about what constitutes the physician’s moral responsibility; the emphasis now is less on traditional ideals of medical benefit and more on the rights of patients (Beauchamp 1994).

Three other principles in addition to autonomy have commonly been invoked to guide moral deliberations. The principle of beneficence refers to the obligation to provide benefits and to balance them against risks; in medicine, it involves acting in the patient’s best interest. The principle of nonmaleficence pertains to the obligation to avoid causing harm. The principle of justice expresses an obligation of fairness in the distribution of benefits and risks, and it refers particularly to the criteria by which scarce and expensive resources are distributed. For example, concerns about distributive justice raise questions about how much treatment ought to be provided for young children with severe central nervous system anomalies who are expected to die or how expensive, scarce medical treatment should be distributed.

In general, the four-principles approach assumes that ethical decisions can best be made by applying the principles and more specific rules to particular situations. Moral dilemmas arise when moral considerations can justify taking either of two opposing courses of action (Beauchamp and Childress 1979). Disputes often involve complex disagreements about factual interpretations, as well as conflicts between moral principles. Bioethicists attempt to identify the values implicated by the various choices, discuss the implications of these choices, and assess conflicting ethical principles. They aim to assist clinicians, patients, family members, or policy makers by clarifying relevant issues, exposing fallacious reasoning, and assisting in the resolution of moral dilemmas.

Bioethics Evolving

In spite of its influence over bioethical thought, the principles approach has been criticized in recent years for being acontextual, ethnocentric, reductionistic, and sterile (cf. Hoffmaster 1992a). The approach has been called a “mantra of principles” where “the principles have functioned . . . like a ritual incantation of norms repeated with little reflection or analysis” (Beauchamp 1994:8). Clouser and
Gert (1990) have cautioned that “principlism” cannot offer a unified guide to action because it lacks moral theory to tie its principles together: “the four principles often have great rhetorical value but they play no useful role in determining how one morally ought to behave” (Clouser and Gert 1994:260).

Some critics have rejected the principle of autonomy, in particular, claiming that bioethics has been overwhelmingly preoccupied with the notions of autonomy and individualism (Callahan 1984; Pellegrino and Thomasma 1989; Veatch 1984). Attention is being drawn not only to the theoretical and practical problems created by the notion of autonomy (e.g., Clouser and Gert 1990, 1994), but also to the priority autonomy has assumed in moral reasoning in health care ethics. The “absolutization of patient autonomy” (Pellegrino 1992:17) in bioethical analyses raises serious concerns for some critics because its thrust toward individualism ignores the duties we owe others as members of the human community, thereby diminishing a sense of communitarian ethics or the common good. The focus on autonomy has also been criticized for reflecting the interests of white, middle-class North Americans (Fox 1990; Fox and Swazey 1984; Hoffmaster 1990; Weisz 1990). Others claim that the rhetoric of individualism does not capture the realities of the doctor-patient relationship or clinical practice, where a web of social relationships may have more weight than the individual patient in addressing bioethical dilemmas (e.g., Hoffmaster 1992a; Pellegrino 1994; Zaner 1988).

The dominance of a U.S. perspective in bioethics has also been challenged by those advocating a more international approach (Crigger et al. 1988; Gillon 1994; Pellegrino et al. 1992; Veatch 1989). While in industrialized countries bioethical dilemmas have arisen in large part out of the use and abuse of high-technology medicine, less is known about concerns in developing countries, including deficient provision of health care, extremely inequitable distribution of medical services, and national differences in response to bioethical dilemmas. As Donnelley (1988:2) points out, the ethical answers to questions about abortion, genetic screening, or reproduction seem significantly determined by where the questions are asked.

Many of these concerns about the conceptual framework and application of orthodox bioethics have been voiced by advocates of new trends in bioethical thought (e.g., casuistry, virtue theory, feminist ethics, and ethics as narrative, experiential, or interpretive phenomena). Although varying in theoretical orientations, foci, and methods, these alternative approaches share the perception that principle-based ethics is overly abstract, removed from moral and psychological realities, and anglo, male, and middle-class in its orientation. Moreover, it ignores the gender, life stories, and cultural identities of moral agents (Pellegrino 1994:362). The emerging theoretical movements offer other approaches to ethical decision making. The contemporary version of casuistry holds that moral thinking rarely begins with the invocation of a principle; rather, moral knowledge must develop incrementally through the analysis of concrete cases (Arras 1991; Jonsen 1991, 1994; Jonsen and Toulmin 1988; Wildes 1993). This case-driven approach contrasts with the theory-driven method where a moral theory is developed first and then applied to particular cases.

Feminists argue that medical ethics does not reflect the lives and experience of women; therefore, its principles, the questions it asks, and its conduct of moral debates should be altered to focus more on issues of inequality, diversity, and
ordinary experience (Cook 1994; Liaschenko 1993; Warren 1989). Proponents of virtue ethics (Drane 1988; Pellegrino 1994) stress the doctor-patient relationship and the virtues that characterize the “good physician,” such as benevolence, caring, and respect. Advocates of ethics as interpretive, experiential, or narrative phenomena argue that morality is created and enacted through experience as interpreted by the participants (Carson 1990; Zaner 1988). Moral categories are seen as embedded in ongoing forms of social practice and experience; therefore, ethical reasoning should focus on practices rather than on the application of abstract moral theory (Hoffmaster 1990, 1992a; Jennings 1990). Those suggesting the use of narrative ethical theory claim that paying attention to the narratives of patients and providers will reveal ethical reasoning as well as ethical comportment by examining moral dilemmas within a biographical framework (Benner 1991; Brody 1988, 1994; Maciunas and Moss 1992; Uden et al. 1992).

An Anthropological Approach to Bioethics

What do anthropological perspectives add to the burgeoning field of bioethics? To begin to explore this question, I outline in this section four overlapping dimensions of an anthropological approach to bioethics. They pertain to the contextual nature of bioethical dilemmas, the cultural embeddedness of moral systems, the multicultural character of many bioethical dilemmas, and the challenge of examining the field of bioethics as a cultural phenomenon. For this discussion, I draw on the work of social scientists and others who take anthropological perspectives in their work. Although these studies reflect differences along disciplinary and theoretical lines, they all represent efforts to broaden, deepen, or refine bioethical analyses.

Let me preface this discussion with two disclaimers. First, it is by no means only anthropologists who offer these perspectives. The bioethics literature has a growing number of examples of writings by nonanthropologists who are sensitive to these issues (e.g., Fox 1990; Hoffmaster 1990, 1992a, 1992b; Jennings 1990; Weisz 1990, to name but a few). Second, just as it may be dangerous to assume that all moral conduct in health care settings can be explained by recourse to a set of four principles, so it is equally dangerous to assume that there is only one anthropological approach to bioethics; anthropology encompasses numerous theoretical approaches, methods, and foci of study. In spite of this diversity, however, anthropology has embodied particular points of view and assumptions that shape an anthropological approach to bioethics.

Moral Decision Making Is Contextual

It is a basic anthropological tenet that all cultures have some degree of internal consistency and that many items of behavior and many customs form patterns and interrelationships that, in turn, compose the cultural tapestry of a group (Rosman and Rubel 1992). When translated into the realm of moral behavior, it is assumed that moral dilemmas and the means to resolve them cannot be separated from the institutional, political, economic, social, and cultural contexts in which they are embedded. The anthropological position sees the definition of a medical dilemma and the ways in which it is handled as inextricably bound to broad cultural

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conditions that influence health and illness behavior generally. This notion, now appearing with increasing frequency in the bioethics literature, is a radical departure from orthodox bioethical analyses, which typically built their arguments on decontextualized normative principles and rules and often lacked an empirical base or consideration of the many factors that shape particular circumstances. The "contextualist" approach, on the other hand, takes as its point of departure two basic assumptions. First, to understand the "rumpled reality" of moral decision making, it is critical to examine how people actually behave in problematic situations and the reasons or justifications they give for their behavior. The application of abstract rules or principles often is not sufficient to grasp the complexities or subtleties of real-life situations of moral conflict. Second, in order to understand how something becomes defined and acted on as moral or immoral, careful scrutiny must be given to the political, institutional, and sociocultural factors that lead to the conditions in which ethical dilemmas appear. Organizational structure, power and status differentials, explanatory models of different actors, or varying expectations regarding the patient-practitioner relationship all shape the definition and resolution of moral problems.

These assumptions become apparent in the few studies that have been done by social science investigators in North American health care settings in which the focus has been the same issues that have triggered bioethical debates. While not all of these studies explicitly frame their results in terms of ethical discourse, their focus is on understanding actual decisions or the complex contextual features that shape specific clinical encounters. For example, the work by Koenig (1988) provides one of the few cultural analyses that touches on the ethical implications of changing medical technologies. She looks at how a moral imperative to provide treatment is created among physicians through the routinization and consequent acceptance of a new medical technology and argues that the moral meaning of a technology is embedded in and expressed through changes in social organization. The evaluation of a new technique as a standard therapy must derive, therefore, from an understanding of the social setting in which treatment takes place.

An area that has attracted extensive bioethical analyses in the United States but few anthropological inquiries so far is that of truth-telling and disclosure of medical information. This issue has been examined in relation to the "discourse of hope" surrounding the treatment of cancer (Good et al. 1990), telling a patient for the first time that she has breast cancer (Taylor 1988), and revealing HIV status (Marshall et al. 1991). Similarly, the ethical issues concerning informed consent, although discussed widely in bioethical debates, have received relatively little anthropological consideration. Discussions of informed consent that have been influenced by anthropological perspectives (e.g., Hahn 1982; Kaufert and O'Neil 1990; Levine 1991) have examined how cultural factors affect obtaining consent and have questioned the universal validity of the informed consent model. Kaufert and O'Neil's study (1990) of health professionals' attempts to get signed consent agreements from Native Canadians is a particularly good example of what can happen when health practitioners and patients speak different languages and attach different meanings to symptoms and treatments.

The ethics of decision making at the beginning and end of life has also received sustained attention in the bioethics literature. What level of treatment should be
given to seriously ill newborns? When should therapeutic measures be used to prolong physiological function beyond the point at which a person's capacity for social interaction is gone? How should decisions about the use of life-sustaining technology be made, and who should make them? Although these questions have been debated extensively, less is known about decision making in clinical settings and the factors that influence it. These issues, however, are beginning to be addressed in recent ethnographic studies of clinical settings. Studies of neonatal intensive care units (e.g., Anspach 1982, 1987; Frohock 1986; Guillemin and Holmstrom 1986; Hahn 1987; Levin 1986) have shown the dominance of the technological imperative in shaping the definition of moral issues in these settings and the limited role of parents in neonatal decision making. These studies also demonstrate that the meaning of such notions as "treatment," "prognosis," or "personhood" cannot be taken for granted but emerges out of the particular situations. When a "baby" becomes a "person," for example, depends not only on the medical nature of the newborn's condition, but also on his or her response to treatment and the perceived personality characteristics that caregivers read into the behavioral responses of the newborn. Jennings, referring to Frohock's work (1986), reminds us that "the moral status of the newborn is not something that is simply given. It grows out of rational interaction in a cultural setting that gives that interaction meaning" (1990:270).

Anspach's (1982, 1987) discussion of the treatment of seriously ill newborns in the neonatal intensive care unit relates life-and-death decisions to the social context in which they take place. She found that nurses and physicians made different prognostic judgments about infants because of the way work is divided in a neonatal intensive care unit. Physicians, who had brief, sporadic contacts with patients, assessed prognosis largely on the basis of diagnostic technology, while nurses, who sustained more continuous contact with infants and parents, assessed prognosis on the basis of cues gleaned from interaction with infants. These differing prognostications often led to conflicts in decisions about whether to initiate, maintain, or withdraw life-sustaining treatment, leading Anspach to conclude that the organizational features of technology-intensive medical settings shape the life-and-death decisions that have to be made.

Similar observations are emerging from ethnographic studies at the other end of the life cycle, regarding dying and death in contemporary U.S. hospitals. Slomka's research (1992) found that when family and physicians had differing views about the use of life-sustaining treatment in an intensive care unit, the patient's demise was a "negotiated death" involving progressive bargaining over the meaning and use of various medical technologies. She concluded that "decision-making is less a question of the application of traditional ethical values than one of a 'cascade' of decisions, which occurs in the context of differential power relations among professionals and patients and families" (1992:252).

In my analysis (Muller 1992) of the use of "slow" or "limited" codes, less than full resuscitation attempts, situations in which cardiopulmonary arrest is met with, I considered the negotiated and culturally constituted nature of a practice that is considered ethically questionable. Rather than analyzing this practice in terms of conflicting abstract moral principles, I analyzed it in the context of resident physicians' work in hospitals, where it emerges as an unofficial, negotiated re-
sponse to the complex and often ambiguous situations that arise within contemporary medical practice.

This research also revealed that how and when physicians-in-training determined that patients were dying was not simply a biological “given” but was shaped by the ways they constructed a vision of therapeutic possibility and interpreted clues about patients’ capacities for interaction (Muller 1987; Muller and Koenig 1988). In other words, pathophysiological states and transitions were given meaning and significance in this biomedical realm through a process of interpretation of certain cues and information emerging in the context of treatment. Bioethical considerations arose when participants involved in the care of a patient had differing definitions of the patient’s situation and, therefore, failed to reach consensus about the status of that individual or the appropriate goals for patient care.

The Cultural Embeddedness of Moral Systems

A second dimension of an anthropological approach to bioethics is its comparative, cross-cultural emphasis. It is an anthropological given that different cultural systems have different moral codes with different standards for behavior and different expectations for relationships that are played out in health care arenas. Views about what is ethical vary by cultural group, and the mechanisms that exist in different cultural groups for handling ethically problematic situations are also culturally specific.

Fabrega (1990) and Lieban (1990) suggest that to explore the ways in which morality and medical practice are embedded in culture, we need to broaden our gaze beyond the issues defined as moral within the bioethics framework and deal broadly with comparative medical ethics. The anthropological imperative is to investigate what Lieban (1990:223) calls the “ethnoethics” of medicine in non-Western societies, which would tell us not only about cross-cultural variations in ethical principles of medicine, but also about variations in the issues that in different societies become defined as morally relevant or problematic.

Investigators are now beginning to look directly at the moral dimensions of medical practice and systems of healing in cultures other than our own. For instance, Brown (1992) examines the influence of cultural values on approaches to death and the allocation of scarce resources in cross-cultural health care. Hunt’s (1992) study of cancer treatment in southern Mexico exemplifies the ethical problems that can arise when biomedical knowledge and technology are transferred from one cultural setting to another. Using her experience as a program officer for the Ford Foundation in Egypt, Lane (1994) describes efforts to develop a code of research bioethics for Egypt. She describes how the social and cultural context of the production of biomedical research in Egypt influences the interpretation and application of the four bioethical principles upon which international codes are based and argues that for bioethical codes to be effective, their application must be sensitive to Egyptian cultural, social, and political values.

Other studies have focused on the culturally constituted nature of ethical issues and moral systems. Fox and Swazey (1984) point out in their comparative study of medical ethics in the United States and China that medical morality in China is rooted in a conception of the individual in relation to status and role and enmeshed in the network of human relationships. Unschuld (1979) presents a compendium
of the ethical writings of physicians in Imperial China, which elucidates the expected ethical obligations of these medical practitioners. Locke and Honde’s paper (1990) on organ transplants and definitions of death in Japan illustrates the different ways medical ethical questions are handled in different countries. The work of Gordon (1990, 1991, 1994) and Gordon and Allamani (1989) demonstrates how cultural beliefs and values shape the practice of nondisclosure of “bad news” in Italy. Feldman (1992a, 1992b), in her comparison of the treatment of patients with AIDS in France and the United States, suggests that the processes of decision making and truth telling are fashioned out of distinctive cultural values—those of autonomy and information in the United States and trust and social ties in France.

These studies suggest that even in countries that rely on a biomedical conceptual framework, biomedicine is not uniform, and ethical issues differ. Moreover, they illustrate the vital role of culture in medical ethics as it shapes the definition of ethical dilemmas, the designation of the important players, and the resolution of the dilemmas.

Cultural Pluralism and Bioethics

Another dimension of an anthropological approach to bioethics is a primary emphasis on dilemmas resulting from cultural pluralism. Within bioethics, there traditionally has been little interest in exploring the ethical implications of cultural pluralism and cultural contact (Kunstadter 1980). Experiences in North American health care, however, demonstrate that cultural groups do not necessarily share the cultural traditions and premises in bioethical analysis, nor do they accept bioethical principles as guides for moral behavior. The practice of disclosure, for example, while fundamental to patient care in the United States, is not taken for granted by all cultures. Similarly, the principle of autonomy, which has flowered in the particular cultural climate of the United States, is not universally acclaimed as a guiding moral principle. Other cultural groups, as the Japanese, for example, may stress conformity and the suppression of individualism for the sake of group harmony and social responsibility (cf. Kimura 1992; Locke and Honde 1990).

Reflecting anthropology’s traditional interest in cultural pluralism and cross-cultural comparison, as well as an increasingly heterogeneous population, investigators are now beginning to explore bioethical issues in North America, where there may be fundamental differences in the cultural traditions and values of providers, patients, and families. Studies that have examined these issues include investigations of ethical decision making about cancer treatment in cross-cultural situations (Koenig et al. 1992), differing cultural expectations of the treatment of ethnic elders (Kim 1983), differing constructions of prenatal diagnosis among geneticists, genetics counselors, and patients (Rapp 1993), discrepancies between the explanatory models of health care workers and patients that affect informed consent (Kaufert and O’Neil 1990), the different languages of risk used by health care providers and Inuit women (Kaufert and O’Neil 1993), differing responses to life-support decisions (Klessig 1992), and cultural differences relating to disclosure of information about diagnosis and prognosis or termination of treatment (Barnes et al. 1993; Beyene 1992; Meleis and Jonsen 1983).

Analysis of cross-cultural ethical issues in an outpatient clinic of a large, multicultural urban hospital focused on the ways in which cultural values and
practices shaped the interactions between a team of U.S. physicians and a terminally ill Chinese woman and her family (Muller and Desmond 1992). This study illustrates the fundamental differences in the way biomedicine and certain immigrant groups conceptualize the role of the sick person, the family, and the health care provider in medical interactions. In discussing differing expectations regarding the role of family members in medical decision making, the telling of bad news about prognosis, and the withdrawing or withholding of life-sustaining treatment, this study demonstrates the conflicts that can occur when biomedical practitioners encounter members of an immigrant group with cultural values vastly different from those underpinning biomedicine.

**Bioethics as a Cultural Phenomenon**

The final dimension is the premise that bioethics is a social, cultural, and intellectual phenomenon (Fox 1990) that should be examined in its own right. Its ideology, structure, activities, culture patterns, and social traits are worthy of investigation, especially regarding their support for the beliefs, values, and norms of U.S. society and U.S. medicine. Few social scientists have engaged in social or cultural analyses of bioethics as a system of inquiry and action, with the important exception of the work of Fox and Swazey (1984) and Fox (1990). They have stressed the importance of examining values and beliefs emphasized and de-emphasized by bioethics, its cognitive framework and style, and its social organization.

Researchers are beginning to report on specific aspects of the bioethics enterprise. Flynn’s (1992) study of the underlying assumptions, discourses, perspectives, and practices of hospital bioethics committees examines how bioethics is constructed in a particular fashion through bioethics committees. Marshall (1989) has analyzed the cultural assumptions underlying clinical ethics consultations. Armstrong and Humphrey (1994), in claiming that ethics is another "belief system" that deserves social analysis, suggest that ethical debate can be analyzed as a situation of high social drama that displays and reinforces some of the core social values of our society.

**Contributions of an Anthropological Approach to Bioethics**

Generalizing from this discussion of empirical work at the intersection of bioethics and anthropology, I propose several ways to apply anthropological methods and knowledge in the bioethics arena as we move into the second half of the 1990s. If we accept the notion that bioethics will be enriched by developing a more empirically grounded theory of morality, as suggested by Hoffmaster (1990, 1992a) and Jennings (1990), then anthropology’s use of qualitative methods and particular interest in ethnography make it quite suited to the examination of how moral problems are actually perceived and handled by those whom they affect. The researcher can explore for a particular group which issues are defined as moral issues, how moral questions are framed, and which moral values are invoked. Ethical issues are situated in the moral discourse employed by the people themselves rather than in the language of the bioethicist. By letting participants speak about their concerns in their own words, the anthropological approach offers what
Warren believes bioethics needs: “In medical ethics, we need to do a lot more listening” (1989:83).

This concern with the meaning that just individuals themselves attribute to events stimulates anthropological inquiry not into the crises typically discussed in bioethics (e.g., abortion or withdrawal of life-support), but into everyday ethics—what Warren (1989:78) calls “housekeeping” issues, the personal issues that affect people in their everyday lives. For example, what factors influence people’s decisions about whether or not to use a Durable Power of Attorney for Health Care? What do physicians perceive as ethical issues in their clinical practice, in what terms do they discuss them, and how do they attempt to resolve them (e.g., Kaufman 1993)? The moral decision making of people at risk for specific diseases could also be examined. For instance, research could be carried out with those who are now faced, many years before the onset of fatal disease, with the choice of whether to be tested for the gene determining Huntington’s Disease.

In contrast to bioethical analysis, the anthropological approach “has not measured ethical problems against a definitive standard of moral rectitude but instead has viewed them as culturally constituted and continually evolving” (Marshall 1992:54). Research on the culturally constituted nature of moral behavior reveals not only how ethical dilemmas are culturally constructed, but also how these constructions influence decisions about ethics in medical settings. Along the lines of Gordon’s (1994) work in Italy, anthropologists could examine cultural assumptions of a particular group in dealing with disclosure, including what it means to be a person and expectations about daily life, social relationships, and the ordering of the world. Analysis could examine how these assumptions affect ethical decision making in medical settings.

As we have seen, anthropological inquiry also offers the contextual perspective. It recognizes that decisions about matters of health and illness are not made in isolation but are made in the context of a web of everyday activities and social relationships. The focus is not on the individual alone but takes into account the setting and cultural group. Consequently, ethical issues should be examined in context; the ethical ramifications of a situation cannot be addressed without considering the associated economic, legal, social, or policy issues.

In addition, the cross-cultural perspective of anthropology can expand the scope of comparative ethics. Cross-cultural studies can show, for example, how cultures vary regarding protection of life, the moment of death, and definitions of normal and abnormal. Through examining the moral dimensions of medical practice in various cultures, anthropological investigations can add to the empirical knowledge of ethical dilemmas as they are defined, responded to, and acted upon in systems of healing other than our own. Having an understanding of the cultural meanings associated with such practices as the telling of bad news, withholding life-sustaining treatment, or involving family members in health care decisions can also clarify ethical dilemmas appearing in multicultural situations. Bioethical considerations would be informed by more comparative analyses of the meanings and practices related to issues such as these.

Moreover, examination of how ethical issues or dilemmas are interpreted in particular cultural contexts could also elucidate the “transcultural shapings” (Mainetti 1992:44) that occur when Western bioethical concepts are transplanted.
to other cultural settings. Along the lines of Lane’s study (1994) of ethical principles relating to informed consent in medical experimentation in Egypt, cross-cultural research could address decisions to terminate treatment, abortion, reproduction, definition of death, genetic screening, and other issues.

There are also theoretical discussions in bioethics to which anthropologists could contribute their cross-cultural, comparative approach. Those particularly relevant to anthropologists concern context and relativism. What, for example, does “context” actually mean? What are its elements? Whose context is it? To what extent can contextual factors be critically appraised and changed (e.g., Hoffmaster 1992b)? With respect to relativism, what can anthropologists offer to the ongoing debate about the need for, and possibility of, some form of metacultural ethics or universal principles (e.g., Armstrong and Humphrey 1994; Pellegrino 1992; Shweder 1990)? These questions deserve anthropological reflection.

Finally, it is incumbent upon the anthropologist to answer the challenge of Fox (1990), Fox and Swazey (1984) and Armstrong and Humphrey (1994) to direct more attention to the field of bioethics itself. One could examine, for example, how the term “ethics” is seeping into everyday medical discourse, as in “ethics rounds” or “ethics consultations,” or how bioethics’s concepts and methods of analysis are being transformed by clinicians, policy makers, journalists, and hospital administrators. Since bioethicists have paid relatively little attention to the social and cultural sources and implications of their field, Weisz (1990) suggests that social scientists consider the practitioners of bioethics as well as its issues and dilemmas. This pursuit can provide both an analysis of bioethical discourse and an opportunity for bioethicists to engage in critical reflection by offering the perspective of the outsider.

Conclusions

By examining the culturally constituted nature of moral thought and action, as well as bioethics itself, anthropologists can enrich bioethical analyses and contribute to the overall development and refinement of this segment of medical thought and practice. At the same time, anthropologists, by examining matters of medicine and ethics, will expand the cultural study of medicine in their own societies. The study of moral thought and behavior provides an important domain for anthropological inquiry. It offers theoretical challenges, opportunities for interesting empirical research, and the chance to apply research findings to situations that, in one way or another, affect all of us. At this point in the development of the fields of anthropology and bioethics, it is the work of bioethicists that has provoked much of anthropological reflection and research in the area of bioethics. By pursuing the areas of study outlined above and assembling a larger corpus of empirical data, the anthropologist may take a turn at provoking the bioethicist’s inquiry. This effort may further conceptual development, debate, and empirical research at the intersections of anthropology, bioethics, and medicine.

Notes

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1. A conference entitled “Humanizing Bioethics,” sponsored by the Westminster Institute for Health and Human Values, was held in London, Ontario, Canada, in April 1994. In 1992, there was an invited session at the Annual Meeting of the American Anthropological Association entitled “Rocking the Boat: Autonomy, Reality, and Anthropological Critiques of Bioethics.” In the same year, another invited session was called “The Anthropological Enterprise in Clinical Ethics: Issues of Ethics for Medical Anthropology.” Another invited session at the 1993 Annual Meetings of the American Anthropological Association was entitled “Studying Physicians: Methods, Ethics and Interpretation.”

2. For a discussion of the antecedents of the interpretive approach and some of its current manifestations, see Marshall 1992:53–54.

3. This is a legal document used in California and some other states; it specifies the medical treatment a person wants and does not want, should one become incompetent, and invests a designated person with the legal authority to make medical decisions on that person’s behalf.

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