

Global Bioethics:
A Descriptive Analysis of the Function of Bioethics in Health and
Medicine on a Global Scale

by
Stephen Charles Ruffenach

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Graduate Supervisory Committee:

Jason Scott Robert, Chair
Daniel Hruschka
Jane Maienschein

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ABSTRACT

This thesis explores concept of “global bioethics” in both its development as well as its current state in an effort to understand exactly where it fits into the larger field of bioethics. Further, the analysis poses specific questions regarding what it may contribute to this field and related fields, and the possibility and scope associated with the continued development of global bioethics as its own discipline. To achieve this, the piece addresses questions regarding current opinions on the subject, the authorities and their associated publications related to global bioethics, and what the aims of the subject should be given its current state.

“Global Bioethics” is a term that, while seen frequently in bioethics literature, is difficult to define succinctly. While many opinions are provided on the concept, little consensus exists regarding its application and possible contributions and, in some cases, even its very possibility. Applying ethical principles of health and medicine globally is undoubtedly complicated by the cultural, social, and geographical considerations associated with understanding health and medicine in different populations, leading to a dichotomy between two schools of thought in

relation to global bioethics. These two sides consist of those who think that universality of bioethics is possible whereas the opposing viewpoint holds that relativism is the key to applying ethics on a global scale.

Despite the aforementioned dichotomy in addressing applications of global bioethics, this analysis shows that the goals of the subject should be more focused on contributing to ethical frameworks and valuable types of thinking related to the ethics health and medicine on a global scale. This is achieved through an exploration of bioethics in general, health as a function of society and culture, the history and development of global bioethics itself, and an exploration of pertinent global health topics. While primarily descriptive in nature, this analysis critiques some of the current discussions and purported goals surrounding global bioethics, recommending that the field focus on fostering valuable discussion and framing of issues rather than the pursuit of concrete judgments on moral issues in global health and medicine.

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Preface

This project represents the culmination of the official requirements of a Master of Science in Biology and Society at Arizona State University. But, beyond that, it is also representative of the culmination of my academic career here at ASU as I move on to the next stage. Biology and Society, both as a degree path and subject, aims to address the connections and crossover between the biological and the sociological. Being a pre-med student with the goal of one day becoming a physician, this relationship has always interested me and is the means by which I have informed my worldview in relation to health, medicine, and biology in general as well as the way these subjects relate to society, technology, and ethics. With that, the subject of this project, global bioethics, gains significance as it represents not only an analysis of a term/field within bioethics but also a mentality I hope will stay with me as I continue on my educational path. My academic career thus far and in particular my Masters education and thesis project have constantly reminded me of the complexity of the world around us in relation to health and medicine and I believe this experience will be invaluable to me as I move forward to study medicine at The University of Arizona College of Medicine–Tucson.

Chapter 1

Introduction

Global Bioethics is an important but ill-defined concept that fits somewhere within the more general topic of bioethics: the exploration of ethics related to biology and medicine and the complex situations that arise from developments in these fields. Though its exact definition and possible function are points of contention among many, it is clear that the topics and goals associated with the topic are extremely important, particularly when applied specifically to health and medicine on a global scale. As the world becomes increasingly interconnected and essentially smaller, people and their associated cultural and geographic groups will interact more than ever. With this trend, it is inevitable that there will be clashes in the ways in which different individuals and groups see the world and this is a phenomenon we must be prepared for in all areas.

When it comes to bioethics specifically, constant awareness of different people and cultures and how they consider notions of health and disease will affect the continued development of bioethics as a field. Further, by attempting to promote discussion and awareness of these differences in perceptions of health, contributions may be made to fields like public health and global

health that currently deal with important subjects that already lend themselves to ethical discussion. In this way, principles of global health that emphasize social and cultural context on a global scale may serve as a guide for the continued development of bioethics. Concepts like distribution of resources and the effective implementation of health programs in different countries are pertinent to this type of development and discussion as are the perhaps more obvious examples of actual health interventions and general health principles. Given all this it is important to explore current literature on global bioethics specifically in an effort to determine how such a topic might function in biomedical ethics globally. Exploring the topic in this way will allow for an analysis of the subject as it continues to frame bioethical thinking in coming years

The goal of this analysis is to examine bioethics in general in an effort to determine where global bioethics may fit into this larger field while also tracking and analyzing the development of global bioethics itself, from its advent to its current state. This endeavor also inherently involves a discussion of the health disparities within and between nations and cultures that draws attention to the myriad of factors that make medicine and health so complex when considered globally. Further, an examination of

example topics from global health that clearly lend themselves to bioethical discussions is also useful for this analysis, showing instances in which ethical discussions are complicated by cultural and social context. All this is done in an effort to promote discussion and exploration of global bioethics with the thought that doing so may provide some sort of contribution to bioethics as well as fields related to global bioethics including global health and medicine. While primarily descriptive in nature, this project will hopefully be a useful tool for those attempting to continue examining the link between bioethics and global health which will be increasingly important in coming decades as medical practices and theories are applied on a global scale.

When formulating this project, the preliminary literature exploration performed focused on bioethics and general ethics literature that not only addressed what these fields aim to do but also how they should be organized and reorganized to be most effective with worldwide development in health, medicine, and other biological pursuits. In examining these subjects, it became clear that commentary on bioethics as well as other subfields of ethics in general was plentiful. This was promising as it showed that analyzing the current state of various aspects of ethics was commonplace and allowed a template of sorts for this analysis,

its components, and possible goals. The focus of this preliminary reading involved looking at current prescriptions about the aims of bioethics as well as literature dealing with possible extensions of aspects of bioethics in specific realms. One such endeavor is the work of Ben A. Minteer and James P. Collins (2008) in their presentation of “ecological ethics” as an important new interdisciplinary field of current ethical endeavors.

In addition to this, current literature and opinions on bioethics as it is now as well as prescriptions on where it may be going were explored, with a few pertinent papers being examined closely as preliminary reading for this thesis. One in particular is Michael P. Nelson’s short commentary entitled “On Doing Helpful Philosophy” from *Science and Engineering Ethics* (Nelson, 2008). In this short piece, Nelson (2008) presents a criticism of current undertakings of philosophy departments at various universities as well as the field of philosophy in general saying philosophers may suffer from a “failure to be helpful [which] has lead to a failure to promote philosophy” (Nelson, 2008, p.611). With this, Nelson is calling for strategies that could be employed to make the field of philosophy more relevant to scientists, engineers, and the like as well as the public at large. In essence, Nelson is calling for philosophy and its focuses to be

more outcome-centered. This is not to say that every aspect of philosophy must be normative in nature but rather the lengthy discussions and plethora of literature on philosophical topics should be filtered and organized to provide actual benefits to other fields and those that work within them.

In this same vein, Jason Robert's piece entitled "Toward a Better Bioethics" looks at similar tendencies of those explored by Nelson but in relation to bioethics explicitly (Robert, 2009). Robert (2009) discusses the tendency of bioethicists to work with "forbidding science", scientific pursuits that are both controversial in nature as well as actually recommending that certain pursuits not be allowed. Robert pushes for the movement toward a better bioethics (and therein, better bioethicists) in response to Leon Kass' apparent dismissal of bioethicists as self-proclaimed experts, able to render decisions on "moral" grounds in relation to biomedical issues and practices. In general, Robert (2009) recognizes the fact that bioethicists often fall short in attempting to promote worthwhile discussion and exploration of controversial topics, often siding with scientists and their endeavors in an effort to contribute to scientific advancement even in the face of opposition from the public and government officials or policy makers. Robert presents the different

tendencies that exist in bioethics work currently showing how bioethicists attempt to sway public opinion toward supporting scientific research when great results are promised, acting as “bio-evangelists”, to being seen by scientists as impediments to progress no matter how much they promote scientific inquiry (Robert, 2009). In the end Robert discusses the role of bioethicists as “architects of moral space”, presenting the framework to promote quality, beneficial discussion about important moral issues in relation to science, medicine, and health. In this way the goal of the field is more focused on promoting bioethical thinking as opposed to making explicit moral and ethical prescriptions.

Robert’s piece (2009) presents many ideas crucial to the understanding of this thesis by highlighting what many think bioethics has been doing lately as well as what he sees as a more worthwhile goal for the field and those in it. By pushing for the role of bioethicists as “architects” constructing space for worthwhile discussions in ethics, Robert gets at the heart of the issue at hand in this piece. At this stage, exploring global bioethics is not about mandating how and to what degree ethical principles should be applied globally but rather should be aimed at creating awareness of ethical issues and general discussion on

the subject. Further, bioethics could benefit from following cues of global health that promote awareness of culture and context in general. By keeping this goal in mind, this exploration will remain descriptive in nature, attempting to track the development of global bioethics in its current form in order to determine how to best use this subject for future work in health and medicine globally.

As stated, this exploration was also inspired in many ways by the work of Minter and Collins, authors of "Why we need an "ecological ethics" and "Ecological Ethics: Building a New Tool Kit for Ecologists and Biodiversity Managers" (Minter and Collins, 2005; Minter and Collins, 2005). These pieces, while obviously dealing more with ecological and "environmental" ethics, are not specifically useful for this analysis in terms of their content but rather have functioned as guides for presenting this sort of message. In these works, Minter and Collins recognize a group, research ecologists and biodiversity managers, who work in a field fraught with ethical issues and dilemmas and yet have no organized means to approach these issues and take them on effectively (Minter and Collins, 2005). Thus, the authors present a new field of ethics called "ecological ethics" in an effort to promote discussion on these pertinent topics while also

providing a support system for the aforementioned workers who encounter the ethical dilemmas in their fields. Essentially, the authors present the idea that, although guidelines of ethical principles exist, the fields of focus for their purposes are complex and dynamic and thus lend themselves to dedicated ethical systems in the form of their own subfields within the larger subject of ethics (Minteer and Collins, 2005).

Minteer and Collins (2005) make a point that also applies to the situation with global health and bioethics. Bioethics as it is studied now, particularly in relation to health and medicine, attempts to foster discussion and is even able to make normative claims but is somewhat inadequate for thoroughly assessing the complexity of these topics globally. When considering bioethics and health on a global scale, the ethical questions and dilemmas become increasingly complex, exacerbated by the rate at which the world and different populations in it are developing, changing, and interacting. So with this it becomes necessary to examine global bioethics as a new possible subfield within bioethics, applying ethical principles to situations of health and medical practice on a global scale. Doing so inherently involves discussions of the differences in global societies both in terms of objective health as well as how

it is affected by social, economic, and cultural components and therein lies the complexity that mandates an organized field or subject for making ethical decisions in health around the globe.

Goals and Means

This project aims to take on a number of different questions within the realm of global bioethics. In its advent, this project was oriented toward making prescriptive claims on how global bioethics should be presented in academia generally as well as in specific curricula but, through preliminary analysis and research, it was found that the subfield was by no means cohesive enough to be presented as a framework for effective ethical discussion or decision making. With this realization, the project shifted and is now more descriptive in nature. By looking at bioethics in general, health as a function of social and cultural variables, and the specific development and current state of the term and topic of global bioethics, this thesis will describe the type of thinking that may be promoted through exploring global bioethics as well as how this type of thinking may benefit bioethics in general. To narrow the goals of this study, the following questions will be addressed through the course of the analysis:

- What does it mean to discuss global bioethics today, what authorities have emerged on the topic, and what evidence and arguments exist for current opinions of the subject?
- In what ways may bioethics benefit from a topic like global bioethics?
- Given the lack of cohesion on the subject of global bioethics and its possible contributions to related fields, what realistic goals should remain the aim of continued discussion and exploration of the topic?

These questions are clearly very open-ended but are intended to be that way given the nature of the subject.

To answer the different aspects of these questions effectively, the following analysis will take a compartmentalized approach to all the general subjects related to global bioethics. First will come an overview of bioethics within the framework set up by Robert's piece described above. Next, health disparities between different populations and nations will be explored with attention given to the factors contributing to and affecting these differences, further making a case for the complexity of health on a global scale. Then, the explicit history of the term and

subject of global bioethics will be explored to show how it has functioned in the vernacular of bioethics literature as well as what authorities on the subject say about its function, benefits, drawbacks, scope, and very possibility. Finally, an exploration of pertinent global health topics with specific attention given to a select few that lend themselves to questions of a bioethical nature on a global scale will be presented to show the need for and benefit of promoting this type of discussion even in lieu of a succinct, cohesive field represented by global bioethics.

Chapter 2

Bioethics

In order to examine and analyze the possibility of global bioethics as a subfield of bioethics both in organization and in practice, it is important to examine bioethics as a discipline itself. The history of bioethics is a complex one, displaying some of the same lack of cohesion and disagreement problems that mark the discussion of global bioethics. But despite this, the field has continued to develop and gain prominence and functionality in relation to progress seen in biology and medicine as well as related fields. Given its current use and supposed goals and application, it is important to briefly explore where the field has come in recent decades as well as how it functions as an umbrella field for global bioethics.

The development of both the term and field of bioethics are attributed to the United States of America (Fox and Swazey, 2008). Like many origins stories, there are some discrepancies as to the actual advent of the field but the general narrative attributes the term to Van Rensselaer Potter, coining the term in 1970 (Fox and Swazey, 2008) and describing his work in his 1971 book *Bioethics: Bridge to the Future* (Potter, 1971). However, credit for the term has also been given to

contemporaries of Potter, André Hellegers and Sargent Shriver working at Georgetown (Fox and Swazey, 2008). In both instances, the term was used to describe a new field that would reconcile general principles and knowledge of biology and human values systems, in essence undertaking ethical questions and discussions coming from developments in the fields of biology, medicine, and health (Fox and Swazey, 2008; Thomasma, 2002). It has been reported by many that the advent of bioethics as a subfield of ethics came in response to technological advancements in the realm of biomedicine (Fox and Swazey, 2008), although bioethics can and should focus on a wide range of issues related to health more broadly.

Early Bioethics

Given the myriad of topics and challenges which bioethics attempts to address, it may seem somewhat strange that technological advancements really spurred its creation rather than philosophical questions related to health and biology. However, upon closer examination, this narrative makes sense, given the biomedical interventions made possible by technological advancements. As early as the 1950's, various practices and associated debates were emerging on topics like

human experimentation, showing that even before major technological advances people were trying to reconcile human values with interventionalist medical research and care (Fox and Swazey, 2008). However these discussions only intensified with the advent of the cardiopulmonary life support system and development of methods to transplant organs from deceased individuals to those in need of them (Fox and Swazey, 2008). Such milestones have been cited as major advancements leading to more serious considerations of bioethics as a field of importance in relation to biomedicine (Fox and Swazey, 2008). The inclusion of technology in medical care has been seen by many as potentially problematic, separating the patient from the humanized care that had marked medicine in the past (Fox and Swazey, 2008; Thomasma, 2002). Some worried that such technologically based care would further desensitize medical professionals, allowing them to forget they are treating an actual person rather than just a body (Thomasma, 2002). It became alarming to think that as medical professionals were trained, more and more time was devoted to understanding developing medical technologies, thereby taking time away from teaching workers about compassion and empathy toward their patients and the decisions associated with their care (Thomasma, 2002).

Thus, given the directions in which biomedical research and medical care were moving, it was clear that a new discipline needed to be formed that would emphasize continued discussions on ethical and moral matters in these fields.

The precursors of Bioethics as an organized discipline first found prominence as early as the 1950's though these institutions and programs might not fall into what would be considered "mainstream bioethics" today (Fox and Swazey, 2008). Programs emerged in this decade that attempted to discuss and promote consideration of moral, religious, and ethical human values with medical practice and research while also taking legal aspects of such practices into consideration (Fox and Swazey, 2008). From here, various programs began appearing at different institutions across the United States including the University of Texas Medical Center and Boston University while meetings and conferences on topics related to human values, ethics, and biomedicine became common (Fox and Swazey, 2008). Such meetings and institutions developed as a response to both specific events (like the first successful heart transplant by Dr. Christiaan Barnard in 1968) as well as a general trend toward more invasive and controversial medical practices as techniques and technology advanced (Fox and

Swazey, 2008; Thomasma, 2002). With programs and conferences on (what would later be known as) bioethics becoming more common, humanities programs were introduced into medical schools, taking an interdisciplinary approach to these issues including considerations from the fields of theology and philosophy (Fox and Swazey, 2008). From these beginnings, it is clear that bioethics had close ties with philosophy and religion early on, relationships that would contribute greatly to the continued development of the field into the form we see it today.

Bioethics, Religion, and Philosophy

As described, the advent of bioethics as a dedicated field was not the result of one singular event nor did it occur in one specific place (Fox and Swazey, 2008). The development of the field came as a result of various forces though it is clear that developments in biology and medicine, particularly technological advances leading to more invasive procedures, sparked extensive discussion about how human rights factored in to rapidly developing fields related to biomedicine. Given the emergence of this field marked by fragmentation, it is no surprise that the various fields contributing to its development

influenced it in different ways and that these early influences still exist in the application of the field now. The following examines the early influences of philosophy and religion to track some of the means by which bioethics has reached the state it is in today.

As the discipline now most accurately described as bioethics continued to develop in the 1960's and 1970's, the influence of various fields became more concrete. Obviously scholars from biology, medicine, and health weighed in on new discussions of ethics as they related to biomedical pursuits but beyond these fields, individuals from moral theology and religious studies backgrounds also provided their thoughts on matters, doing a lot to shape preliminary development of bioethics which remained separate from philosophy at this point (Fox and Swazey, 2008). Prominent theologians of the time like Joseph Fletcher, James Gustafson, Richard McCormick and others contributed to early development of bioethics including having influences in program developments at the Hastings Center and Kennedy Institute (Fox and Swazey, 2008). These institutions, particularly the Hastings Center (founded in 1969), are often associated with the first organized forays into bioethics (Fox and Swazey, 2008). While having a large influence on the early development and

institutionalization of bioethics, the general role of religious contributions and specifically the role of theologians in the history of bioethics is somewhat disputed.

Many scholars, including Renée C. Fox and Judith P. Swazey, recall religious scholars as major contributors to early bioethics “as much for their moral stature as their intellectual contributions” (Fox and Swazey, 2008, p.38). However, regarding the question of how influential theology and religious scholars are to modern bioethics, while their early contributions are respected and valued, their continued input in relation to bioethics application and methodology often fragmented the approaches to various subjects and discussions related to bioethics (Fox and Swazey, 2008; Turner, 2003). Thus, although religion and moral teachings associated with religion contributed to the early backgrounds of bioethics pioneers (Fox and Swazey, 2008), its continued influence proved problematic. This was due to the fact that these religious backgrounds could not be applied in all instances, resulting in individuals making different decisions regarding certain topics, behavior, and practices related to the ethics of biomedicine (Fox and Swazey, 2008; Turner, 2003). Topics of interest in this realm include religious views on death and the afterlife, suffering, and even distribution

of medical care as well as which medical procedures and interventions are considered acceptable (Turner, 2003). Given this, the subsequent "secularization" of bioethics took place, as everywhere religious leaders and institutions fell out of favor as general authorities on subjects largely considered secular (Turner, 2003). Such a movement allowed philosophy to become more influential in the development of bioethics as a field, though initially neutrality towards all religions was emphasized in these matters (Turner, 2003). This separation from religion was a trend seen in political and societal matters dating back to the Enlightenment (Turner, 2003) and thus a similar theme appearing in the development of a field like bioethics is to be expected.

K. Danner Clouser of the Hastings Center delivered a short report on the link between philosophy and bioethics in 1993, looking back on the contributions of religion and religious scholars while lauding the role of philosophical principles in the continued development of bioethics (Clouser, 1993). In this piece, Clouser (1993) states that it was the influence of philosophy that allowed for the systemization of the field and was responsible for eventually yielding useful discussion and even answers to ethical dilemmas in biomedicine. Clouser also

claims that this beneficial relationship worked bilaterally, with philosophy also gaining prominence and respect from its role in questions related to bioethics subjects (Clouser, 1993). The main focus of the article, however, explains exactly why philosophy was a successful addition to the development of bioethics and, as mentioned, why bioethics was able to contribute and even revive philosophy. In short, the two fields worked well in that the abstract, hypothetical discussions marking philosophy were met with situational and detail-based dilemmas in bioethics (Clouser, 1993). As Clouser describes it, the contribution of philosophy to bioethics was that of concrete experience, though this relationship does not extend so far as to say either field wholly enveloped the other but rather that the exchange of ideas and discussions allowed for the continued development and application of bioethics while philosophy was given a breath of fresh air in many ways (Clouser, 1993). This account succinctly describes the ways in which philosophical thought allowed bioethics to distance itself from various religious influences. Such an influence provided a fragmentation in the field and was more about religions designing their own guidelines for biomedical ethics rather than working toward an independent

field to promote discussion and decisions on such matters in a universal sense.

Bioethics Today

Given this background on the advent of bioethics, it is no wonder that the field, over time, has been the subject of scrutiny and dispute. This should not come as a surprise given the scope of topics the field attempts to address, many of which relate to biomedical topics that are quite divisive in nature. However, over the decades of development of the field, as described above, there have been trends of systemization and institutionalization, adding consistency and organization to a field that saw a myriad of influences from various sources and fields in its initial developments (Fox and Swazey, 2008). With this type of development, it is important to recognize how the field functions today, the extent to which such organization has continued and how this progress has affected the general ideology of the field.

From its very early beginnings, bioethics as a field continued to gain legitimacy and attention, displayed by advancements seen in the mid 1970's (Fox and Swazey, 2008). It was during this time that many recollect bioethics programs becoming more established and organized within institutions and universities in

the United States while also marking the time in which bioethics began making its way into Washington DC, affecting political and legal discussions of topics in biomedicine (Fox and Swazey, 2008). As philosophers and other leaders in the field of bioethics became more accepted by the scientific and medical community, consultation services for bioethical issues also began appearing at hospitals around the country (Thomasma, 2002). Obviously this time also marked a transition in the actual applications of the field of bioethics. As the field became more institutionalized degree paths in the field began to appear in various institutions (Fox and Swazey, 2008; Thomasma, 2002). All of these trends contributed to the legitimacy of the field and soon authorities in bioethics began to emerge and it became more commonplace for those in the field to actually make normative claims about biomedical procedures and controversial situations. All of this was of course a result of moving away from the religious influence seen early in the development of the field as only with the inclusion of philosophical considerations and associated institutionalization was the field taken seriously as a means of decision-making and discussion promotion on matters related to bioethics. But have these trends continued today, resulting in a field that attempts to apply philosophical thought to all instances

of ethics in biomedicine equally in order to achieve valuable discussion and concrete results?

As noted by Robert (2009) in his piece discussed above, the role of bioethics and bioethicists currently is not completely cut and dried. It is important, as Robert outlines, for bioethicists to work with scientists as well as the general public in order to contribute meaningfully to ethical dialogue in relation to biomedicine. This idea is supported by the current landscape of bioethics as it relates to global medical practice as more is being written on topics outside of specific health intervention and medical practice, focusing on topics like public health ethics (Holland, 2006). This dynamic is important because, as Robert puts it, bioethicists need to understand how science and society are advancing, how such developments affect the nature of how people live and perceive health, as well what effects such developments may have on general expectations of biomedical science (Robert, 2009). It is in this way that bioethicists may be, as Robert puts it, "architects and not arsonists" (Robert, 2009, p.290), contributing to open discussions and debates that aim to be less divisive and more collaborative in nature. Such a task, however, is complicated by the fact that science itself as well as

social and political landscapes in the world in which science operates, are quite dynamic (Robert, 2009).

Thinking Globally

Given this brief exploration of the advent of bioethics as well as views on the way it functions now, what does this mean for the exploration of bioethics in a global sense? First of all, applying the efforts and goals of bioethics on a global scale immediately exacerbates the complications that marked its initial development. Religious influence that marked the field's early development gave a moral structure to bioethical discussions but ultimately hindered advancement by preventing objective, universally minded development in favor of development catered to certain ideologies and dogmas. As cultural influence becomes more important in the field, the problems that eventually came to light from religious influence are once again appearing. Further, the pursuit of the kind of "better bioethics" described by Robert (2009) in his piece is also made difficult when applied globally. Just as the dynamism of political and social atmospheres complicate the job of bioethicists in any circumstance, the same diversity displayed by cultural and social ideologies from country to country around the globe will only

fragment any attempts to make universal judgments on ethical matters which could contribute to more effective policy and social interventions to improve health and the practice of medicine worldwide. Does this problem demonstrate an overall problem with the very goal and possibility of global bioethics? Or should there be a subfield of bioethics dedicated solely to looking at bioethics in this way?

Chapter 3

Health and Society

From the preceding exploration of bioethics, it is clear that the field came to be out of necessity given advances in biology and medicine. In short, humankind's abilities to use science to change people's lives reached a point where debates arose regarding what should be considered acceptable and allowed. However, when considering the complexity of applying such goals globally, it is important to determine whether such application is necessary. Beyond the use of medical technology and implementation of health interventions, global health concerns also must address issues of healthcare and distribution of resources, definitions of health and related concepts, as well as general human rights and values related to health and medicine. All of these topics demonstrate the complexity of health as a topic and when applied in different contexts in various areas of the world, things become even more convoluted. The reason a discussion on these topics is important is that the social and cultural differences that exist between groups often translate to disparities in health outcomes. Thus, any exploration of bioethics on a global scale is made significant due to the fact that opinions on health and medical practice in

different areas are often the result of a myriad of different factors and thus it becomes important to look at bioethics within the context of these factors. Whether such an endeavor is worthwhile or even possible is still to be determined but at this point it is at least clear that as long as disparities are seen in different areas based on some factors that are unique to groups based on their social and cultural characteristics bioethics may need to be applied relativistically. This inherently means that there should be some thought given to how and to what extent medical practices should be used in these areas; bioethical discussions quickly follow once that idea is broached.

In order to determine the strict biological manifestation of social factors, the World Health Organization's (WHO) report entitled "Closing the Gap in a Generation" was explored. In this report from 2008, WHO set out to examine "social determinants of health" in order to come up with recommendations on how to combat the health disparities that exist within and between different populations around the world. The report comes from the WHO's Commission on Social Determinants of Health, established to assess and make plans to combat factors in various societies that contribute to poor health outcomes (CSDH, 2008). The goal is to pursue health equity across the globe

though the Commission explicitly states the lofty nature of such a goal (CSDH, 2008). Rather than demand advances be made to this specific goal, the Commission instead states that their main objective is to push policymakers and powerful entities around the world to have this goal in mind in order to combat worldwide problems with health and disease more effectively (CSDH, 2008). Further, the Commission also recognizes that although distribution of health care is a major component to this discussion, they choose to focus more specifically on the conditions in which poor health outcomes are seen in an effort to accurately determine how such circumstances translate to failures in health outcomes as well as how these issues might be best combated (CSDH, 2008). This analysis will demonstrate, in the eyes of the WHO, how social factors that differ across societies relate to health problems, thereby making a case for the myriad of factors that contribute to actual health outcomes, perceptions of health, and associated attitudes on medicine and health interventions.

Moving away from these societal factors, this section of the analysis will also take a more focused look at cultural determinants of health. Taking on such a topic is complicated for a number of reasons and thus such a task is met with caution.

First, the very definition of “culture” is somewhat complex though for the purposes of this thesis the simple definition of values and behaviors that are learned and transmitted through social mechanisms will suffice (Hruschka, 2009). Further, looking at different cultural beliefs and practices as well as their relation to health disparities is a very ambitious undertaking. Despite these obstacles, an overview of culture as it relates to health and medicine will demonstrate, though in another sense than described above, how health is considered and pursued differently based on cultural beliefs and traditions. This once again will make a case for the complex manifestation of health in different groups though this aspect of the analysis will differ from the section restricted to social determinants as there are cultural components in play that must be assessed outside of the social components outlined by the WHO (CSDH, 2008). While different, these two aspects of the analysis make the same general point: health and a given group’s means and priorities of striving for health for its people are different from place to place around the world. And with these differences, it may be more important than ever also to consider the differences that may inherently exist in bioethical analysis of biomedical and health situations in these places.

Social Determinants of Health

In the reports provided by the Commission on Social Determinants of Health from the WHO, three overarching recommendations are presented to guide the pursuit of health equity around the world (CSDH, 2008). These recommendations include improving daily living conditions, tackling inequitable distribution of power, money, and resources, and measuring and understanding the problem while assessing the impact of action (CSDH, 2008). These recommendations are telling of the initial goals of the Commission as well as the results found from their exploration of health disparities. The Commission, as stated, is more concerned with the conditions and circumstances in which these health disparities exist. It is those factors that are explored in the reports and by exploring these recommendations and their components one at a time, this analysis aims to understand the situation as depicted by the WHO, their reasoning for singling out these aspects of society and how subsequent plans of action may result from such this characterization.

The first recommendation from the report focuses on the living conditions of various countries around the world and how different aspects of these conditions affect health (CSDH, 2008).

This component of the report begins by discussing early child development and its importance in lifelong health outcomes (CSDH, 2008). The major point in this case is that the nutritional and health situation of a mother in most cases translates to similar outcomes for her child and thus it is important for mothers to have knowledge on these topics but also have access to resources to nourish their offspring to ensure proper development (CSDH, 2008).

Moving along, the report then discusses the concept of health as a result of where individuals physically live. This aspect of living conditions specifically deals with the way people arrange themselves in society and explicitly mentions that as of 2007 the majority of humans are living in urban settings (CSDH, 2008). Living in these urban situations has direct effects on health in that such living conditions actually result in more problems with non-communicable diseases for the poor as well as an increase in death from violent injuries and impact from natural disasters (CSDH, 2008). Further, living location is usually directly related to a person's ability to access clean water, quality housing, sanitation, and other important means of pursuing healthy living (CSDH, 2008). Given this, it is important to consider the breakdown of global living situations to understand how health

trends and thus medical needs may be shifting due to a movement toward urban living.

The next aspect of living conditions explored involves employment which may affect health in a number of ways. First of all, the direct connection between occupation and health involves one's health actually being affected by a job whether it be negative due to dangerous working conditions or psychological effects from lack of job security or positive from the benefits of having a steady job which can be financial as well as psychological (CSDH, 2008). These issues relate closely to the next topic discussed, the idea of social protection throughout one's life. This involves the idea of social structure supporting individuals at all stages in life from early development to end of life stages and is closely related to the infrastructure set up by a given government (CSDH, 2008). This topic is extremely complex from place to place as determining where funds should be allocated in terms of social programs is a subject fraught with debate. For example, many programs such as hospitals, water cleaning repositories, and others may all benefit a society but who is to say which programs take precedence. Obviously these standards are variable from place to place but it is important to remember that the ways in which government-sanctioned

programs in the form of social protection translate to health outcomes, usually through financial means (CSDH, 2008). Such a concept is obviously fraught with ethical discussion as much debate surrounds how to best utilize funds to implement health programs effectively. Finally, this exploration of living conditions looks at the concept of universal health care and the general possibility of providing some level of health care to individuals in any living situations around the world. The extent of the need for health care differs from country to country but it is an issue that all countries deal with in one way or another (CSDH, 2008). Despite the different degrees to which this problem affects different countries it is clearly a complex issue that deals with not only the infrastructure of a country but the actual individuals that may administer care effectively whether they are from the area or, in poorer examples, are brought in from elsewhere to provide care (CSDH, 2008). It is also stated in the report that the Commission sees health care as a common good, which is telling regarding its thoughts on how health care should be made available in various countries (CSDH, 2008).

The second broad recommendation included in the report focuses on the distribution of resources around the world and the ways in which such distribution in different areas affects health

trends. This portion of the report moves away from the specifics of daily living described above and instead tries to take on the policies and social norms that shape distribution of goods, translating into living conditions and thus, health outcomes (CSDH, 2008). Specific topics included in this section of the report include looking at policies and programs enacted by governments in different countries, including things like urban planning, public transportation, and others, that can affect the health of the people in those countries (CSDH, 2008). Including community input in these programs is a way to ensure quality output that works towards equity in these programs and this is done in the hopes that these potentially beneficial programs will indirectly promote health equity (CSDH, 2008). Fair financing and market responsibility are other topics covered in this section which take on the strictly financial occurrences in countries all around the world. These topics emphasize the need for funding and good market activity for positive health outcomes, while emphasizing that although health is not a tradable commodity, it can be strongly influenced by these factors (CSDH, 2008). Putting money into the right programs in a fair way while also considering how positive shifts in health trends might be manifested in a country's market can be beneficial to all

involved—though carrying out such a strategy is a complex endeavor teeming with ethical issues.

Shifting from financial to more political considerations, the report moves on to discuss gender issues, political empowerment, and global governance as the last topics of interest in this section. Again, these are issues that affect the daily life topics mentioned earlier but attempt to determine the actual roots of the problems, often embedded in long-standing social and political frameworks in various countries (CSDH, 2008). In terms of gender issues, the report focuses mainly on women as they make up half the world's population but are often still not afforded the same opportunities as men in many countries, and this disparity is often linked with poor health outcomes for women and children (CSDH, 2008). The report emphasizes the social construction of gender inequality, stating that because these differences are a result of history and little else, they can be changed to ensure the continued pursuit of health equity within societies and thus, also on a larger scale (CSDH, 2008). Further, political empowerment is also related to the idea of gender representation as it describes the extent to which the people living in an area are able to influence the government and associated policies affecting their lives. It is

important to have such input because only with accurate representation of people's lives can effective changes occur to promote improvement, particularly in terms of living conditions, resources, and health outcomes. The final section of this portion takes the issues related to political organization and control and applies them globally, emphasizing that health equity will become increasingly important as globalization continues (CSDH, 2008). With this trend, it is important to continue to strive for health equity by following the recommendations and findings of this report and that only with cooperation at an international level will real progress be made.

The report summary closes by emphasizing how important it is to continue monitoring not only social determinants of health but also to accurately assess the impact of any actions that attempt to emphasize health equity among different societies (CSDH, 2008). Reports like this one can be very important in affecting policy all over the world and thus it is crucial that similar research is performed to get down to the root of exactly what is causing health inequities around the world. Obviously biological research on general health and epidemiology is important but it must also be remembered that social, economic, and political factors also affect health trends and should be

analyzed and dealt with accordingly. The WHO report on Social Determinants of Health does a great deal to make this point clear, looking at the characteristics of countries that may indirectly affect health outcomes, providing a glimpse into the complex nature of exactly how health is affected differently in different places based on a myriad of factors. With this analysis alone the bioethical issues facing the pursuit of better health outcomes across the globe are evident, dealing with topics of distributive justice and political power. To further illustrate this point, however, it is also important to explore how more specific cultural considerations factor in to health outcomes all over the world.

Health and Culture

While the exploration of social and political factors presented above is very important to understanding some aspects of health disparities around the world, an exploration of cultural factors is also very important, particularly in relation to the idea of global bioethics. Culture, which can take on a variety of different meanings depending on the context, is generally used to describe the behaviors, traditions, and characteristics that are socially learned and passed on in a group (Hruschka, 2009).

Such a definition is often linked to historical or religious background though this is not always the case. Further, the extent to which cultural factors actually affect different groups is variable though it is safe to say that some level of cultural influence exists in any group around the world though the form that influence takes is also quite variable. With all this, it is clear that cultural diversity can also translate to diversity in many other areas, particularly health and medicine. A given group's thoughts on what health is, how health should be pursued most effectively, and the extent to which certain types of medical intervention should be utilized to attain health are often culturally defined and thus any general characterization regarding global health should include a cultural component. An example of this is a subject like obesity which is perceived and reacted to very differently based on culturally learned values and ideas of health and its pursuit (Brewis et al, 2011). This shows the diversity that may exist between countries that are seemingly very similar based on less descriptive social characteristics like political structure, economic status, and others though it is important to remember that such cultural characteristics are often perpetuated or reinforced by established social organization and programs.

Given the history of human civilization, health needs to be considered as a function of social and cultural development. The movement of humans from hunter-gatherer populations to more sedentary living had predictable effects on health and disease (McKeown, 1988; McNeill, 1976). Like any shift of this nature there were good and bad outcomes as the dangers of constantly moving and hunting were not as severe while living in close proximity with others increased the incidence of communicable diseases (McKeown, 1988; McNeill, 1976). This is not to say that certain lifestyles were more conducive to improved health outcomes but rather that the social structure of developing human civilizations had effects on their health. And though such social developments are also concurrent with (or even synonymous with) cultural development, the two are examined separately for the purposes of this analysis. The following will look at the concept of culture and health in relation to health as well as how cultural differences around the world may also denote the need for different standards of health and medical practice.

When discussing the idea of culture and health, it is first important to determine exactly what is meant by culture. As stated, this analysis will utilize the definition of culture as those

norms, behaviors, and values that are learned and transmitted socially (Hruschka, 2009). In an effort to be thorough, the phrases "race" and "ethnicity" should also be addressed. Malcolm MacLachlan's text entitled *Culture and Health* was used as a guide as it provides a succinct introduction of these matters that delivers a suitable differentiation between the concepts (MacLachlan, 2006). Race is the term most often associated with strict biological, usually genetic, variation and will be used as such. Ethnicity tends to remove the biological component to encompass groups that may differ on strict racial definitions but come from a common background, making it the term most closely related to culture though this thesis will use the term culture exclusively. As MacLachlan explores the term culture, he contends that the word can refer to a vast number of characteristics to describe a group of similar individuals from their biological makeup to the area from which they come from to specific behaviors, traditions, languages, and history associated with a group of people (MacLachlan, 2006). Further, MacLachlan goes on to explore the ways in which culture has developed in different groups while also taking the time to explore how cultural differences are defined, attempting to show the compartmentalization that can result from cultural labels

(MacLachlan, 2006). But, again, the crucial point for the definition of culture used here is the social learning and transmission of its components (Hruschka, 2009).

MacLachlan (2008) clearly makes a case for the fact that cultural influence, no matter the form it takes, can shape much about how a person views the world and defines their role in the world. In order to explore this further in relation to health, it is important to look at exactly how culture may translate to health (and vice versa) as well as specific instances in which culturally defined differences in groups are also representative of differences in perceptions of health and medicine. In the following sections these topics will be explored, from the ways in which generic cultural identifiers actually affect perceptions of health and biomedicine in general as well as specific practices and ailments that are particularly significant in a cultural context.

Given the variety of aspects of a group that can be considered socially learned and transmitted, narrowing down exactly how culture relates to health for certain people can be a difficult task. For the purposes of this analysis, traits that are considered more social, political, or economic will not be explored here as they have been covered in the previous section

with the WHO report on social determinants of health (CSDH, 2008). As MacLachlan (2006) discusses health and culture early in his book, he uses the context of cultural differences to discuss the practice of medicine and study of health on a global scale. Inherent in this discussion is a question MacLachlan poses, relating to whether human behavior is universal or at least to what extent human behavior can be considered universal (MacLachlan, 2006). This question gets at the root of any cultural discussion as those behaviors that can be seen in all humans, universally are those that should exist outside of any specific culture and thus can be analyzed on a global scale without employing relativism (MacLachlan, 2006). Of course, human behavior is much more complex than this and MacLachlan recognizes this, contending that human behavior differs between cultures but may be universal in that all humans are trying to generally answer the same questions or pursue the same general goals (MacLachlan, 2006). This is a nice exercise and certainly may simplify things but does not change the fact that human behavior can be motivated by any number of factors, often stemming from cultural understanding, and thus behavior may only make sense in its cultural context (MacLachlan, 2006). The result from this is often pluralism in

health, manifested in diverse understandings of health itself as well as how best to be healthy which differ cross-culturally (MacLachlan, 2006). MacLachlan (2006) references various groups all over the world including here in the United States that utilize supernatural explanations of health problems and thus attempt to employ similar tools to combat such problems. This can range from spiritually based healing practices to actually believing health and health outcomes are the will of a supernatural power and should thus be treated accordingly (MacLachlan, 2006). Given this, it is clear that discrepancies exist between groups regarding not only what is healthy but also how health should best be pursued. Further, this also brings up the much more complex topic of whether or not an objective definition of health really exists or if it is relative based on one's culture. Nonetheless, in MacLachlan's exploration of cultural differences, it is easy to see how even basic cultural identity, such as that tied to religious or spiritual belief systems, can affect definitions of health as well as guidelines for administering medical care. This idea is illustrated with a topic like death and dying as religious and cultural beliefs often address these topics as well as how to best interpret and react to them. This fact inherently makes health a culturally defined concept when

considered on a global scale including countries of all social, economic, and political development.

In terms of cultural influences that specifically affect health, it is once again seen that there is an overlap of cultural and social components, depending on what definition is used. Nonetheless, it is important to explore these influences as they show ways in which populations that may seem similar in generic terms actually interpret and react to health issues very differently. With that, Racher E. Spector's text entitled *Cultural Diversity in Health and Illness* is used as a tool for exploring such topics (Spector, 2000). Spector provides a succinct, well-organized exploration of some of these specifics while keeping in mind that many of these cultural aspects also fall into other categories including biological, social, technological, and others.

Spector (2000) references biological variation early in his analysis, stating that certain traits often associated with cultural groups such as skin color, body build, enzymatic and genetic variation, and others are all important when it comes to health outcomes (Spector, 2000). The connection to health here is obvious as these topics deal with explicitly biological mechanisms but the important point is that these traits, while affected by learned cultural behaviors, fall within the bounds of

more race-related traits as they are not socially learned but are rather passed on through biological mechanisms (Spector, 2000). Social organization is another aspect of culture that can affect health though it is also important to look at the roots of such social organization and their possible role in health outcomes. Social organization often defines a hierarchy within a society, giving certain individuals guidance as to where they should be learning about the world and their own role in it (Spector, 2000). In many cultures information is taken in by children from the example set by adults and such information is often linked to health though such organization may also assign more importance to certain individuals such as the nuclear family, political or religious leaders, the elderly, and other groups (Spector, 2000). Examples of information being passed include ways children interpret birth, death, sex, disease, and other important events and topics related to health (Spector, 2000). Communication is another cultural component of a given society that can affect health though it becomes more important when viewed in a cross-cultural context (Spector, 2000). Health and medicine are topics that are discussed in specific ways using certain languages and signals in cultures and this must be kept in mind when attempting to understand these topics in an

unfamiliar group (Spector, 2000). Spector (2000) brings up another more nuanced cultural principle, space, stating that the way an individual defines their own space and what they feel comfortable with in that space is often culturally learned. The way a cultural group interacts normally may provide a guideline as to how a person feels comfortable being dealt with in terms of medical care and health research and thus the idea of space and territoriality can directly affect perceptions of health as well as the possibility of receiving outside medical care (Spector, 2000). Lastly, Spector discusses another abstract idea in relation to culturally-based worldviews which involves time orientation, how certain people view time and its importance (Spector, 2000). Again, this topic may touch on some very significant aspects of certain cultures including how they value their own history and the people in it as well as their perceptions of lifespan and afterlife. Though this also relates to one's general mindset about planning for the future, learning from the past, and living life according to related principles, all of which also relate to one's views on health and medicine (Spector, 2000). With these general topics, Spector is able to describe broad cultural components in an effort to evoke personal cultural beliefs as well as known beliefs from other cultures in the reader to make the

case for the degree to which culturally learned principles actually affect a person's perception of their world and how to most appropriately behave within it. Because of the extensive nature of many of these components, seeing the basic link between culture and health is not difficult; culture can define a group's worldview so extensively that to try to separate health perceptions and medical practice from that is seemingly impossible.

From this, another generic topic becomes pertinent to this discussion, the idea of "culture-bound syndromes", as discussed by MacLachlan (2006) as well as other authors. MacLachlan dedicates an entire chapter to this concept, though his definition of the concept involves those syndromes that are specific to certain cultures and areas, discussing syndromes like "Koro" and "Latah", two ailments found exclusively in China and Indonesia, respectively (MacLachlan, 2006). While MacLachlan's (2006) contentions on the subject are generally correct, they are also somewhat limited which may be a result of the scope of MacLachlan's text. MacLachlan's (2006) view is that the syndromes that fall into this category are those that are quite literally bound to the culture they are found in – meaning, they are found in that culture and no where else and thus must be

considered within that context to be fully understood. However, literature exclusively examining the subject of culture-bound syndromes utilizes a broader definition, applying the term to other more common syndromes as well. Cheryl Ritenbaugh has used the term to describe obesity, saying that although obesity is a problem seen in many different parts of the world, it is important to consider it as a culture-bound syndrome in that trying to effectively understand the syndrome universally, outside of its context, does not get the full account of the phenomenon (Ritenbaugh, 1982). This more general account is appropriate, especially compared with that delivered by MacLachlan (2006), in that just because a syndrome appears in different cultures, or even universally, does not take away the importance of analyzing it within that context. In fact, considering even common syndromes cross-culturally can often elucidate aspects of them that might have not been clear in universal consideration of their incidence.

MacLachlan (2006) goes on to expand his thoughts on the subject of culture-bound syndromes, saying that with any syndrome there are usually cultural components to its appearance and propagation and that taking such aspects into account will benefit the overall understanding and treatment of

such syndromes in modern medicine (MacLachlan, 2006). From both the accounts of Ritenbaugh and MacLachlan, as well as this section in general, a case is made for the cultural and social aspects of health and disease. Time and again these components are highlighted in an effort to more fully understand disease in different areas and “culture-bound syndromes” embody this more thorough analysis of health and disease in a global society.

In the pieces discussed here, the complex relationship between culture and health is explored and through this analysis it is clear that any meaningful, thorough insight into such a relationship is difficult to provide in a succinct way. However, for the purposes of this project, it suffices to present the role that culture can potentially play in the definition and promotion of health in different areas which both Spector and MacLachlan touch upon in their works. From this it is a natural extension to think that the practice of medicine on a global scale, and thus the ethics associated with such a practice, may need to be applied in specific contexts as opposed to universally.

Health, Society, and Bioethics

As the different environmental components of health in diverse societies are discussed it is important to recognize the concept of “biological embedding” (Heymann, Hertzman, Barer and Evans, eds, 2006, Ch. 2). This hypothesis, used and developed by many over the last two decades, essentially says that diverse environmental factors affect developing humans from a very young age and this inherent diversity is embedded into their biological, particularly neurological, development (Heymann, Hertzman, Barer and Evans, eds, 2006). More specifically, socioeconomic, psychological, and developmental environments all work together to influence how a person will think about their world in all aspects but also how their actual biology develops and works. The hypothesis goes as far as to contend that all of these environmental factors have a significant enough effect on the brain and other organ systems that they can affect a person’s general health across a lifespan, including his or her general body function and susceptibility to disease (Heymann, Hertzman, Barer and Evans, eds, 2006). While this hypothesis is mainly supported by population health research and not strict biological mechanisms, much work has been done and continues to be pursued on the idea. Obviously to get such a

direct mechanism in the link between environmental factors and health outcomes would be incredibly important to studies in global and population health and for the purposes of this analysis it continues to support the idea that health is not universally applied but is the result of a number of different factors that often different between groups in different areas. Further, the idea of “local biologies” is also important to the continuation of this discussion (Heymann, Hertzman, Barer and Evans, eds, 2006). This term refers to the different ways that actual physical sensations and general well-being related to health are experienced differently by different groups (Heymann, Hertzman, Barer and Evans, 2006). This idea supports the contentions of “biological embedding” in that not only do different environments both social and cultural affect biology and health but the same environments may also affect the reporting and interpretation of things related to such outcomes.

With this exploration of environmental determinants of health it is clear that the categories of social and cultural aspects certainly overlap to some extent. The line between society and culture is difficult to define especially when comparing different populations at different levels of development. But nonetheless, the point is clear that health and medical care used to promote

and pursue health are affected by many factors outside of just biological components or any generic traits that are considered universal to all humans. Thus, when approaching the task of practicing medicine on a global scale as well as educating people on health in different areas, the endeavor becomes almost insurmountably complex. However, what is important is to promote discussion and awareness of these complexities as only in this way will the goals discussed in the WHO report (CSDH, 2008) be feasible. Further, culture must not be seen as an obstacle to increased health equity globally but rather as a tool that can aid such a movement as well an important aspect of the global society that continues to grow closer together.

Chapter 4

Global Bioethics

Thus far, this analysis has been concerned with bioethics and global health in generic terms, discussing the history and subsequent role of bioethics currently while also touching on the complexity of health on a global scale. This was all in an effort to illustrate both the difficulties and significance of global bioethics, a subject that aims to take on the complex nature of practicing medicine, promoting public health, and educating about health matters on a global scale. Now that the framework has been established, the focus will move to the actual subject of global bioethics, a term that has taken on a variety of meanings since it was first used by Van Rensselaer Potter in his 1988 book *Global Bioethics*. But given discrepancies in the use and purpose of the term and field, the current discussion on the topic involves exactly what is meant by global bioethics, whether applying bioethical values on a global level is feasible or even possible, and what benefits may come from emphasizing continued discussion and organization of such a field. This section will attempt to address the current discourse on these matters, making a case for the development of global bioethics as a possible subfield of study within bioethics while keeping in mind

that the lack of cohesion that exists now is not necessarily a detriment to its continued maturation and possible contributions.

As technology and society develop at a rapid rate, globalization is an issue that continues to affect all aspects of daily life in different groups all around the world. Globalization is a very real phenomenon and has been described as being influenced heavily by Western powers and is continually pervading global societies and cultures at all levels; economic, technological, political, social, and otherwise (Giddens, 1999). With such importance given to the continued interconnectedness between nations, there are no topics more important than health and medicine to consider as the world continues to “shrink” in many ways. As westernized, developed nations continue to have influence in the world, particularly in underdeveloped nations, the effects on health and medical practice in different societies must be carefully examined. Cross-cultural influences on health related subjects like nutrition, definitions of health, biomedical practices, and health promotion strategies have the ability to undermine long standing cultural tradition as well as social infrastructure (MacLachlan, 2006; Heymann, Hertzman, Barer and Evans, 2006). Given this, any health or medical interventions emanating from one place and being injected into

foreign populations should be done with great caution and consideration for what is actually going on in that context. Thus, bioethics on a global scale is a subject that will become increasingly important in the growing global society and a field dedicated to such discussion and exploration may be warranted. To explore the possibility and proposed function of such a field is a worthwhile endeavor at this point as little consensus exists on the matter currently and only through continued promotion of awareness and discussion may any results actually come from the attempted development of global bioethics.

History and Early Development

As mentioned, even the term “global bioethics” has been the subject of discussion and disagreement among global health and bioethics authorities alike. In his 1988 book *Global Bioethics*, Van Rensselaer Potter was attempting to separate bioethics in general with a subfield that focused more on environmental ethics, a movement supported by his contemporary Burnetto Chiarelli (Giddens, 1999; Whitehouse, 2003). In this book, Potter (1988) aims to, as the subtitle of the book states, build on the legacy of Aldo Leopold, an American ecologist and environmentalist who promoted the importance of the earth in

the study and application of ethics (Potter, 1988). Though Potter's discussion of bioethics on a global scale was more literal, actually referring to the earth itself, the legacy he left was more about his contributions to the scope of bioethics, emphasizing that it include more than just medical and environmental considerations but also religious, legal, and philosophical aspects (Whitehouse, 2003). In essence, Potter emphasized the importance of context in the pursuit of bioethics by constantly stressing the importance of the globe as a whole in terms of human health (Potter, 1988). In this way, Potter tried to get bioethicists, in the early years of their field, to think critically about bioethics on a global scale. This meant considering the function of the globe itself in bioethical matters but also the complexity and diversity associated with the people residing all over the world. And with this the term global bioethics was added to the general bioethics lexicon though discussion and exploration of what the term could and should mean would occur for years to come, continuing today.

As the development of bioethics continued into the early 1990's, discussion of global bioethics also persisted as publications arose discussing bioethics including Potter's contributions and proposed direction of the field. However, given

the infancy of bioethics in general, literature focusing specifically on the possibility of global bioethics became more commonplace in the early 2000's as authorities in the field began discussing how the more established field of bioethics might be applied globally. A number of publications arose with titles like *Cross-cultural Perspectives on the (Im)Possibility of Global Bioethics* (Po-Wah, 2002), "What is Wrong with Global Bioethics" (Takala, 2001), and "Critical care: Why there is no global bioethics" (Engelhardt, 2005). Clearly literature on the subject questioned the very possibility of global bioethics as well as the problems facing the attempted implementation of bioethics on a global scale. The aforementioned articles and others like them (Sakamoto, 1999; Dwyer, 2003; Finkler, 2008) essentially discuss the role bioethics plays in modern biomedicine and healthcare while explicitly exploring the challenges of applying such principles on a global scale. The articles all touch upon the general debate within the discussion of global bioethics which is whether bioethics may be applied universally or whether relativism must be employed to apply bioethical principles effectively (Finkler, 2008). This debate comes up often when discussing cross-cultural application of scientific or medical technologies and practices, as explored in the preceding section.

Put simply, many are unsure as to whether attempting to apply bioethics within the contexts of certain cultures and societies is a worthwhile endeavor. Some contend that doing so is nearly impossible (Po-Wah, 2002; Engelhardt, 2005) and while cultural consideration is important it simply makes the practice of bioethics too complex, especially when that practice involves the pursuit of normative claims for specific situations. Further, there is a question as to whether universal bioethical principles can be formulated for all clinical and health education settings though the analysis provided here has illustrated the difficulty of doing this given the complex factors affecting opinions on health and medicine in different areas. And thus discussion and publication on the matter continued with little resolution, up until the delivery of the most significant, official declaration related to global bioethics, coming from the United Nations Educational, Scientific, and Cultural Organization's (UNESCO) Declaration on Bioethics and Human Rights in 2005 (UNESCO, 2005).

UNESCO and Global Bioethics

UNESCO's declaration came as an update to policies dating back to 1948 (UNESCO, 2005). The declaration, in short, states that it is important, as medical and scientific technological

advancements continue, to honor universal human rights afforded to all citizens of the world though it still gives credence to the cultural and social context in which such principles should be applied (UNESCO, 2005). The declaration, while significant in its acknowledgement of the issues of human rights that surround a pursuit like that of establishing global bioethics as its own subfield, did not add much in terms of cohesiveness to the discussion. Essentially it just recognized the debate that was already prevalent in current discussions on global bioethics, that of universality versus pluralism in applying ethical principles with human rights in mind on a global scale. Further, with this declaration, articles continued to appear on the subject of bioethics with many speaking out against UNESCO including Mary C. Rawlinson and Anne Donchin in their piece "The quest for universality: Reflections on the universal draft declaration on bioethics and human rights" (Rawlinson and Donchin, 2005).

Rawlinson and Donchin criticize UNESCO's declaration saying that it inherently aims to disregard structural factors between groups that contribute to health disparities while also pursuing universal ethical values that disregard the pluralism that exists on such matters in a cross-cultural context (Rawlinson and Donchin, 2005). This notion was a common theme in a great

deal of the literature published after 2005 on the subject as more articles surfaced discussing the difficulty in attempting to universalize ethical values on a global scale given the cultural differences that often translate to different moral and ethical frameworks, particularly in relation to health and medical practice.

Beyond the work of Rawlinson and Donchin, Michael J. Selgelid also delivered a response to UNESCO's Declaration soon after it was adopted which also voiced many concerns of writers of the time. In his piece, Selgelid also criticizes UNESCO for attempting to establish universal principles on human values that inherently contradict their emphasis of differences between people (Selgelid, 2005). Selgelid (2005) contends that the Declaration essentially ignores the inevitable conflicts that will arise from the pursuit of such universality on a global scale, particularly in relation to health and medicine. These contentions make sense as UNESCO's Declaration does seem to ignore the fact that attempting to determine universal human values as a framework for the application of ethical principles will no doubt result in conflicts over the means by which many cultures define their worldview. Attempting to reconcile the different moral and human value systems of all the cultures of the world in the effort

to determine which values or morals are universal is an incredibly complex endeavor and this fact, according to Selgelid, should carry more clout in UNESCO's Declaration (UNESCO, 2005).

Global Bioethics Since UNESCO

In the aftermath of the direct responses to UNESCO's Declaration described above, articles exploring global bioethics and its possibility continued to be published. These articles continue the important dialogue relating to global bioethics, continually questioning the role of the field within bioethics, its scope, and even its very possibility. These questions are expected, of course, particularly in the aftermath of UNESCO's Declaration, which attempted to add some official organization to the pursuits of global bioethics but instead seemed only to point out the difficulties authorities on the subject had been discussing years earlier. This, in many ways, only exacerbated concerns with the continued development of the field, as illustrated by subsequent writings on the subject which displayed the same amount of tribulation – if not more – as seen in articles from the early 2000's.

Sirkku K. Hellsten provides an interesting contribution to the discussion with her 2008 piece in *Developing World Bioethics* entitled "Global Bioethics: Utopia or Reality?". In this piece, Hellsten provides an exploration of the history of global bioethics similar to what is presented here but makes an important distinction between global bioethics research and actually globalizing bioethical norms, the latter of which is a much more difficult undertaking. Hellsten emphasizes the fact that bioethics on a global level would be descriptive rather than prescriptive while also contending that even in the descriptive sense there are some normative aspects associated with bioethics in different cultures (Hellsten, 2008). Overall, the message provided by Hellsten is similar to other authors writing on this topic recently (Holm and Williams-Jones, 2006; Donovan, Green, and Jaus, 2008; Finkler, 2008): bioethics needs to be researched and thought about critically in a global context (Hellsten, 2008). Hellsten (2008) believes that doing so is a step in the right direction for bioethics as a whole as thinking this way will promote discussion and engagement of bioethics issues around the world within a global mindset. However, Hellsten (2008) also believes that this is only the first step in a longer process, endorsing the idea of global bioethics as both a descriptive and

normative tool that will be increasingly important in coming generations.

Continued Development of Global Bioethics

From this analysis, it is clear that there has been a great deal of discussion on the topic of global bioethics both from scholars in the general field of bioethics as well as from international organizations like UNESCO. From its advent, global bioethics has been subject to the general idea that as bioethics continues to grow and gain prominence in all aspects of biomedicine, a global component must be included. For some the term "global" has meant striving for universality, finding principles of bioethics and human rights that can be applied to all situations in the hopes that there can be an international standard on issues related to health and medical practice and associated ethics. However, as discussion on the topic continued, supplemented by more thorough research on cultural and social factors and their relation to health, many authors now contend that this "global" approach to bioethics needs to be acutely aware of contextual differences between groups far as bioethical principles are concerned (Whitehouse, 2003). Only in this way will the subject avoid homogenization of global groups, as task that is not only

extremely difficult but also unwarranted. Attempting to avoid cultural influences as a means of finding universal applications of bioethics would undermine what makes bioethics as a normative practice interesting: looking at specific instances and examples of biomedicine and critically discussing the context in which they occur to promote ethical and moral thinking in all global health situations. This goal also avoids the narrow-minded pursuit of the field of global bioethics striving to make specific normative claims for all situations, a task the field is not suited for currently and maybe something that it wants to avoid completely.

Further, from this analysis it is also clear that global bioethics has not developed to the point that it can be considered its own field of study. The initial goal of this project was to analyze global bioethics as it has developed within the field of bioethics in an effort to design a curriculum of some kind to study global bioethics. But with the continued fragmentation on the subject, such a goal is not realistic at this point. Given that, what can be learned from the development of global bioethics to this point and how can the field continue to move forward in a meaningful way? Given the preceding analysis of social and cultural components of health as well as the variety of publications emphasizing exploring global examples of bioethics

issues, it seems that in moving forward, this subject should focus on promoting discussion and awareness on topics crucial to the study of bioethics on a global scale. The following section aims to explore just such topics, those that lend themselves to complexity on a global level based on their strong cultural and social components. In this way, the complexity of exploring global bioethics will be on full display while simultaneously emphasizing the need for continued discussion on the subject within the context of specific issues that make the case for the need for such globally minded analysis on ethics issues related to biomedicine and health.

Chapter 5

Global Health Topics Through a Bioethics Lens

Given the preceding exploration of health in society, bioethics in general and the advent of global bioethics, it is important to look forward and determine how considerations of global bioethics may be important for the continued development of these fields. As explored in the preceding section, global bioethics is still a widely discussed topic with many debating its scope and possibility. More specifically, many question how to apply the topic most effectively and whether bioethical principles can be applied universally, on a global level, or whether relativism should be employed, thereby thwarting what some consider the goal of “global bioethics”. Given this lack of cohesion on the subject, it is clear that the time may not be right to establish global bioethics as its own independent field. Discussion on the subject, however, is still important because only in this way will continued developments in both bioethics and global health continue to consider ethical principles in the context of society and culture as they develop. Whether global bioethics will develop into its own compartmentalized subject within general ethics and bioethics is still yet to be seen.

While continued discussion of bioethics on a global level is important, there is still more specific and applicable discussion to be had on subjects related to global bioethics, particularly within the realm of global health. When global health topics are examined closely within the context of ethics, the importance, as well as the complexity, of these topics in a cross-cultural perspective comes to light. Certain specific topics like obesity, death and dying, as well as specific procedures female genital cutting are all topics that involve both biomedical and health issues as well as important and highly debated ethical issues. When considered in different cultures on a global scale, these topics become even more important to global health as it becomes clear that not all people view these topics in the same way, creating uncertainty in continued development of health education modules and medical interventions in different countries and societies around the globe. Despite these problems, however, the following exploration of such global health topics will demonstrate the need for consideration of these complex topics in a cultural context. This idea relates to the previously discussed concept of culture-bound syndromes in that generic diseases or syndromes, when examined in the framework of global health topics, demonstrate why health and

culture must be considered together (MacLachlan, 2006; Ritenbaugh, 1982). Through analysis of topics of this nature, considerations of what goals global bioethics should be exploring will be addressed while the general benefits of exploring these topics even in lieu of a defined field of global bioethics will come to light. In this way, the relativism in ethical issues will be highlighted and the complexity of these issues when examined globally will be on full display. For the purposes of this project, this complexity is a good thing, supporting the need for continued discussion and organization relating to global bioethics though it will also show why application of such a field is difficult and thought to be impossible by many. However, despite what the future may hold for global bioethics as its own discipline, the following will show that global health issues, particularly in relation to ethical principles, are much too complex to be approached with the current state of bioethics in general.

The following topics attempt to address different categories of important considerations in global health. From specific biological ailments like obesity to more philosophically minded concepts related to medicine like death and dying, all of these topics relate in some way to perceptions of health. From their

examination, this analysis hopes to demonstrate that while relating to health and medicine, these topics are also incredibly important to social and cultural aspects of societies. Thus, when they are addressed even from a purely biological and medical standpoint, there may be unavoidable cultural components that need to be addressed depending on the context. And in this way any ethical considerations related to these topics are also dependent on such social and cultural components.

Obesity

The concept of obesity is incredibly important in global health today as many countries, particularly the United States, witness increasing rates of obesity in their populations (Caballero, 2007). As obesity continues to pervade industrialized societies all over the world, global health researchers are working to better understand this problem as well as how it is perceived by different groups, particularly cross-culturally. This work is important because, beyond a strict biological definition and interpretation of obesity, its causes, and its ramifications, understanding how the problem is interpreted socially and culturally may contribute to effective education and intervention against obesity. In this way, the actual strict biological

interpretation of obesity almost takes a backseat as even if a group of scientists and physicians agree on a certain definition of obesity and what it means, this definition loses significance if it is not recognized and corroborated by cultural and social perceptions of obesity. Further, it is difficult to work effectively to thwart of obesity around the world if strategies to do so may be effective in one area but wholly ineffective or even counterproductive in other areas.

To understand obesity as a function of developing societies and cultures, it is crucial to look at the history of obesity and exactly how it has become prevalent in some populations and societies but not others. This phenomenon has a lot to do with the history of food production and consumption in human societies which was dynamic across societies as humans developed, resulting in modern societies that have different opinions and perceptions on calorie consumption and associated ramifications, such as the incidence of obesity (Ulijaszek and Lofink, 2006). Obesity is actually a relatively recent development in human health, being seen as a serious problem only within the last 60 years or so, though sporadic instances of obesity have been recorded as long as 10,000 years ago (Ulijaszek and Lofink, 2006). The increased appearance of obesity in countries

all over the world is closely tied to industrial development and increased food security, demonstrating that historically speaking, obesity trends are the result of a combination of biology and environmental factors (Ulijaszek and Lofink, 2006). The technological advancements leading to these trends include better food storage tools as well as more efficient food production systems, allowing societies to abandon foraging tactics in favor of more efficient means of obtaining, consuming, and saving sources of sustenance (Ulijaszek and Lofink, 2006). As societies continued to use these tools, food security was increased and as societies continued to develop around the world, obtaining food and appropriate calorie intake became less of a problem (Ulijaszek and Lofink, 2006). Thus, as societies around the world began to show disparities in development and affluence, food intake began to be a problem in some areas but not others, a problem we see even today.

What's important to realize about these developments, however, is that social and technological developments surrounding the consumption of food were progressing faster than evolutionary forces could affect the genetic tendencies of humans in terms of calorie storage and use (Lev-Ran, 2001). Put simply, human behavior in societies where food was readily

available did not match the genetic tendencies of humans at the time which stored fat as much as possible due to the expected scarcity of food that had been seen in earlier human society (Lev-Ran, 2001). This relates to the idea of a “thrifty genotype”, a concept first discussed by Neel in 1962 in relation to diabetes (Neel, 1962). This idea basically states that there are certain genotypic tendencies which were selected for as humans developed which eventually became unnecessary or even detrimental as human societies developed faster than evolutionary forces could act (Lev-Ran, 2001, Neel, 1962). With this genetic phenomenon still existing even in areas where food has become abundant due to advancements in human societies, it is no wonder that obesity has become a problem in many industrialized societies whereas it still remains a sign of abundance, status, and wealth in developing countries and indigenous populations (Ulijaszek and Lofink, 2006; Lev-Ran, 2001; Brewis et al, 2011).

Given the close ties of obesity to social development, it is logical that there is a cultural component to obesity, its causes, and opinions on its incidence in populations. Obesity has been described as a “culture-bound syndrome”, a concept discussed earlier, which means that it is difficult to fully understand the

concept outside of the cultural context it appears in (Ritenbaugh, 1982). For obesity specifically, this label makes sense as it states that opinions on obesity and the varying levels of value given to it are very much a product of the society in which it appears, as well as the development of that society over time (Ritenbaugh, 1982). Studies on the concept of obesity as a global issue have shown varying levels of stigma related to the ailment depending on the area in which it appears, though the general attitude toward obesity in industrialized societies has been negative (Brewis et al, 2011). Dr. Alexandra Brewis of Arizona State University has been conducting a widespread study attempting to study the diffusion of opinions on obesity in different areas around the globe, showing that while generally opinions on obesity show negative attitudes toward it, ideas on causes and responsibility related to obesity are usually culturally learned (Brewis et al, 2011). Studies like this one aim to demonstrate the complex problem that obesity represents, being a concept that is not strictly biological but rather heavily dependent on the society and culture in which it is seen.

From this discussion, the topic of obesity as a global health topic is clearly just as dependent on social and cultural factors as it is on biological components. To truly understand obesity as a

global epidemic, as it was classified by the World Health Organization in 2000 (Caballero, 2007), global health scientists and physicians must work together to incorporate social science research such as that being done by Dr. Brewis (2011). As discussion of the topic of obesity continues to pervade scientific journals as well as popular media, these considerations will be increasingly important, particularly in the pursuit of effective measures to educate individuals on obesity as well as combat against it. Further, as these goals are considered in terms of their ethical merits, it becomes clear that cultural and social considerations are immensely important to the idea of obesity, particularly when trying to determine what methods of education and intervention should be considered objectively “right” or acceptable. In some societies intervening on increasing levels of obesity seems like an ethical and beneficial endeavor, given the way environments are contributing to such a health problem without people’s conscious knowledge. However, in other areas, doing so may disrupt the social organization of a group where obesity may not necessarily be prevalent or extremely problematic and thus intervention may not only be unnecessary but also unethical.

Death and Dying

While obesity represents a more strictly biological condition that, as discussed above, has come about from both genetic forces as well as social and cultural development, other topics in global health are more nuanced in their relation to strict biology though their place in cultural identity is clear. Perceptions and traditions of death and dying are exemplary. Death and dying is a topic that clearly relates to health while also being interpreted very differently in various societies. This section will briefly examine some examples of how death and dying, an objectively medical phenomenon, is interpreted and dealt with in varying ways cross-culturally as well as how this phenomenon affects health in general in different areas.

Rituals surrounding death vary greatly from culture to culture and are often rooted in historical or religious tradition. Spector's previously mentioned text, *Cultural Diversity in Health and Illness*, explores this topic, discussing the various ways in which different groups of people interpret and deal with death. Spector lists various rites and rituals associated with dying from countries all over the world, exploring rituals attributed to specific groups and countries ranging from explicit rites dictated by religions such as Islam to cultural practices seen in some

areas, such as "Death at home preferred" ,"Close family members stay with person", "Fatal diagnosis not discussed with patient and family" (Spector, 2000, p.130-138). Beyond this, Spector also covers some of the more religious or philosophical cultural components of dying including believing in reincarnation, belief in an afterlife, consciousness at the time of death and after, and many others (Spector, 2000). In essence, Spector displays the wide variety of death rituals and beliefs associated with the locations and cultures of the world, showing that death is not interpreted or dealt with in a universal way by any means. Of course, each group has reasons for believing and acting the way they do when it comes to death, but this leaves a lot of questions for medical professionals and bioethicists looking to interpret and make end of life decisions for all people, despite their backgrounds. With this, once again the overlap between cultural and social health with biological health is seen and the topic of death and dying, particularly in relation to ethics, becomes much more complex.

A major discussion related to this topic involves definitions of life and death, particularly pinpointing the criteria by which death may be defined in all people. Of course, with culture being such a strong influence on a subject like death, it makes the job

of physicians and bioethicists in relation to this topic very difficult. Ahmed Ammar in "The influence of different cultures on neurosurgical practice" discusses the way globalization has contributed to the interaction of different cultures in clinical settings and the way this complicates many medical topics including definitions of death (Ammar, 1997). Ammar (1997) discusses the way in which less developed nations have a tendency to accept death more easily as they do not expect medical intervention to extend life the way many in more affluent countries expect it to. Further, Ammar (1997) contends that "brain death" is, for the most part, accepted by most cultures as biological death but also mentions that the grieving process and associated rituals may also have their effects on health and may go against what medical professionals would recommend. Even with strict biological definitions of death like "brain death", death is a complicated subject for many cultures and anecdotal evidence demonstrates how this can be detrimental to universal practices related to death and health care at the end of life.

One such example of this comes from James Hughes' piece on "Buddhism and Medical Ethics" in which he explores many aspects of bioethics and traditions of Buddhism, taking the time

to specifically explore death and dying in the culture (Hughes, 1995). Here, Hughes (1995) specifically discusses the way in which rituals that take place even after medically and culturally accepted death occurs actually inhibit effective transplantation of organs (Hughes, 1995). This example, while anecdotal, still gets at the root of the discussion of this topic. If a physician or any medical practitioner has a patient die who is an organ donor, do they have the right to override the culturally based wishes of the grieving family to immediately harvest the organs because this will ensure the highest rate of success in transplantation?

Obviously this is an incredibly complex medical and ethical question in which a universal pursuit of health is hindered due to cultural beliefs not shared by all people. And, as Hughes discusses, instances in which medical personnel from one culture treat patients from another culture are becoming more commonplace and questions like this are inevitable (Hughes, 2005).

From this analysis, it is clear that death and dying, much like obesity, are phenomena that while obviously related to health concerns are also deeply connected to cultural and social beliefs. Much like obesity, perceptions of death as well as how it should best be approached and responded to are often culturally

learned (Spector, 2000), and thus medical and ethical questions related to this topic must take social and cultural context into consideration. However, unlike obesity, death is an inevitable phenomenon in all societies and cultures and thus, as globalization continues, it is something that medical professionals will constantly have to deal with in different ways. Questions about the extent to which medical professionals will need to be aware of cultural considerations related to death and dying need to be addressed and this is exactly the type of discussion that could be facilitated by the continued development of global bioethics as a whole.

Female Genital Cutting

Yet another topic in the vein of those discussed thus far is the act of female genital mutilation or cutting (FGC), a set of practices described by the World Health Organization as “procedures that intentionally alter or injure female genital organs for non-medical reasons” (WHO, 2010). FGC is not as common now but has still been seen in East and West Africa as well as the Arabian Peninsula (Cook, 2002) and it has been reported that 130 million girls and women worldwide have been subjected to FGC while many more are still at risk for being

subjected to it even today (Cook, 2002). The reasons for the procedure are a mixture of cultural, religious, and social ones including giving into social norms, the pursuit of proper sexual behavior as dictated by religious dogma, striving for culturally valued ideals of femininity as well as modesty, as well as others (WHO, 2010). More specifically, the procedure is intended to make women “cleaner”, while also decreasing their libido, thereby promoting religious and cultural tenets related to women in society (WHO, 2010). Further, the procedure has been perpetuated due to various social groups attempting to assimilate with other nearby groups who traditionally perform and undergo FGC as they try to adopt and become part of local culture (WHO, 2010). Given all of this, it is clear that, while the stance of the World Health Organization and many other authorities is that there is no medical benefit to the procedure, it is still a topic that relates very closely to health on a global level and specifically the way that cultural, religious, and social beliefs can affect the health and well-being of those subjected to them.

Given this history and explanation of the phenomenon as well as its continuation even today, it is logical to consider the role this topic and others like it play in the big picture of global health and global bioethics, particularly as globalization continues to

affect clinical medicine on an international scale. In short, FGC is a prevalent practice in certain parts of the world and is something that medical professionals from all over the world may encounter in clinical settings and thus is something they must be familiar with in order to deal with it properly. Further, knowledge of the factors contributing to the continued implementation of this procedure might be important information for these medical workers as they attempt to communicate with their patients on what exactly has happened to them and what it means for their future sexual and reproductive health.

With the prevalence of this practice in various parts of the world, political and social outcry against the act has become more frequent. The WHO definition of the act states that there is no medical benefit to FGC and thus those subjected to it are seen as victims, forced to undergo procedures in order to remain accepted members of their cultural, social, and religious groups despite possible health problems and negative consequences that may result from the unwanted procedure (WHO, 2010; Cook, 2002). This puts medical professionals in tough position, particularly with the movement toward the “medicalization” of the procedure in which health professionals would perform the FGC under monitored, hygienic conditions rather than the less

than ideal circumstances in which the procedure is often carried out (Shell-Duncan, 2001).

This brings up a complex ethical debate in that any health professional's primary goal is to do no harm, and many consider FGC to be harmful and not beneficial in any way (Shell-Duncan, 2001). However, medicalizing FGC would also ensure that a procedure that would be carried out anyway is done in the safest way possible, thereby minimizing many complications and negative effects that make FGC such a heinous act in the eyes of anti-FGC advocates (Shell-Duncan, 2001). Many believe that the movement toward making the procedure more medically sound, even when performed by health professionals that may disagree with the act, there is movement away from the goal of total eradication of FGC (Shell-Duncan, 2001).

No matter what side of the aforementioned debate a person is on, it is clear that there is a need for medical information on FGC for physicians and other health professionals that may encounter the phenomenon in a clinical setting. Such information already exists in the form of clinical guides to genital mutilation, usually detailing the most common types of the procedure and pertinent medical information related to the act. These guides also often include cultural information on the subject as it has

become more clear that it is hard to treat and discuss the consequences of FGC outside of its cultural, religious, and social contexts. Guides like Dr. Nawal M. Nour's "Female Genital Cutting: Clinical and Cultural Guidelines" from the *Obstetrical and Gynecological Survey* are invaluable tools for clinicians that already encounter these issues in their practices (Nour, 2004). The guide emphasizes the idea of cultural competency when dealing with a sensitive subject like FGC though the inclusion of such information is out of necessity rather than with the goal of actually promoting meaningful discussion on the subject, why it continues to exist and what to do about it. Despite this, the guide is important for current clinical intervention and education on FGC as it details what the clinician may encounter when dealing with a patient that was subjected to the procedure as well as guidelines on how to best direct the patient in future care (Nour, 2008). In this way, the guide is pragmatic, it deals with the situation as it exists now and facilitates effective treatment and spread of information on the subject. However, given the extensive ethical, cultural, and health-related aspects of the topic compounded with the harmful nature of the phenomenon, there is still a need for continued discussion and debate on FGC

with many pushing for the eventual complete eradication of the act.

As discussed, the link between FGC, global health, and cultural and social considerations is quite clear. Like the topics discussed thus far, there are clearly a number of considerations both clinical as well as ethical for medical professionals to take into account when dealing with this subject. However, unlike topics of obesity and death and dying, this subject surrounds a phenomenon that many consider an avoidable and tragic occurrence restricted to far away cultures and people. And yet, this is still something physicians all over the world may have to deal with in one way or another and thus it is important to promote awareness and discussion on the topic. Not just on the medical and cultural guidelines but also on the development of the debate on the topic, the ethical principles that may apply in different situations related to FGC, and how these implications affect clinical approaches to the topic. Again, the complex nature of this subject lends itself to organized discussion on the matter, discussion that could be commonplace in global bioethics as it continues to develop.

Global Bioethics and Global Health Topics

The preceding section attempts to illustrate the current state of global bioethics by demonstrating just a few of the extremely complex topics that may fall in its realm. These topics are only a few of the myriad that could have been selected. Other topics of importance include organ transplantation, general epidemiology, reproductive health technologies, sexually transmitted diseases and associated prevention topics, and many others. Further, more abstract global health topics are also important including ideas of distributive justice in public health, patient autonomy and rights, and even specific theories of global health like personhood theory, the pursuit of understanding how a person is defined within a certain group and how this relates to specific health issues (Macklin, 1983). The topics explored thoroughly in this section, however, are more concrete and thus provide a clearer illustration of bioethical considerations as they relate to global health. Future discussion and consideration of such topics should be aware of the more nuanced public health-related topics as these are continuing to gain prominence and importance (Holland, 2006). The general points illustrated with these topics, however, may easily be extrapolated to other topics of global health as even in the analysis of these three

topics comes a vast number of ethical dilemmas and situations that may not be easily addressed universally.

As stated, global bioethics as its own discipline does not seem organized or developed enough to merit degree paths and entire curricula dedicated to it. However, when considering the goals and tenets of global bioethics in relation to global health topics like those here, it is clear that there is already a need for bioethical considerations on a global scale in relation to health and medicine in different cultures. Such discussion is assumed to naturally occur in the discussion of these topics but for the benefit of global bioethics as its own field these discussions should be framed within the developing subject. By doing this, extensive, meaningful discussions on global health ethics topics may give way to an actual framework for the field itself. Debates like universality versus relativism will be brought up organically in these discussions but it is also important to ensure that awareness of these topics and their relation to global bioethics is emphasized. Only in this way will discussions on these topics – which are undoubtedly already occurring – benefit both global health as a field while also contributing to the development and legitimization of global bioethics as its own discipline within bioethics and ethics in general.

Chapter 6

Discussion/Conclusion

Due to the descriptive nature of this project, it is difficult to say succinctly what conclusions may be drawn from this analysis that translate to explicit developments in the continued growth of global bioethics. However, the lack of cohesion in the field is evident as a result of this analysis, showing that even with years of discussion and growth, little concrete application exists for global bioethics right now. Thus, as explored in the preceding section, the most important goal related to global bioethics now might be promoting discussion and awareness on the topic, its development this point, and the aspects of global health and medicine that may benefit from its establishment as its own field.

Global bioethics is a compelling and important subject because of the way it contributes to larger, established fields like bioethics and global health while also showing foresight to issues that may lie ahead. Specific topics of health technologies and interventions lend themselves easily to ethical discussions and, as shown, are even more interesting and complex when discussed cross-culturally. Beyond this, issues inherent in comparing health in different countries such as those related to

distributive justice, cost-effective healthcare implementation, perceptions of health in social and cultural contexts, and many others also bring about important moral and ethical discussions. And in all of these topics, it is important, particularly at this point, to not attempt to pursue universal normative claims on global health and its practices but rather facilitate discussion of and contributions to a general ethical framework of health and medicine globally.

As discussed, the idea of globalization will affect countless aspects of interaction between people in different parts of the world and this phenomenon is particularly clear in health and medicine. Obviously, many health care providers exist around the world that aim to deliver a high standard of care to those they serve, though they are often limited by their resources. Given this, international organizations also exist to try to make up for health disparities that are seen currently, attempting to provide medical care from developed nations to areas that do not have the personnel or equipment to treat patients effectively. Further, beyond direct care, the dissemination of information about health and disease is important, particularly in underdeveloped nations where such information is not readily available. Technological developments contributing to the

“shrinking” of the world means that people from all over the globe can interact more readily and more frequently. This increased global interaction highlights the differences between people that define them and their worldview and behaviors. These cultural components mean that the practice of medicine and study of health is not specific to one area or type of person. And with this trend, undoubtedly a movement to universalize medical practice and perceptions of health would seem inevitable, while a similar movement pushing to constantly take context into account when considering these ideas is also expected.

Global bioethics is at the intersection of these two movements, but should not necessarily aim to make a judgment for one side or the other but rather recognize how complex health and medical concerns are when considered on a global scale. Such an idea may help guide continued development of bioethics itself as it is clear that this field is going to face issues of social and cultural context more and more in coming years. This will in turn promote discussion and awareness of these issues for professionals working in fields related to health and medicine globally.

With this current goal, the natural question is exactly what a more developed iteration of global bioethics could offer to global health, medicine, and bioethics in general. From this analysis, it seems that the major debate within the development of the field is that of universality versus relativism. This makes sense, as the core of this subject explores exactly what role the cultural and social context of a medical or health situation should play in carrying out clinical care and health research and education. However, given the specific topics discussed that lend themselves to in-depth discussion of bioethics in a global and cultural context, this debate might be missing the point. As clinicians and health researchers continue to explore their fields on a global scale, it is not a question of whether they should recognize the cultural context they encounter as such aspects of societies exist and affect things – regardless of whether these workers choose to acknowledge them. Thus, a better goal of global bioethics, rather than solving the relativism versus universality debate, might be to simply approach health and medicine knowing that cultural and social components are a major part of these subjects on a global scale just as they are on a local scale. With this, the goal of the field no longer relies on actual prescriptions for global health and international medical

practice. Instead the field would aim to objectively determine what makes health and medicine more complex and interesting when analyzed globally, setting up a reference or framework for medical and health workers that are attempting to reconcile the objectivity of medicine with the fragmentation of perceptions of health and medicine seen in different societies and cultures.

Goals of this Thesis

With these ideas in mind, it is important to address the original questions posed by this thesis now that the analysis has covered many of the components that have contributed to the development of global bioethics historically as well as examining contentions on where it might be going. Based on the preceding exploration of bioethics, health as a function of society and culture, global bioethics itself, and health topics pertinent to this discussion, it is no wonder that many bioethics authorities have contributed their thoughts on exactly what it means to discuss global bioethics. Stemming from Potter's (1988) initial discussion of the idea, the term has evolved and taken on a variety of new meanings and associated debates, but threads of Potter's initial ideas remain. When speaking on the subject of global bioethics, Potter (1988) emphasizes the myriad of considerations that

bioethics in general should encompass while making specific references to the globe and environment itself. But as Potter (1988, p.151) extends these ideas and attempts to define the term more specifically, his focus is that of giving consideration to the context in which bioethical considerations are applied, emphasizing diversity of all kinds in the world and the associated importance of recognizing this diversity in matters of health and medicine.

From this, subsequent decades of discussion and publication on global bioethics wrestle with this general concept. Aforementioned articles on the subject and its scope and possibility attempt to articulate the importance of context of culture and society in health and medical issues while also struggling with how such components fit into bioethics in general. Thus, when it comes to authorities on global bioethics currently and the evidence used to support their opinions, fragmentation still exists. Even a cursory exploration of global health as it relates to bioethics provides evidence of the complexity of trying to give cultural context its due in relation to health and medicine. Whether from specific topics like those in the preceding section or more politically minded issues related to health, the complexity of issues raised by these issues when

considered globally is striking. And thus, little consensus marks discussions and publications on global bioethics currently as it seems some are attempting to elicit the wrong kind of results from the continued development of the subject. As discussed, the idea of relativism versus universality in the application of ethical principles in health and medicine globally may be misguided. In many ways, the current exploration of the topic is beneficial in that it may lead to the realization that not only is this debate devoid of a clear winner but is also unnecessary in the pursuit of global bioethics as a concrete subject and contributor to bioethics as a whole.

When considering the role of global bioethics within the larger fields of bioethics and general ethics, Robert's piece on a "better bioethics" provides pertinent framing. As Robert discusses, bioethicists should strive to be architects of moral space as the field continues to develop and this seems to be very applicable to the development of global bioethics. Rather than striving for concrete normative claims in all instances of global health ethical situations, the field should be more concerned with constructing usable frameworks and styles of thinking related to global health and bioethics. In this way, the field may emphasize discussion on complex topics and situations related to health

interventions globally and may even be able to make judgments on specific situations but, perhaps more importantly, the field may also be apt to discuss far more complex topics that might not lend themselves to concrete moral and ethical judgments. In this way the subject of global bioethics may benefit bioethics in general by infusing it with some principles that guide work in global and public health research.

Thus, when looking forward to goals that should be pursued by global bioethics through its development, the emphasis should not be on relativism versus universality of health and medicine and, in turn, universal bioethical principles but rather the continued awareness of why these issues are worth discussing and exploring. Universality on these topics might facilitate policies and intervention procedures related to health and medicine but would also take attention away from cultural and social components that make the world interesting. Awareness and discussion on these components will contribute to the fields of medicine and global health by continually reminding clinicians, health researchers, and educators that medicine and health may not be fully understood when taken out of their social and cultural contexts.

General Application

What is important to consider regarding global bioethics is that, although applying bioethics in such a way has resulted in a great deal of disagreement and divisiveness, such a pursuit may also benefit the general field of bioethics greatly. While cultural and social context complicate many of the aims of bioethics, they may also contribute to the continued development of the field in general by adjusting some of its goals and means. Particularly in relation to normative claims of bioethics, global bioethics illuminates the fact that pursuing concrete decisions on ethical matters may not be the most beneficial means of improving biomedicine and public health in their relation to human values. The difficulties and complexities associated with global bioethics are the result of attempting to reconcile the vast differences between societies and cultures across the globe but what is important to remember is that these differences exist and affect health and medicine whether or not they are explicitly recognized and taken into account. By constantly emphasizing these issues and the ways they complicate ethical application will benefit the ways in which bioethics itself is practiced.

This type of thinking should make bioethicists as well as clinicians, researchers, and even policy makers more apt to

address issues of global health and health disparities that lie ahead. Considering the context that contributes to these issues between countries, particularly those related to resource distribution and human rights as they relate to medical care, may bring about a more complete understanding of why disparities occur and how to best combat them. This idea touches on the concept of public health ethics, applying much of what has been discussed here to how health may be best researched, pursued, and understood globally. This concept will be increasingly important as bioethics develops and is applied globally as such an application is not just about specific health topics and medical interventions but also related to how health is perceived by the public and thus, how the public chooses to interpret health information and interventions. This will be important to groups like WHO and UNESCO as they attempt to understand the reasons for trends in health and disease globally and attempt to implement strategies and plans of action for responding appropriately to health disparities and epidemiologic trends and associated interventions.

Further, when considering specific health interventions and technologies, promoting bioethics in this way may alleviate some of the confusion and ignorance that contribute to

misunderstandings of health interventions as well as perceptions and pursuit of health. Clinicians, no matter their background, will be more aware of cultural and social matters as they relate to health and medicine, thereby making them more adept at caring for patients from different backgrounds. This is important for the practice of medicine all over the world as international health organizations continue to utilize workers and their tools to promote global health but beyond this, it may benefit the fields of global health and medicine domestically as well. As these fields continue to develop and change, a globally focused viewpoint will be increasingly important, particularly in relation to increased globalization and technological advances discussed earlier.

Conclusion

With this, it may be off-base to try to consider the role of global bioethics as its own subfield within bioethics. Rather, the continued discussion of the topic as it is now may benefit the continued development of bioethics as a whole. The logistics of how global bioethics will be discussed and taught are not a priority at this stage. Instead, it is important to make sure that discussions on the subject are shaping the continued

development of ethical frameworks and associated styles of thinking as they relate to health and medicine across the globe. This mindset will assure the most beneficial contributions from global health to related fields as development continues on all fronts.

Global bioethics' contributions to global health considerations in relation to specific topics and ailments like those discussed in the preceding section are obvious. People interpret these topics and procedures differently based on their cultural and social backgrounds and thus when trying to understand how these topics should best be dealt with globally, these contexts must be taken into account. Topics more related to the ethics of public health on a global scale contain the same ethical issues but may be even more complex, getting at the root of the social, political, and economic factors that contribute to health disparities. Given the complex nature of these topics, global bioethics should not concern itself with making specific claims for all situations related to global health, public health, and medicine cross-culturally but should hope to guide the continued careful consideration of these topics, their ethical pitfalls, and how dealing with them effectively may improve health worldwide.

Moving forward, it is important again to consider Robert's call for bioethicists to be architects of moral space (Robert, 2009, p.287). This prescription marks the development of global bioethics as only through such means will the subject contribute positively to general developments in bioethics, global health, and medicine in general. As the world continues witness a growing global society teeming with people from different cultural and social backgrounds, context must always be considered in the practice of medical care and pursuit of health and this is a concept that should be important to all health and ethics professionals in coming years.

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