

Original Article

Culture and the principles of biomedical ethics

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ABSTRACT

This paper examines the roles of culture in the principles of biomedical ethics. Drawing on examples from African, Navajo and Western cultures, the paper maintains that various elements of culture are indispensable to the application of the principles of biomedical ethics.

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INTRODUCTION: CULTURE IN PRINCIPLISM

THIS PAPER MAINTAINS that the principles of biomedical ethics are *always* culture specific in the sense that their validity, applicability and moral force of persuasiveness is dependent upon the assumption of a plethora of cultural categories. These categories often operate tacitly as background assumptions in the architecture of reasoning, thereby giving the illusion that biomedical decision making on the basis of principles is culture-free.

Deontological ethics is one of the three main approaches to biomedical ethics. It is an approach that emphasizes principles, rules and duties as the basis of moral justification. Deontological ethics can be contrasted to virtue ethics (which emphasizes moral character as the basis for ethical decision-making) and consequentialism (which emphasizes the consequences of actions and rules).

Principlism is a deontological theory that relies on the application of a set of four basic principles in the resolution of biomedical ethical dilemmas. These principles are: respect for autonomy (physicians should respect the voluntary healthcare choices of rationally competent patients); nonmaleficence (physicians should not needlessly intentionally inflict harm or injury); beneficence (health care should be of benefit to the

patient); and, justice (fairness is important in the allocation of resources— “*give to each that which is her due*”). Principlism is considered by many to be the Gold Standard for the resolution of biomedical ethical dilemmas. This is because these four principles are claimed to be culture free, universal, context independent, and globally applicable.

Suppose, for example, that T, an unconscious 25 year-old woman, was admitted to hospital after a car accident. T is known to everyone in the local community (including the attending doctor) as a devout Jehovah’s Witness who has on many occasions preached against blood transfusion. Her purse has a card that confirms her objection to blood transfusions on religious grounds. Without blood transfusion the doctors cannot perform the required surgery to save her life. However, her mother insists on blood transfusion. A utilitarian assessment of this dilemma would look into the consequences of actions (or rules) to determine what the doctors ought to do to maximize wellbeing in this situation. A virtue ethicist would appeal to character traits such as generosity, benevolence, or trust. A deontologist would base her decision on a moral rule like “Do unto others as you would be done by”, or the principle of autonomy which requires respecting T’s right to self-determination.

Suppose further that T was admitted at a hospital somewhere in the Western world where the primary focus of biomedical ethics is on the application of these four principles of principlism to the doctor-patient relationship. Since some of the physician’s main duties include respect for autonomy and the need to gain fully informed consent, the morally correct decision for the

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Western physician is to respect the implications of T's religious beliefs.

Suppose, however, that T had been admitted to a hospital in a rural village in the Southwestern parts of Nigeria. Suppose further that the physician is an indigenous medical practitioner and that the hospital is African-Western because it incorporates the best of both worlds. The supposition is not so far-fetched. An example of one such fusion is the "Aro Village System" introduced by Professor Thomas Adeoye Lambo at the Aro Psychiatric Hospital, Abeokuta, Nigeria:

The world recognition of the hospital came about during the pioneering effort of Late Professor Thomas Adeoye Lambo (CON) when he started way back in 1960, the "ARO VILLAGE SYSTEM" of treating the mentally ill. The thrust of this system was a community participatory system of treatment of the mentally ill that involved the psychiatric professionals, the relatives of the patients and the co-tenants, neighbours and the community where the patients were admitted. This treatment paradigm was achieved by creating "Aro Village System" a few kilometers from Aro Hospital where patients were admitted into "normal" houses where there were other tenants alongside their relatives. The principle of the village system was subsequently adapted all over the world and virtually opened the hitherto locked gates of psychiatric hospitals. (<http://neuroaro.com/history> Last viewed 28 September 2012)

So, suppose that T had been rushed to the emergency unit of Aro Psychiatric Hospital, where fully trained Western and indigenous Yoruba physicians are on call. As Gbadegesin (2007) has observed, in this alternative Yoruba Western-indigenous world, parents often serve as surrogates for their children (including adult children); just as children could serve as surrogates for their parents. As such, T in the West is more likely than T in South-Western Nigeria to have her wishes of no blood transfusion respected. Does this mean that the principles of biomedical ethics are not respected in the Yoruba indigenous-Western world? Gbadegesin makes some important observations:

First, it is clear that ... in traditional African health care systems ... family members assume the role of health care givers, acting as de facto nurses, physician's assistants, medication dispensers, and so on. This is usually in addition to their roles as family members ... Second, it is important to note that family members, especially parents even of

adults, are perceived as metaphysical extensions of their wards. Mother's destiny is tied to daughter's destiny. ... Third, there is an expansive notion of the self, which makes the patient see her mother as part of her extended identity ... There is an enlarged notion of patient autonomy, which includes daughter and mother as one entity. It is a notion that daughter, like mother, internalizes and accepts. For if circumstances were to change and the mother becomes ill, the daughter will play the same role that the mother is now playing. It is a notion that is perhaps different from contemporary Western notion of self, but which is not thereby morally deficient. (Gbadegesin, 2007, p.40-41.)

Since some of the indigenous physician's main duties include respect for autonomy (*Mother's destiny is tied to daughter's destiny* in the sense that daughter is the metaphysical extension of mother; hence *the individual* here is a "mother-daughter" dualism) and the need to gain fully informed consent before treatment (in this *mother-daughter dualism*, the voice of the entity is currently that of mother), the morally correct decision for the physician is to respect the decisions of the mother.

In what follows, I highlight the ways in which culture shapes, influence and directs biomedical decision making on the basis of the four principles of biomedical ethics.

THE COMMON/UNIVERSAL MORALITY AND ITS IMPLICATIONS FOR PRINCIPLISM

One recent development in biomedical ethics is the idea of "common morality." Tom Beauchamp and James Childress, two of the most influential defenders of principlism, use this notion as the starting point of their position. I will make use of Beauchamp and Childress' version of common morality and principlism in my critique of the claim that the principles of biomedical ethics are culture-free.

The central claim of the idea of a common morality is that all humans — at least all morally conscious humans — have a "pretheoretical" awareness of certain moral norms. According to this view, every normal (i.e., cognitively competent) human has an intuitive ability that endows them with pretheoretical moral knowledge such as: it is wrong to lie, kill or break promises. These intuitive insights are *empirical* in the sense that they are, *as a matter of fact*, relied on in moral judgments. Moreover, they are *universal* in the sense that *all* thoughtful and rational persons have an intuitive

awareness of their moral force of appeal. Hence, failure to act in accordance with these pretheoretical insights generates feelings of remorse, moral criticism, and moral rebuke. Particular moralities, according to Beauchamp and Childress, are not universal. They are content-rich, and are made-up of the concrete norms, ideals aspirations and attitudes of specific/individual cultures.

Beauchamp and Childress' version of common morality and principlism commit them to the following claims:

- i. ... [T]he common morality is a product of human experience and history and is a universally shared product. The origin of the common morality is no different from the origin of the norms of particular morality in that both are learned and transmitted in communities. The primary difference is that the common morality is found in all cultures, whereas particular moralities are found only in one or more cultures forming a subset of all cultures.
- ii. ... [W]e accept moral pluralism (some would say moral relativism) in *particular* moralities ..., but reject a historical pluralism (or relativism) in *common* morality. The common morality is not relative to cultures or individuals, because it transcends both.
- iii. ... [T]he common morality comprises moral beliefs (what all morally committed persons believe), not standards prior to moral belief.
- iv. ... [E]xplications of common morality ... are historical products, and every *theory* of common morality has a history of development by the authors of the theory." (2009, p.3-4).

Implicit in these four claims are two general types of assumptions:

- a. **Historical assumptions** about the origins of both universal and particular moralities. Both are "pre-theoretic" in the sense that they originate in, and can be found within specific cultures. They can be learnt and transmitted from generation to generation and across cultures. They are empirical in origin "and they make no appeal to pure reason, rationality, natural law, a special moral sense, or the like" (2009, 387).
- b. **Philosophical/theoretical claims** about the normativity of common/universal

morality, and of the four principles, which are supposedly derived from them. "Our common-morality theory does not hold that *customary* moralities qualify as part of common morality. An important function of the general norms in the common morality is to provide a basis for the evaluation and criticism of groups or communities whose customary moral viewpoints are in some respect deficient. Criticisms of those customs and attitudes are warranted to maintain fidelity to common morality." (2009, p. 387.)

Since the pretheoretical assumptions of the common morality are "abstract, universal, and content thin" (2009, p.5), the four principles of biomedical ethics "which [are] derived from considered judgment in the common morality" (2009, p.25) are also abstract, universal and content thin.

THE CULTURAL GOODS OF MEDICINE

The word, culture, has at least two everyday usages: on the one hand, it means "high culture." That is, the "best" exemplars of a society's achievements and products in the arts, literature, music, science and technology. A second sense of the word culture is that in which it refers to the *artificial* cultivation and growth of microscopic organisms, species, plants, ideals, beliefs and social mores. This second sense of the word derives its meaning from the verb "to cultivate", "to husband" (in the sense of a "tending activity"). These two senses of culture are linked. For, not only are achievements in the arts, literature, science, etc., "artificial" in that they are *artefacts* of human creations, the elements of "high" (and, of course, "low") culture also have to be cultivated, learnt, nurtured and transmitted—otherwise, they will wither away and die. (Locke, 1989). Implicit in these two senses of culture is the dialectic of opposition between the artificial and the natural (Eagleton, 2000).

Social anthropological discussion of culture therefore recognize that it is about the full range of learnt human behavioural patterns, including "knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Taylor, 1871, p.1). Culture is a complex combinational arrangement with various parts playing numerous roles and functions in their import on individuals and societies. Culture, is "the distinctive way of life of a group of people, their complete 'design for life'" (Kroeber & Kluckhohn, 1952 p.86). In effect, the everyday and the

technical items of culture are themselves constituent elements of a larger complex that is also culture, and which has other elements. No item of culture exists on its own. Its meaning, signification and use are always embedded within layers of other cultural elements.

The development of the vaccine for smallpox by Edward Jenner in the 1790s illustrate the confluence of various cultural elements within medicine, medical practice and, ultimately, in biomedical ethics. Jenner was a naturalist who was committed to the Enlightenment's secular, empirical and rational approach to scientific methodology. He was an English country doctor in Berkeley, Gloucestershire, England. Sometimes during the 1770s, he heard a dairymaid boasting as follows: "I shall never have smallpox for I have had cowpox. I shall never have an ugly pockmarked face." (Stern and Markel, 2005, p.613). Investigating this boast further, Jenner discovered that it was common knowledge among the local farming community that dairymaids who had been infected with cowpox became immune to smallpox, a disease which periodically ravaged Gloucestershire.

Jenner set out to test this boast and the local knowledge. He took some pus from a cowpox lesion on a dairymaid's hand, and then inoculated eight-year old James Phipps with cowpox. Six week later, Jenner variolated Phipps with smallpox. James Phipps was unaffected by the variolation, nor was he affected by subsequent outbreaks of smallpox. Jenner conducted twelve further experiments and sixteen case studies.

Two different aspects of culture informed Jenner's observations, theory, experiments, and his subsequent discovery of the smallpox vaccination. First, there is the *customary factual knowledge* (and belief) amongst the local farming community that dairymaids already infected with cowpox became immune to smallpox. Second, as an Enlightened naturalist, he was knowledgeable of the contrasts between Asian and African techniques of inoculation by variolation (deliberately blowing infectious scabs into nostrils so as to infect an individual with a mild form of the disease, but thereby making the person immune to the full disease), and the alternative European and American method of inoculation by vaccination (subcutaneous punctures on the skin).

The foregoing indicate that medicine is cultural since it is an encapsulation of a society's factual, theoretical and methodological knowledge in its quest to understand itself as the biological knower (best exemplars of a society's achievement), just as much as it is about the cultivation and transference of methodological knowledge about how to enhance our wellbeing as the medical subject (to husband — a tending activity).

To these two cultural goods of medicine, three further dimensions of culture in

medicine can be identified: the communal/sociological, the individualistic/psychological, and the practical/heuristic action-guiding dimensions.

Third, medicine is communal. It is the shared set of beliefs, practices and methods that make up a society's communal bank of knowledge on the prevention, alleviation and curing of diseases and injuries. Medicine in this communal sense is reflected in the social activities of a people *as a group*. In this sociologicistic/communal sense, medicine is learned; structured, dynamic and variable.

Fourth, medicine is cultural in the *psychological* sense that it is a manifestation of individual and societal beliefs about ontology, metaphysics and methods for the realization and achievement of health, wholeness and wellness. In understanding ourselves as the knowing subject, we uphold various medico-cultural beliefs. These beliefs operate as biomedical assumptions that are embedded within medical practice and medical culture.

Fifth, at a "practical-belief" level, all the four different types of cultural assumptions above form the content of heuristic action-guiding principles that moderate and affect human biomedical action and decision-making. This practical-belief layer of commitment to medical culture should be distinguished from all the other layers because individuals and societies do not always follow the concepts, ideas, words, methods and other symbolic structures they claim to rely on. In this fifth sense, medicine as a cultural good is about the application of fact, beliefs and values in biomedical action and choices. Cultural assumption can therefore be found in those unstated convictions that implicitly guide and govern practical conduct in issues of health, wholeness and wellness. We may refer to this cultural dimension of biomedical culture as *practical beliefs*.

The five cultural goods of medicine (i.e., ways in which culture is indispensable to the practice of medicine) can be summarized as follows:

- i. Medicine is a repository of a society's factual, theoretical and methodological achievements in the human sciences. These achievements rely on
- ii. cultivated techniques that have to be learnt, nurtured and transmitted; and in the process of accepting and transmitting (i) and (ii), these two goods of medicine
- iii. become part of a community's or society's general belief structures, *and* at the same time,
- iv. they become part of the specific beliefs accepted by specific individuals.
- v. Acceptance and reliance on (i) to (iv) makes medical beliefs *practical-beliefs*.

That is, they become heuristic action-guiding principles on the basis of which we moderate, regulate and control action and inaction in issues of health, wholeness and wellness.

The foregoing account of the cultural goods of medicine (i.e., the claim that culture is indispensable to medical practice in the five senses above) should be relatively uncontroversial when applied to medical facts and beliefs. However, these cultural goods of medicine also have implications for value, methodology and reasoning in biomedical decision making; and this gives culture some moral weight in the principles of biomedical ethics.

CULTURE IN BIOMEDICAL VALUES

Western discourse on biomedical ethics emphasizes the need for physicians to gain fully informed consent from their patients before treatment. In the United States case of *Schloendorff v Society of New York Hospital* (1914), Cardozo J famously claimed that “every human being of adult years and sound mind has a right to determine what shall be done to his own body; and a surgeon who performs an operation without his patient’s consent commits an assault.”

Medical treatment is *prima facie* a legally forbidden act. It is informed consent that transforms this illegality into a legally permissible act. Neill LJ makes this claim explicitly in the United Kingdom case of *F v W Berkshire HA* (1990): “treatment of surgery which would otherwise be unlawful as a trespass is made lawful by the consent of the patient.”

Beauchamp and Childress (and many other deontologists) base the moral justification of informed consent on the principle of autonomy: “... Respect for autonomy ... provide[s] the primary justification of rules, policies, and practices of informed consent.” (2009, p.118). And since “respect for the autonomous choices of persons runs deep in common morality as [a] principle,” (2009, p.99) informed consent is proclaimed to be one of the universal and culture-free principles of biomedical ethics.

Autonomy literally means self-rule. It is the capacity to think, decide, and act on the basis of one’s own thought without let or hindrance. In very general terms, three conditions have to be satisfied before consent can be regarded as “full” and “informed”:

1. The patient must be competent to make the particular decision in question;

2. The patient must understand the true nature and purpose of the procedure or intervention she is consenting to; and,
3. The patient’s decision must be *voluntary* in the sense that it is free from the coercion and undue influence of *other persons*.

Implicit in these three conditions is a Western conception of the person in which *selfhood* is a *state* or *quality of being*. In this state of being, an *autonomous person* is conceived of as separate, distinct and distinguishable from *other persons*. *A person is an individual who possesses his or her own needs and goals, and therefore, has the freedom and liberty of thought, will and action in the making of healthcare choices.*

But surely, this account of autonomy (just as any account of autonomy) is culture-dependent! The idea of an *autonomous being* requires metaphysical, theoretical, and or spiritual/religious assumptions about what constitutes a person. The predominant Western medical conception of the self is based on some version or the other of René Descartes’ dualism. In Cartesian dualism, a person is made up of two different *substances* or *things*: the mind and the body. The body is extended in space, it has dimensions and a location, and it is publicly observable. The mind, however, is the exact opposite of this: it is indivisible, it has no special dimension or location, and it cannot be publicly observed.

There are other Western ideas of the self: idealism (persons are nothing but bundles of ideas in God’s mind); materialism (the mind is nothing but a by-product of brain function; it is a process generated by the activities of the brain and not a separate substance); and other versions of dualism. For example, the German philosopher Leibniz developed the dualist view called “parallelism” in which the mind and body do not interact with each other. The body has no causal effects on the mind, and activities of the mind do not bring about changes in the body. In Leibniz’s dualism, the mind and body only appear to interact because God has pre-established a harmony between the activities of these radically different substances. These alternate Western ideas of the self are not implicit or assumed in Western medicine.

The Cartesian style substance dualism on the basis of which modern Western medicine is predicated has one Achilles’ heels: if the mind and the body are so radically different substances, they must be incommensurable. How, then, could they ever possibly interact? Yet, interact they must have if pharmacology, psychiatric medicine, neurology, toxicology and some other branches of medicine are to be valid.

Empirical studies by Blackhall et al. (1995) have also shown that Korean-Americans and Mexican-Americans

operate like the Yoruba of West Africa in the sense that they adopt a family-centred model of biomedical decision making in which the autonomous unit is not the individual, but the family. As such, if the metaphysical, ontological, epistemological and other assumptions on the basis of which a culture operates were to be different from those of the type currently assumed in Western medicine, the conclusions about the morally right or wrong choices would be different.

It could be objected that the Yoruba, Korean or Mexican “extended” notions still rely on a unit as “autonomous”; namely, “the family”. Hence, the argument could be made that Beauchamp and Childress are still correct in their claim that “respect for the autonomous choices of persons runs as deep in common morality as any principle, but little agreement exists about its nature scope and strength.” (2009, 99) The differences between *individual autonomy* and *family autonomy*, the Beauchamp-Childress defence might continue, are merely about the precise *nature* and *scope* of autonomy.

This defence of the Beauchamp-Childress position would, however, entirely miss the point. These cultural differences are not just about scope. Rather they point to the more fundamental point that these principles cannot be applied unless one assumes a conception of culture in which a complex mix of fact, knowledge, belief, values and methods is already present. The principles of biomedical ethics are by nature ampliative reasoning tools for arriving at conclusions and as such, they have their content-increasing capacities embeddedness within culture. This is precisely what examples such as Edward Jenner’s development of a vaccine for smallpox, or the case of T in the West or T in Africa, indicate. Questions about who the *person* is affect the validity of bioethical decisions at a practical level. If we vary the ontological and metaphysical cultural assumptions, the outcome of the decisions would be different.

Another objection could be raised against my position. It could be argued, for instance, that many physicians, in particular psychiatrists, no longer uphold the Cartesian view of personhood that I have outlined above, and that as such, my arguments are defective in some ways. This objection would also miss the essence of my arguments. My position does not rest on the empirical claim of whether all, most, many or a few physicians uphold the Cartesian view of personhood. Rather my claim is that whatever conception of autonomy one upholds, that conception of autonomy has contained within it a conception of personhood (Cartesian or otherwise).

My position here is somewhat akin to the claim that mathematics is culture dependent because the amounts of digits we choose to represent our numbers

with are themselves cultural variables. Whether $2 + 2 = 4$ depends on the place-values system adopted within each mathematical and logical culture. The current global dominant way of expressing numbers uses the Base 10 place-value system. However, there are other Bases: 2, 3, 4, 20, etc. And these other Bases are not just options reserved for advanced computerised systems that no real persons use. In actuality, there are many living cultures where logic and mathematics still relies on non-Base 10 place-values. Hence, because the Base 10 system is now the global standard, people within these cultures constantly switch between the standard global mathematical and logical systems, and their own local systems. Helen Verran has written extensively on one such mathematical system.

The implications of the foregoing on principlism are staggering. Unlike mathematics and logic where there are standardised place-values that are now globally embedded within all human cultures (such that even in African cultures where people still use indigenous counting systems, people have to constantly switch between local and global mathematical value systems), there are no standardised global value systems in medical ethics. Hence, not everyone accepts the Cartesian conception of personhood; but accept *one* conception of personhood they must. Irrespective of whether one tacitly assumes or is explicitly conscious of one’s conception of personhood, we cannot apply the principle of autonomy without some prior notions of precisely what *that entity* that is supposedly autonomous is.

The point is that the principles of biomedical ethics are not abstract and content-less. Autonomy is not just autonomy *simpliciter*. Autonomy is not *pretheoretical*. It is a complex notion that already includes the acceptance of certain cultural (i.e., culture in the five senses identified above) items of knowledge. Hence, making use of the principle of autonomy (or any other principles) already includes an implicit (or explicit) reliance on culture in practical decision making process.

In 1990, the Patient Self-Determination Act (PSDA) was passed to enshrine the Principle of Respect for Autonomy into United States law. The response of the Navajo to this Act shows clearly that there is no such thing as content-thin autonomy. Unlike the Yoruba of West Africa, or Korean-Americans and Mexican-Americans, the problems of informed consent that arose for the Navajo had nothing to do with an *extended-family conception of “the self”*. It had to do with other ontological beliefs about illness, words and the nature of causation.

The Navajo believe that *thought* and *language* in themselves have the ability to control the future. If you have negative or bad thoughts, or if you use negative words in speech, *the thinking* and *the utterance* of these

negative words *will themselves* bring about these negative consequences. As a result of this, *Hozhooji* (“positive ritual language”) has always been an important element of health, wellness and wellbeing for the Navajo. Indigenous Navajo medical practitioners never described the prognosis of health issues in negative terms. And contemporary Navajos across the United States would tell their healthcare providers: *Doo’ajiniidah* – “Don’t talk negatively.” When healthcare issues have negative prognosis, the Navajo do not want to hear about it. Rather, they prefer some version or other of *paternalism* in which the physician makes a decision about the best healthcare options available, and then communicates these choices to the patients positively. A Navajo man, for example, refused to go ahead with a heart bypass after the physicians informed him that he might not wake up from the surgery. He told them that they had just handed him a “death sentence” because describing the prognosis in those negative terms now has control over the future. The only way he could change that *uttered future* was to avoid the surgery altogether.

CULTURE AND THE HISTORIOGRAPHY OF BIOMEDICAL ETHICS

Thomas Kuhn’s *The Structure of Scientific Revolutions* opens with the following revolutionary claim:

History, if viewed as a repository for more than anecdote or chronology, could provide a decisive transformation in the image of science by which we are now possessed ... This essay attempts to show that we have been misled by [the old image] in fundamental ways. Its aim is a sketch of a quite different concept of science that can emerge from the historical record of the research activity itself. (Kuhn, 1962, p.1)

What exactly is “the image of science by which we [were then] possessed”? Kuhn is surprisingly unclear. Nevertheless, we can identify various counts on which Kuhn’s view of science differ from the “traditional” views of philosophers like Sir Karl Popper and Henri Poincaré. The old image held that there is a sharp distinction between observation and theory, Kuhn denies this. Proponents of the old image held that observation and experiment provide the foundations for the rational acceptance of theories over their competitors; but Kuhn seems to claim that theory-choice is not a rational (or at least not a fully rational) affair. Proponents of the old image held that science can sharply be demarcated from non-science; Kuhn seems to deny this as well.

The most fundamental contrast between the *old image* and the *new revolutionary image* is in their different approaches to the relationship between scientific method, scientific beliefs, scientific practice, and history. According to the older image, scientific beliefs, practices and theories may come and go, but the principles for the objective ranking of such beliefs, practices and theories are timeless. The old image is that of an *ahistorical* methodology in which the correct rules and standards of evaluation have remained stable and invariant throughout history. Methodology was regarded as invariant because the principles, rules and standards of theory appraisal were taken to be *presuppositionless*, or at any rate not dependent upon any specific substantive, empirical, or cultural claims for their validity. Since methodology was regarded as independent of substantive science, traditional philosophers also claimed that the rules and principles of appraisal served as the neutral set of criteria for judging change and progress in science. In short, methodology was the basic tool of rationality, and traditionalists believed that once they had hit upon the *correct* characterization of the criteria of scientific merit, these criteria were valid for all times – past, present, and future.

Principlism defends an ahistorical, presuppositionless, non-substantive, methodology. Principlism thinks it has discovered the only correct culture-free principles for the evaluation of all biomedical decisions – past, present and future. Contrariwise, I have maintained that substantive contents of culture play important roles in the applications of the four principles. A brief history of bioethics further illustrates this point.

The standard historiography of bioethics traces its origins to early Greek thought. Often times, this history starts with the oath of Hippocrates; the discussion of mutilation, flagellation, incarceration, homicide and suicide by Saint Thomas Aquinas in *The Summa Theologica*; the celebrated *Medical Ethics* of T. Percival in 1803; post Second World War reflections on the roles of the medical profession in genocide; and this pre-history of bioethics culminates with van Rensselaer Potter’s 1970 “Bioethics: The Science of Survival.” Indeed, Potter is acknowledged as the author of the term “bioethics.” This usual lineal history, however, overlooks the import of: (i) the writings of Thomas Kuhn and the revolutionaries on the nature of scientific reasoning; and (ii) the implications of this revolution on biomedical standards of decision making.

As scholars such as Atwood D. Gaines and Eric T. Juengst have emphasized, the fundamental assumptions, implications and legitimacy of bioethical decision is crucially dependent upon the historiography we construct about the origins of the field itself. Gaines and Juengst maintain that the “origin

myths” we accept have foundational implications for the principles, standards and rules we choose to apply in bioethics. They identify three general origin myths as follows:

1. **Bioethics as Reactive:** Some scholars begin their historiography of bioethics by conceiving of it as a reaction to moral concerns about the increasing reliance of medicine on technology. The underlying assumption of this historiography is that new moral dilemmas always accompany the usage of new technology. Hence, it is always prudent to regulate the applications of new science and new technology in “bio” issues. The implication of this “origin myth” is that the correct methods of biomedical decision making are subject to change in light of new technologies.
2. **Bioethics as Proactive:** Proactivism is a social movement that begins with the assumption that power is an intricate aspect of bioethical decision making. The power relations in societies inevitably imply that some minority voices will be left out if justice is not the focal concern of applied medicine. Hence, advance directives, genetic screening, hospital ethics committees and the like are important methods for including various perspectives. Just like the reactive historiography, diversity in valid standards is embedded within this origin myth.
3. **Bioethics as Continuity:** This historiography is the dominate origin myth “by which we are now possessed” in biomedical ethics. According to this dominant historiography, biomedical ethics began with Hippocrates, the Greeks, and the objectively rational second order critical reasoning of philosophy. As such, differentiation across human cultures, groups, societies and other types of social variables have no role to play in the principles of biomedical ethics.

Principlism, the so-called gold standard of biomedical decision making, assumes the origin myth in which bioethics is a continuation of the love of the philosophic wisdom discovered by the early Greeks. Principlism assumes that the methods of bioethical decision making can be independent of its subjects and the cultures within which these subjects are embedded. This presuppositionless origin myth is enunciated in principlism's claim that there is a “pretheoretical” common/universal human morality.

CONCLUSION

This paper has been a critical evaluation of the position that the four principles of biomedical ethics are universally valid norms that are devoid of cultural content and context. I have maintained that the adequacy, acceptance and applicability of these principles change in light of the different cultural network of commitments that give them meaning.

The argument here should not be construed as a defence of “cultural relativism” in biomedical ethics. Contrariwise, it is a critique of the version of deontological ethics espoused by principlism. The decision of T's doctor in the West and T's doctor in Africa *cannot both* be *morally* valid, just as informed consent cannot be valid everywhere in America, except on the Navajo Reservation. What has been established is that cultural elements of fact, knowledge, method, ideational beliefs, and practical beliefs are required for the application of the principles of biomedical ethics. To fully and adequately assess the ethical value of biomedical decisions, we need to augment a discussion of principles with an axiology of the categories that make these principles usable and applicable.

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