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BIOETHICS ACROSS BORDERS
AN AFRICAN PERSPECTIVE

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ABSTRACT


Bioethics deals with the ethical problems arising from the developments in life sciences and biotechnologies. Western autonomy-based philosophical framework has dominated the approach of mainstream Bioethics. Yet, many of the assumptions implicit in the Western framework that makes claim to universal validity may not be shared by non-western cultures. Moral pluralism poses a challenge to a common bioethics. Pluralism is understood as a descriptive term, which refers to the existence of different outlooks - moral or religious in a given society. It is another word for diversity.

Within most western societies, the principle of autonomy sometimes implies that every person has an atomistic right to self-determination. In most African culture, however, the person is viewed as a relational self, one whom social relationships and inter-dependence rather than individualism provide the basis for moral decisions.

Through a critical analysis of the *Principles of Biomedical Ethics* by Tom L. Beauchamp and James F. Childress; the *Foundations of Bioethics* by H. Tristram Engelhardt, Jr.; and the *Morbility of Pluralism* by John Kekes, the author addresses two challenges. The first one concerns the possibility and desirability of a common bioethical framework in a society with a diversity of moral visions. The second deals with what could be the contribution of African thought, philosophy, and culture to such a project.

By exploring some of the worldviews of the Igbo of South-eastern Nigeria, the author shows that different cultures have different significances in bioethical analysis. He argues that an acceptable bioethical framework should be sensitive to the cultural realities of the people where it is employed and contextual in its application. At the same time, it should take account of the common morality feature of human experience. He formulates three prima facie common morality principles as meeting the challenge of Bioethics within the African context.

Keywords: bioethics, pluralism, common morality, ethics, Beauchamp, Childress, Engelhardt, Kekes, Igbo, Africa, culture, worldview, solidarity, community, illness, and medical care.
To my father, Iheanaetu
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Introduction

Object of research

Our age arguably can be described as a bioethical and biotechnological period. The reason is that there have been tremendous developments in technology and life sciences. This has given rise to fundamental questions concerning our value systems. Bioethics emerged as a response to these challenges in the life sciences and medical practice.

As a discipline, bioethics has established itself in North America, Europe and in some parts of Asia. Western philosophical systems dominate simply ethical theories and frameworks employed in health care or bioethical issues today. Yet, many of the assumptions implicit in a Western autonomy-based approach to bioethical problems may not be shared by non-western cultures.1 For example, dichotomies such as autonomy versus paternalism, individual versus community characterise much of the Western analyses in bioethics. The concept of autonomy best highlights the contrast between Western and non-western cultures especially Africa. In most of the West, the principle of autonomy implies that every person has an absolute right to self-determination. However, the person is viewed as a ‘relational self’. It is a self for whom social relationships rather than individualism provide the basis for moral judgement within the African culture. The family is the primary social unit and plays a central role in an individual’s life. It is responsible for the well being of her members especially the aged, sick, disabled, and the unemployed.

As many African people migrate to Europe and America and enter the health care systems of the West, it is important that health care

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providers understand their cultural perspectives to health care. This is because all cultures have explanatory models that attempt explicitly or implicitly to account for the phenomena of illness, health, health care, suffering, death, and dying. Thus, cultures differ in their conceptions concerning these issues. There is then need to identify and respect differences between cultural models in order to offer effective treatment. In Western medicine, the primary explanatory model of illness focuses on abnormalities in the structures and functions of bodily organs and systems. On the other hand, traditional African medicine views disease from a meta-religio and social perspectives. By implication, the body, soul, and spirit constitute an integrated whole. African culture, therefore, rejects scientific materialism that constitutes the primary basis for understanding and interpretations of things and events in the West.

It could be argued that most African countries have their moral perspective dominated by their worldview. Following from this, the African conception of the relational self has significant implications for many of the issues in bioethics for example reproductive ethics, human genetics, research ethics, principles of autonomy, justice, illness, health, health care, informed conscience, death, and dying. There are divergent viewpoints and judgements from various cultures regarding these issues. Given this, there is need for health care providers to be sensitive and respectful of the varied explanation models patients bring to the clinical encounter.

Employing relevant tools from medical and cultural anthropology, numerous researches study cultural variations in attitudes toward health, truth telling, informed consent and end of life decisions. These qualitative studies of cultural practices contribute to distinctive understandings of decision-making in relation to family life, informed consent etc. This is a welcome development in bioethics scholarship. The reason is that it makes bioethics sensitive to the cultural realities of people outside the West. Added to this is the fact that cultural explanations of health and illness along with the

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3 I will return to this term later in my explanation of the terms used in this study.
appropriate social roles of the family are interwoven with the interpretation of what constitutes thoughtful and justifiable moral conduct.

As bioethics has gradually developed a global consciousness, new voices especially from some parts of Asia and Latin America have been added to the hitherto western voice. The African voice is missing. The reason is that in many African countries bioethics, as a discipline is not yet established. The pooling together of the intellectual and moral resources of the different cultures constituting humanity, taking seriously its diversity and plurality is the best effective solution to the ethical challenges posed by these developments in biology and medicine. This explains why bioethics from an African perspective is important. One of the aims is to explore how African culture could contribute to an appropriate framework for bioethical problems. There is also need to examine how western framework now employed in bioethics relates to African culture.

My research is an attempt to confront this challenge. In particular, I am exploring what could be the contribution of African, specifically Igbo culture to bioethics. Bioethics could be argued to be irrelevant to African culture since much of bioethics is dealing with cutting-edge technologies that are hardly affordable in most countries of Africa. The obvious implication and relevance of cultural values to bioethical deliberations, however, meet this objection. As I noted earlier, there is need for health care givers to understand the various cultural models of explanation patients bring to the health care setting. There is need for this kind of study not only to highlight bioethical issues in Africa but also to empower people to make informed decision as it relates to these technologies. Furthermore, it is important to provide health professionals in a pluralistic society, who often care for patients whose cultural, religious, or social contexts, differ from their own bioethical framework that could help them in their work. Studies show that attention or lack of attention to cultural differences could have significant implications on the outcome of health and healthcare between physicians and patients.4

Why the focus on Nigeria

My study is about Africa but focuses on Nigeria especially with the Igbo people of South Eastern Nigeria. At the movement, there is little or no knowledge of bioethics among most Nigerians including health care professionals. However, some initiatives have been taken to create ethical awareness in the country. The Institute of Advanced Medical Research and Training (IMRAT), College of Medicine, University of Ibadan held a national bioethics workshop for researchers of the Ethics Review Committees in June 2004. It was equally an occasion to launch the Nigeria Bioethics Initiative (NBIN), an organisation that aims to improve the researchers and members of Ethics Review Committees on how to conduct acceptable research involving human participants. There is the West African Bioethics Training Programme located in Ibadan that helps organisations with establishing Internal Review Board (IRB). However, current efforts are not sufficient to meet the needs of the country. Apart from some articles and a few doctoral projects, very little materials are available in this field.

Problems and Aims

Post-modern society is pluralistic. Africa is a pluralistic society with diverse peoples and cultures. Taking pluralism seriously is a fundamental requirement of bioethics. Although, most of the cutting-edge technology that gave birth to bioethics is scarcely available in most countries, however, the need for bioethical knowledge is present in the continent. Already research involving human participants has been the topic of controversy especially in relation to the testing of HIV vaccines on infected mothers.

There is an increasing desire in most countries today to integrate considerations of ethical issues into policy and political decision-making. The developments in technology and biosciences and not least the globalisation processes have given rise to practical, theoretical, ethical, legal and anthropological problems. The impact of this has been great in the fields of medical research and practice. These developments necessitate the need for a re-examination of the underlying assumptions of established practices originating from religion, politics and various moral traditions. One of the major problems these developments raise in bioethics concern how one can rationally justify a given position to others that may not share the same theoretical or moral framework. What could be the framework for such a practice? My presupposition is that African value system and culture could provide some insights in these issues.

The problem of my investigation is to explore if it is possible for people with different conceptual and moral visions to share a common bioethical framework. There are various positions that have been defended in response to moral and ethical pluralism. For my part, what interest me in this study are the theoretical and normative questions of how African moral thought and value system can contribute to this discussion. I hope to formulate what I consider an appropriate framework for African bioethics. This research shall focus on three fundamental research questions:

a) Is it possible and desirable to formulate a common bioethical framework that could be shared by individuals and groups in a pluralistic society and how?

b) What is the basis for such a common bioethics?

c) What could be the contribution of African culture and value system to the issues of bioethics?

In the light of the foregoing, the aims of my study could be simply stated.

1. To critically analyse three western theories in the fields of moral philosophy and bioethics that have tried to answer the question of how a common bioethics could be articulated.
2. To analyse what could be the contribution of African thought, culture, and value system to a common bioethical framework.

3. To contribute to the discussion regarding what could be an appropriate framework for a common bioethics in a pluralistic society.

It might be asked why I have chosen to address both the question of a common morality and the issue of an African contribution to bioethics in the same thesis. The reason is that the two questions are interrelated. The discussion of a common morality is applied in the area of bioethics using African contribution as a test case. Common bioethical framework refers to that framework that emerges for bioethical resolutions because of the existence of a common morality. Pluralism in itself is not an alternative to common morality. In its neutral sense, ‘pluralism’ simply means diversity and does not preclude common morality. Pluralism is not a new phenomenon. Perhaps what is different is the intellectual response to this fact, which tends to dismiss talks about common morality as impossible and undesirable.

The title of this work: Bioethics Across Borders. An African Perspective is informative. The first part looks at the problem concerning the possibility and the desirability of a common bioethical framework. The second addresses the method employed in responding to the first problem. It informs us that an African culture is used as a test case. In short, the title looks at both the question of a common morality and the question of African contribution to its articulation. In this sense, it is related, and connected to the research problems, and the aims of this study.

**Why is African bioethics important?**

Why should we worry ourselves with bioethics largely unaffordable in Africa? The simple reason is that research in African countries raises many issues that are particular to African cultural context. It raises questions originating from cultural, economic, religious and
socio-political factors specific to Africa. Questions such as autonomy, informed consent, justice, beneficence, distribution of scarce medical resources, obligations of researchers and research sponsors to participants and the wider community are issues of international debate in Europe, some parts of Asia and in North America. These problems raise particular ethical questions within the context of African culture.

It is estimated that over 3.5 million Nigerians are living in the U.S.\textsuperscript{5} In the last two decades many Africans have migrated to different countries in Europe and America. As these people become part of the health care system of these various nations, it is important that health care professionals understand these peoples’ views concerning life, sickness, disease, health, death, autonomy, informed consent, justice and all other issues related to health care and research practice. Bioethics in a global context must acknowledge ethical pluralism. There is need for this kind of study to highlight ethical issues in Africa and provide much needed knowledge, by critically analysing ethical issues and formulating bioethical frameworks from an African perspective, which are not the focus of western bioethics. Furthermore, it may foster the activities of The Global Bioethics Research (GFBR), a body that provides a forum for developing and developed countries to debate the ethical issues surrounding international collaborative research sponsored by industrialised nations and carried out in developing countries. This is why African bioethics is important.

Although bioethics has established itself as a discipline in Europe and North America, this is not the case in many developing countries like Nigeria. In most African countries, bioethics is either nonexistent or is rudimentary.\textsuperscript{6} In some parts of Africa, some bioethics conferences and workshops have been held in the past decade to raise awareness on the difficult questions research ethics creates in Africa especially in relation to the participation of human subjects in clinical trials. This is the most topical in the area of bioethics in Africa. Pan African Bioethics Initiative (PABIN), a pan-African organisation founded in 2001 to see to the development of bioethics

\textsuperscript{5} Personal communications with the Association of Nigerians living in the U.S. 2005.
in Africa with special focus on research ethics has been its pioneer. PABIN is committed to developing ethics in the context of African culture and practices. Furthermore, it is dedicated to preserving and promoting African traditions in ethics and bioethics, especially as these relate to facilitating high standard health research and health care. Apart from some countries in southern and eastern Africa and a few universities in other parts of Africa, there is no formal ethics education in most African’s medical schools. There are serious shortages of trained bioethicists in Africa. Even where biotechnology has taken some root in Africa, the level of public debate on the ethical, social, and legal implications of it is very low and many issues are ignored.

**Theoretical framework**

Having established the importance of this work, it seems right to explicate on the theoretical context in which I plan to answer the question concerning if it is possible and desirable to formulate a common bioethical framework that individuals and groups in a pluralistic society can share in. I carry out my investigation within the field of theological ethics. By this term, I mean in this study the theoretical reflection on morality that takes place within Christian tradition. Such reflection would address issues such as what it means to be a human being and how moral judgements can be justified. Christian anthropology and humanism in addition to contexts and worldviews are significant in such a reflection. It is important for me to relate to two main fields that constitute my dialogue partners in this project. First, I am in dialogue with philosophical ethics through a critical analysis of the ethical theories of Tom Beauchamp and James Childress, Tristram Engelhardt and John Kekes. These authors have formulated ethical theories that have significant relevance for bioethical questions. I will explore the theoretical, normative, and methodological questions that arise in their responses to the challenge of moral and ethical pluralism. Second, given the constructive aim of this study, it is important for me to relate to African value system, worldview, thought and culture.
The first theoretical starting point for my work is the problem of the possibility and desirability of a common morality. I have no intention of defining or discussing this concept at this stage. I shall take it up later in this study especially in the discussion with Beauchamp and Childress and in my constructive part. This work is located within the humanistic tradition. Such a position implies that human experience is a determining element in the justification of a moral judgement. This entails that all human beings have both freedom and responsibility. It also means that they are both individual and communal persons who have an intrinsic dignity.

Another theoretical starting point for me is traditional African worldview. This means that a theory can be considered as bioethical if it helps us to address bioethical problems even if it was not intended as one. It is African if it is located within the African culture and traditions even if the author is not African. In this sense, an African bioethical framework is the consequence of any bioethical reflection that takes traditional African worldview seriously. Such views would include African conceptions of the human person, illness, individual, community, health care, death, and dying. In my critical analysis of the three western ethical theories, it is these concepts that will inform my interpretations of their positions. It will also be the fundamental concepts in my formulation of an African bioethic. In this study, bioethics will be understood as the study of ethical issues raised by the life sciences. In this regard, it embraces the study of values, value-conflicts and norms related to biomedical sciences and medical practices. It will also be used as an interdisciplinary field that systematically studies ethical issues in biosciences, health and health care. In this regard, bioethics includes medical ethics, nursing ethics and health care ethics.

A people’s understanding of the world around them determines their approach to medicine and health care. Worldview deals with how humans perceive the world in relation to themselves. Prof. Ikenga Metuh defines it as “the complex of a people’s belief about the origin, structure and organisation of the universe, and the laws governing the interaction of beings in it”. In this sense, worldview may be understood as cosmology. The latter refers to “a branch of systematic philosophy that deals with the character of the universe as

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a cosmos by combining speculative metaphysics and scientific knowledge, especially a branch of philosophy that deals with the process of the nature and relation of its parts”. According to O.U. Kalu, the function of worldview includes “The intellectual or rational explanations of the order which undergird human lives and environments. This undergirding order is derivable from myths, taboos, customs and proverbs of a community”. Explicating on this, V. C Uchendu observes that “to know how a people view the world around them is to understand how they evaluate life and people’s evaluation of life (both temporal and non-temporal) provides them with a ‘charter’ of action, a guide to behaviour.” Worldviews help us to explain reality. This is the sense the term worldview is understood in this thesis.

Further, pluralism of moral vision constitutes an important theoretical starting point for my investigation. There are diversities of moral visions concerning the applicability of developments in biology to health care. Ethical issues in reproductive technology, genetics and end of life care continue to generate heated debates and divergent views. This concept will be discussed in chapter five.

Issues in biotechnology not least the multi-complex issues they give birth to can be studied from different angles. These issues can be looked at from politico-economic standpoint, from biological, medical or ethical standpoints. Biotechnology as understood in this work, refers to any technological applications that use biological systems, living organisms or derivations thereof, to make or modify products and processes for specific use.

The first delimitation I shall make is that this study addresses itself to ethical issues of bioethics. The areas in which this will be demonstrated are those of issues at the beginning of life, allocation and distribution of scarce medical resources and health care at the end of life.

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10 Uchendu, 1985, The Igbo of South East Nigeria, p 1.
Human beings have been discovered to share a lot in common with other non-human animals. These include capacities for consciousness, communication and to exhibit a neurological anatomy similar to human beings. Yet this study deals with human life and will not attempt to deal directly with the moral significance and the normative status of animal or vegetative life. This is beyond the scope of the present study.

There has been extensive study of the origin, meaning and the name Igbo or Ndigbo by many writers. The Igbo race has no common eponymous ancestor. The Igbo people in this study refers to an amphictynony ethnic group i.e., groups of villages and towns organised around the central Deity called 'Ala' that is united by a common language, social institutions, title taking and customs in South eastern Nigeria. The Igbo people differ from many of the tribes in Nigeria and even from many other tribes in West Africa in their political organisation. Many tribes such as the Yoruba, Beni, Hausa in Nigeria and Ashanti and Fante in Ghana are imperial, hierarchical, aristocratic in their traditions, the Igbo are egalitarian, republican and democratic.

The term Africa in this study applies only to sub-Saharan Africa. The reason is that North Africa has been significantly influenced by Arab culture in almost every aspect of life in such a way that it is reasonable to say that it differs from the other parts of the continent.

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11 Singer uses utilitarian principles to extend the moral community to include sentient animals. In his book, Animal Liberation he argues that discrimination against animals on the ground of species difference is speciesism. He contends that the genetic similarity (98.4%) of some animals for example chimpanzees and gorilla to humans and their capacity to feel pain is adequate ground bring nonhuman animals within our sphere of moral concern. Singer suggests that the life of human beings who lack the characteristics of normal humans based on his conclusions can no longer be preferred to those of other animals simply because they do not belong to the specie Homo sapiens. He accepts Zoologist Richard Dawkins view that the genus ‘homoide’ includes the families of chimpanzees and gorilla. Cf. Singer 1994, Rethinking life and Death. The collapse of our traditional Ethics, pp 176 - 180.


It might also be argued that Christian teaching has influenced sub-Saharan Africa to the extent that it is no longer easy to say what is and what is not African. This is a legitimate point. In this sense, it might be questionable why North Africa is considered as forming a different cultural group from the rest of Africa. Yet, there is a sense in which the focus on sub-Saharan Africa is justified. The point is that in spite of the influence of Christian culture on sub-Saharan Africa, the former has not submerged its customs and values, as is nearly the case with North Africa and Arab influence. The term traditional as employed in this study will refer to cultural and customary. In this study, it does not imply unchangeable, retrogressive or static or the status quo. In Africa, traditional society still exists alongside modern society in many places especially in rural village settings.

I have no difficulty calling my work an African perspective because African people of whom the Igbo are a part share many common characteristics, which include among others, the role of family and community in the individual’s life. The name African bioethics is used exactly in the same way as we refer to the work of an individual in Europe in bioethics as Western bioethics. My study uses the Igbo culture as a theoretical framework for the formulation of an African bioethics. As an Igbo, I am familiar with the cultural realities of the Igbo and understanding them for my purpose in this work is much easier than if I had chosen any other culture or country.

The terms community and society will describe a union of individuals who are united by a specific type of order or organisation. They may also describe a union of people united by some modes of behaviour geared towards certain common end, value or interest. The term society in whatever way it is seen denotes a union of one kind or another. This distinguishes it from the term community.

The term community is here understood as a form of society where people are linked by interpersonal bonds, which may not be necessarily biological and who share specific ends, values, and interests. Sometimes, it is difficult to make clear-cut distinction between society and community. The reason is that some

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characteristics of community are also found in society. In this study, the terms ‘society’ and ‘community’ will be used sometimes invariably. Autonomous villages and towns in Igbo society are communities in the real sense because they have their eponymous ancestors. From this, Igbo tribe has no one eponymous ancestor, but is united by the factors mentioned earlier. In this regard, it makes better sense to refer to the Igbo people as a society.15

Methodological approach

The question of method is an important one every time a scholar undertakes an intellectual project. Debate about method is a highly controversial issue and sometimes can mar intellectual discussion. This can tempt one to avoid going into method question. However, bioethics raises methodological concerns that cannot be side stepped. This is because method helps us to make our reflection upon experience more systematic and each method makes thematic certain factors that could easily be overlooked in every day reflection about moral questions. Books on bioethics often review the philosophic methods: deontology, natural law, casuistry, utilitarianism, principlism, virtue ethics and feminist care ethics. However, the pluralism in this area is much greater than this list indicates. Bioethics strives to resolve moral controversies in clinical treatment, experimentation, medical research, and health care policy. This is why each method in bioethics attempts to establish as much agreement as possible, and different methods try to legitimate themselves, in part, by their ability to articulate agreement. It is important that a researcher is conscious of the method he or she employs and why a particular method(s) is used. This view is in agreement with the position of Sven Ove Hansson in his book *Verktygslära för filosofer*.16

In order to make clear the method I wish to use in this study, it is important that this is seen in relation to the three problems and the three aims of the study earlier formulated. It is also important to

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understand this in relation to the methods that are commonly used in bioethical deliberations. In this study, I will be talking of methods and approaches. By method, I shall mean the fundamental characteristics of an approach. In this regard, approach refers to the specific manner of reflecting on a concrete bioethical issue. This has to do primarily with the model of justification employed by the method. In this connection, there are two broad approaches to method employed in bioethical analysis, namely: top-down method and bottom-up method. The former refers to deductive approaches to justification and the latter to inductive approaches. Deductism refers to those positions that hold that we employ existing social agreements and practices as our starting point and then proceed to norms such as principles and rules. Inductivism maintains that the role of the particular and context are crucial to the validity and acceptability of our moral judgements.

This study makes use of multiple approaches and methods and it recognises the importance of the contribution of each of them in ethical analysis. It will propose a model that incorporates the important features of the two approaches to justification in moral judgements. Some methods in bioethics combine ethical theory and empirical research. There are those who use empirical method. However, my method is primarily a systematic conceptual/ethical analysis. This means that I will engage in a critical analysis and interpretation of my primary material. Although results from empirical research can inform ethical analysis, yet such results are often significantly simplified when employed in ethical analysis.17

The analytic language of this study is developed in relation to the three research questions and the three aims formulated earlier.

I have two major challenges in this study. The first concerns the possibility or desirability of a common bioethical framework for a pluralistic society. An important question in this connection deals with how I plan to engage the challenge of a common morality notwithstanding pluralism of moral visions. The second explores the question of what could be the contribution of African culture and philosophy to a common bioethics. In order to meet these two

challenges, I undertake first to critically analyse and interpret the ethical theories of Tom Beauchamp and James Childress, Tristram Engelhardt and John Kekes. The purpose of the interpretation is to clarify the underlying worldview, philosophical and theological presuppositions behind these theories and to show how they attempt to formulate bioethics in a pluralistic society and how they relate to the African context. An important element of my study will be to clarify and explicate some central concepts and definitions. This will include such concepts as personhood, moral pluralism, worldview, individuality, community, common morality, illness and health care. This part of the study explores and highlights these issues in order to underscore the basis on which my position will be argued. In this work, I will be carrying out text interpretation. This will consist in responding to the theories studied from the background of the general problem being explored. This study is both author-focused and problem oriented. It is not author-focused in the sense of aiming at a complete account of the work of the authors chosen. It is author-focused because three main writers have been chosen for analyses and interpretation. It is problem oriented because it deals with specific questions concerning the possibility or desirability of a common bioethics and the issue of exploring an African contribution to a common bioethical framework. These are the analytic tools for this study. The advantage of combining an author-focused study and a problem-oriented approach is to use the former to illustrate the latter. This means that the analysis becomes more constructive and clear.

What are the criteria for my analysis and interpretation of these authors? The characteristic of an acceptable bioethical theory is that it should be pluralistic. It should be coherent, contextual, and productive. It should also be respectful of different worldviews. In addition, it should be holistic and universalisable. An acceptable theory in this sense refers to that which is accepted as valid within the African context. There is nothing that can be said to be objectively valid for all Africans, it may be argued. This is a reasonable objection. Acceptability in this sense narrowly understood refers to what I consider as acceptable within the African setting. In this connection, it is important to clarify what makes a thing acceptable for me.
The first characteristic of an acceptable bioethical framework is that it should be pluralistic. This means that it has to take the fact of moral pluralism seriously and accept it as something positive rather than negative in our moral life. The reason is that moral pluralism seems to describe and explain better our moral intuitions and the conflict of values that characterise our moral universe. It is a pluralism that has to cut across boundaries and is founded on common morality. The second characteristic is coherence. This means that such a framework has to cohere with considered judgements of the society where a bioethical dilemma is being resolved. It has to strive toward coherence between particular and general judgements. A process of wide reflective equilibrium could achieve this goal. This also means that judgement has to cohere with the worldview of the society in its considered judgements, a term that refers to moral judgements of a society that are most likely to be without distortions having been proven through experience. An example of a considered judgement is the wrongs of murder or harm to the innocent. The third feature is that it should be contextual. Each method in bioethics attempts to discern what action is moral in a given health care setting and what reasons justify that action. The context of moral deliberation plays a vital role in the judgement that is reached in a concrete case. An acceptable framework should take account of all relevant factors such as the context and settings in resolving moral dilemma. The fourth characteristic is that it should be productive. The main goal of bioethical analysis is to provide practical guidance in policy issues and individual cases. An acceptable method should fulfil this practical goal for people in their concrete society. The fifth is that it should be holistic. Human beings most often are at the centre of bioethical analysis. The human person has different levels of being. An acceptable ethical method has to respect and acknowledge these different levels and not to exclude a priori any level of experience. This means that the method has to focus on human beings in their totality. Finally, the sixth feature is that it should strive towards universalisability. This means that an action judged right in a given context should be considered in the same way in all contexts similar in all relevant factors. The
importance of this criterion is that morality is understood as making universal demand by its nature.

The second challenge is a constructive one. I will attempt to articulate an African perspective to bioethical theory. How do I carry out my constructive ambition in relation to the criteria given? I will base this part on the analysis of African thought, culture, ethics and worldview. By employing these elements found especially among the Igbo people, I hope to formulate an ethical theory that can be the basis for addressing bioethical problems within a pluralistic setting particularly within the African context. There are different ways the conclusions of this studied could be tested and criticised. A primary way to judge this study is to see how its conclusions satisfy the criteria outlined in the evaluation of an acceptable ethical theory and how they cohere with the worldview of Africans especially the Igbo.

Chapters 1 and 2 can be said to be mainly a descriptive analysis. They discuss moral pluralism in relation to bioethical issues at the beginning and at the end of life. The purpose here will be to show that there are many bioethical problems and that there are many different positions defended by those who discuss them. Critical analyses and interpretations are conducted in chapters 3-5. These three chapters especially the first two are both attempts to articulate ethical theories in a pluralistic society that could be the basis for a common bioethical framework. They discuss issues relating to the first challenge of this study, the question of the possibility or desirability of a common bioethics. A reasonable interpretation of these theories is achieved by understanding their underlying worldview and answers to specific bioethical questions. Chapter 6 serves as a bridge between chapters 3, 4, 5 and chapters 7 and 8. In this chapter, I begin to address the constructive goal of this work, the question about what African culture could contribute to the project of a common bioethics. This chapter is distinguished by a specific philosophic and cultural anthropology, which is African with particular reference to the Igbo. Finally, chapter 8 is a critical and constructive analysis rooted in the earlier analyses and from the perspective of the criteria already outlined. It summarises the main results of the study. It discusses this by investigating the three research questions outlined at the beginning of the study.
Material

For the purpose of this study, I have chosen three books that have great influence on secular biomedical ethics. They are *Principles of Biomedical Ethics* written by Tom Beauchamp and co-author James Childress, *The Foundations of Bioethics* written by Tristram Engelhardt, and finally, *The Morality of Pluralism* written by John Kekes. A number of criteria have informed my choice of materials. First, these works are dealing with the theoretical and normative problems that interest me. Second, the authors of these books have various publications that illustrate developed reflected substantive and methodological positions in the field of bioethics. Third, their different approaches provide analytically interesting contrasts useful for my purpose. They are concerned about providing a secular framework for dealing with moral problems. Each of them represents a progressive understanding and formulation of secular moral theory in a pluralistic context.

It is understandable why Tom L. Beauchamp and James F. Childress are chosen since their four principles of respect for human life represent the most influential method in bioethics today. Beauchamp and Childress have together offered an alternative model to the deontological and utilitarian models. This work has been selected because it is in my view and in so many circles the best expression of the principle-based approach in bioethics. Until its publication, virtually all published books in this area were organised by topics. *Principle of Biomedical Ethics* is most probably the first systematic, relatively comprehensive work in the field of bioethics organised around principles or philosophical theory. Its approach is practical. Each principle is discussed with the framework of concrete clinical moral problems. The bibliography is excellent. Some of the chapters especially the sections on autonomy and justice are outstanding and exhibit clear thinking. Perhaps one of the greatest

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18 Several books in the field that influenced the writing of the *Principles of Biomedical Ethics* include Shannon, 1976; Veatch, 1976; Brody, 1976; Fletcher, 1954; and Ramsey, 1970. The philosophers W.D. Ross, (who in *The Right and the Good* (1930, 1939) developed the argument of prima facie principles) and William Frankena were also influential in the writing of *Principles of Biomedical Ethics*. 
strengths of their approach is the flexibility of methodology characterising the different editions of their book.

Beauchamp and Childress develop a framework that acknowledges the divergent perspectives in the theory of moral justification and the moral principles. According to them, despite the starting assumptions in utilitarian and deontological theories they agree nevertheless in most cases when it comes to practical moral deliberation. They argue that common morality provides the starting point and the constraining framework of bioethics. For them, a plurality of values and judgements does not stifle the establishment of bioethics. It is in this light that they developed their principle-based bioethics. Their basic assumption is that the function of bioethics is to resolve ethical cases and the best method of bioethics is that which proves most useful in doing this. I share the same interest in bioethical conflicts with them but in contrast to them, I contend that the best method of bioethics is not just that which is most useful in solving moral problems but also that which is consistent with our basic moral sense.

The reason for the choice of Engelhardt is that he is one of the most influential advocates of a secular bioethics and has a well-articulated position on bioethics. One of the reasons why Engelhardt has been chosen for analysis is that secular bioethics in a pluralistic society has probably nowhere been more systematically articulated than in his work. Engelhardt has not only articulated a theoretical framework for bioethics but he has also addressed concrete bioethical issues. Any attempt to articulate bioethics for our age, must take seriously the pluralism of moral visions that characterise our day, the acknowledgement of “real diversity among moral perspectives”. This is obviously one of the greatest strengths of Engelhardt’s secular bioethics. He takes seriously the challenge of ethical relativism and nihilism. Writing on the importance of Engelhardt in bioethics and the philosophy of medicine, Laurence B. McCullough maintains that

Tris has earned the status of being one of the leading international figures in Bioethics and philosophy of medicine. The first edition of

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19 See chapter four.
Engelhardt has also written extensively. He has equally undertaken major editorial works among them the Philosophy of Medicine series issued by Kluwer Academic Publishers. He edits the *Journal of Medicine and Philosophy*. He also helped to launch the Journal, *Christian Bioethics*, for the purpose of Non-Ecumenical Studies in Medical morality. From the forgoing, he has certainly contributed more to develop the field of bioethics and the philosophy of medicine. Engelhardt is a moral and political philosopher (whose work is deeply influenced by Kant and Hegel as well as the scepticism that operates within the secular society). He is as well a physician, a Texan Orthodox Christian who refers to himself as a born-again Christian. His work is important to any adequate understanding of bioethics.

Engelhardt’s position suggests that moral conflicts should be resolved by agreement through peaceable negotiations among members of a particular moral community. This is a *procedural* model, which results in a minimalist ethics rather than a system containing normative views of the concepts of person and the value of human life. One acts with moral authority only when one acts with the informed consent of all those concerned. For Engelhardt the only principle which can establish a secular bioethics is that of *permissiveness* and it is only within particular communities that a content-full secular bioethics is possible. In contrast to Engelhardt, I do not recognise contractual agreement as a substitute for both the rational nature of moral judgement and the common morality of humanity. These approaches do not account for why human life should be protected as human life independent of the particular understanding of different societies. My account argues for a common morality that places both the individual and the moral

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community at the centre of concrete moral reflection. However, their accounts and mine share the same aim of formulating some kind of framework for bioethics.

Kekes’s work is important for bioethics in a number of ways. First, Kekes’s presentation of pluralism could be said to be the first sustained account of an important moral theory that attempts to refute the contemporary disintegration thesis of morality.23 Second, Kekes’s analysis of the morality of pluralism as a conceptual moral view should hold considerable interest for those who want to collaborate in common ventures in pluralistic societies. Third, Kekes is a major voice in modern political thought. The connection between democratic aspirations and pluralism in modern societies is an unarguable one. Fourth, Kekes is a prolific writer and an important contributor to the literature in ethics and social philosophy. His views in these fields are distinctive, typically well argued, and provocative. In this light, Kekes can serve as a powerful dialogue partner on the prospects for developing a common ethics that cuts across national and cultural boundaries, focusing primarily but not exclusively on good life and good and right decision making in bioethics. John Kekes takes the fact of pluralism seriously. The thesis of Kekes’s works hinges on two principal aims. First is the claim that individuals can make a good life for themselves by having a plurality of life at their disposal. Second is the contention that the function of the state in a pluralistic politics is to protect the conditions necessary for the availability of a plurality of values. He argues that plurality of moral values need not compel us to accept the relativistic conclusion that all values are ultimately subjective preferences. The strength of Kekes’s work lies in his discovering that moral conflicts in a pluralistic society is not found only among communities having different visions of the good. It is also discovered among individuals who despite the fact of possessing much in common with regard to ideological affinities are still forced to choose between incompatible values. Obviously, Kekes makes an interesting choice for me since he relates himself to the problem of political philosophy.

23The disintegration thesis especially of western morality is aptly caught in the horror of Picasso’s Guernica, the spiritual exhaustion of Mahler’s Ninth Symphony, and Yeats’ prophetic line, “Things fall apart; the center cannot hold.”
John Kekes presents an account of common morality that is based on the natural law tradition.\textsuperscript{24} He argues for a pluralistic perspective to morality. This implies the acknowledgement of the existence of many standards of rationality that in principle can be accepted as valid. Kekes shares the same view concerning pluralism with my framework. However, he differs from me because I do not base my view on human nature or the natural law as he does but rather on common morality. This is also where his position differs from that of Engelhardt, Beauchamp and Childress. All the same, much like Beauchamp and Childress, he holds that rational moral justification is a possibility, in contrast to Engelhardt who denies this possibility. My study differs from the works of Beauchamp and Childress, Engelhardt, and Kekes because it is a contribution informed by African worldview and culture and formulated particularly for the African context.

In addition to the above, I will also make use of diverse scholarly articles in this area. The reason is that bioethical problems are about conflicts of values and judgements upon them. In order to resolve bioethical dilemma help is acquired from different fields of knowledge.

The relationship to other research

The question of the possibility and the desirability of a common morality have been discussed by a good number of literatures.\textsuperscript{25} The practical and theoretical issues involved in this have constituted the defining criterion in contemporary moral reflection. In particular the field of bioethics amply illustrates that our society is a morally pluralistic one. Theologians, ethicists, philosophers, sociologists, medical professionals and many others have discussed methods that could enable bioethics operate better in our pluralistic society.

\textsuperscript{24} Kekes J, 1993, Morality of Pluralism, p 7.
\textsuperscript{25} Gene Outka and John Reeder eds., 1993, Prospects for a common Morality. This anthology presents an overview of recent debates especially by English-speaking philosophers and Theologians.
In a recent anthology, *Global Bioethics: The collapse of consensus* edited by H. Tristram Engelhardt, Jr, the authors analyse the contemporary diversities of moralities and worldviews and the attempts to develop a global bioethics. In this volume, one encounters one of the major cultural challenges of our times: the difficulty of finding a common viewpoint. Some of the essays in this volume argue that the post-modern situation is the result of the philosophical-theological synthesis of the Western Christian Middle Ages. The diversity of bioethical accounts and norms of reflections illustrated in this book demonstrate the fact of moral pluralism. Each essay and commentary in this anthology from its own perspective investigates the possibility or for that matter the impossibility of a global morality, using bioethics as its heuristic. Engelhardt argues in this book that the persistent moral disagreement characterising the 21st century makes the project of coming to substantive conclusions through rational argument in matters moral or bioethical impossible. The reason why is that we disagree about basic moral premises and rules of evidence. According to him, by default we can find procedures, strategies to live together in the face of moral diversity.26

John Rawls establishes this contract on the willingness and ability of the parties who already have criteria for public reason. Rawls has argued on the idea of an *overlapping consensus* in which there is a broad agreement between people with different comprehensive worldviews and in which they are able and willing to operate with the shared criteria of what he calls *public reason*27. In a similar manner, Robert M. Veatech formulates a triple contractual scheme for the foundation of a secular bioethics, which begins, with the validation of human interaction, which becomes the basis of social contract between society and healthcare givers which gives rise further to individual contractual relationship with health professionals. It is a contractual agreement that gives rise to the fundamental principles of promise keeping and equality.28

Alasdair Macintyre questions the viability of this kind of liberal agreement. He considers moral philosophy as a tradition constituted

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inquiry. Yet, the difficulty remains which tradition, whose rationality should we endorse and under what circumstances. Stanley Hauerwas argues against a common morality based on the ground of social theory, and defends the language of character and community.29 Every community has its own morality.

Kevin Wm. Wildes, S.J., in his book *Moral Acquaintances: Methodology in Bioethics* attempts to investigate the major methods in bioethics and to propose methods that will fare best in a pluralistic society. By applying the concept of ‘moral acquaintanceship’, Wildes builds on values or principles that various methods might share in common. Wildes understands bioethics as “a discipline that resolves moral controversies in medical research, experimentation, clinical treatment, and health care policy…”30 This definition is important in order to understand Wildes’s position. It is different from the understanding of bioethics as the attempt to discern moral action in a given situation in health care delivery and what reasons justify such actions. Wildes’s understanding of bioethics suggests that it is just a pragmatic way of resolving bioethical dilemma. It is in this sense a kind of proceduralism. Whether or not this incorporates moral content is a question that is not clear. The method suggests that a bioethical theory need not be true. Its task is to resolve moral controversies. This is the reason why he evaluates his choice of theories with terms such as ‘appropriate’ or ‘inappropriate’, ‘strengths and weaknesses.’ Wildes’s framework seems to suggest that truth is not a category that should appear in a moral theory. The terms ‘true’ and ‘false’, ‘right’ and ‘wrong’ or ‘moral’ and ‘immoral’ rarely appear in Wildes’s discourse and when they do, they are regularly placed in quotation marks. For him, any theory that fails to achieve a consensus in a pluralistic culture is weak. This raises the problem of truth and justification.

David Little argues for a common morality that is grounded in a kind of intuition. He claims that our basic sense of the wrongs of

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29 Hauerwas, 1983, *A Community of Character: Toward a Constructive Christian Social Ethics*, Chs. 1- 4. He claims that all moral reasoning is a contextual matter located within specific traditions and dependent upon their contingent assumptions and forms of life.

certain kinds of actions for example torture is more fundamental than any moral theory and offers a basis for the justification of all such theories.  

This approach is similar to that of Jeffrey Stout who argues that we know certain moral truths for instance the wrongfulness of slavery, even if they are not always believed and even if we cannot justify them now in terms of some overreaching ethical theory. My account differs from theirs because for me intuitionism is an insufficient ground to formulate a normative theory for bioethics.

In Sweden, some analytic and constructive studies have also been done in this area. Among pioneers in this field are Holsten Fagerberg, Göran Hermerén and Erwin Bischofsberger. Other researchers in this area are Torbjörn Tännsjö, Lennart Nordenfelt, Helge Malmgren, Anders Nordgren, and Christian Munthe. Gunilla Silfverberg and Göran Lantz are representatives of those involved with ethics of care. Some doctoral theses have also discussed the prospect of a common bioethics. They include those of Mats G. Hansson, Kersti Malmsten, and Axel Carlberg.

Fagerberg discusses in his book the role of view of life in medical decision making. This is in line with my study since in my second aim I explore what could be the contribution of African worldview to the formulation of a common bioethics. Hermerén describes medical ethics, as a multidisciplinary teaching and research science that critically, historically, empirically and analytically identifies and analyses moral and ethical aspects of decision-making in healthcare and medical research. This description seems to suggest that the task of bioethics is to analyse the reasons that are given for a particular position taking in health care and medical experimentation. Bischofsberger’s work understands project of ethics as that of given

31 See Prospects for a Common Morality pp 73 – 92.
32 Stout J, 1998, Ethics After Babel: The Languages of Morals and Their Discontents, pp 22-22, he argues strongly using the example of slavery. However, in an essay “On having a Morality in Common” in Prospects for a Common Morality, he also claims that one may be justified in holding certain moral beliefs that one cannot defend theoretically.
33 Fagerberg H, & Erwin B, 1988, Medicinsk etik och människosyn.
direction to human beings on how they are to act morally. He suggests that even if we have different moral views and belong to different religious traditions, we still could have a common ethics that expresses in our common view the meaning of what it is to be human.\textsuperscript{35} Even if I do not completely subscribe to this view of his, yet, it cannot be reasonably denied that there are certain biological and social characters humans share in common. In this connection, his work is related to mine. Malmgren’s study addresses the issue of medical ethics from the perspective of philosophy, health care practice and medical experimentation.\textsuperscript{36} He understands his work as that of analysing how different possible value and norm systems can be applied in medical decision-making and how these positions could have originated in understandings of reality. This present study does not only seek to understand the worldviews behind different bioethical positions, but it also undertakes to explore the possibility of a common bioethical framework. How the studies of Tännsjö and Nordgren relate to this present study will be shown later in this work.

Nordenfelt discusses in \textit{Hälsa och värde} the concepts of health and disease, quality of life, crime, punishment, mental illness, death and the concept of ethical dimension in health care.\textsuperscript{37} While my study relates to his in seeking to understand some of the concepts he explores, yet, it differs from his particularly in investigating the possibility of a common bioethics and what African culture could contribute to the task. Christian Munthe has done a normative and critical analysis of pre-implantation genetic diagnosis. In his \textit{Pure selection. The ethics of pre-implantation genetic Diagnosis and Choosing Children without abortion}, he undertakes a case study for PGD in Sweden. It is also an analysis of the arguments one often meets in this field. Munthe is for the use of PGD in situations such as extreme severe and untreatable diseases where from the point of view of the child, it would have been better for him or her not to exist.\textsuperscript{38}

\textsuperscript{38} Munthe C, 1999, \textit{Pure selection. The ethics of pre-implantation genetic Diagnosis and Choosing Children without abortion}, p 93.
Munthe’s study is not about a general framework for bioethics. It focuses rather on pre-implantation genetic diagnosis. Gunilla Silfverberg in her book *Praktisk klokhet* develops a well-articulated position on virtue ethics in relation to how it can be applied in bioethics. She describes dialogue as the most important method in ethics. She discusses ethical dilemma and how it can be resolved.\(^\text{39}\)

Hansson offers a Kantian defence of a universally binding common morality that concentrates on the differences between utilitarian and deontological theories.\(^\text{40}\) Kantian approach argues for a common morality based solely on humanity’s rational capacity. In contrast, my approach is a pluralistic one. In addition, Kantian rigorous insistence on moral autonomy does not fit well with the relational model of autonomy advocated in this study. Axel Carlberg, in *The Moral Rubicon*, argued that a Rubicon exists in the practice of health care delivery. This Rubicon is located between those who consider human life as inviolable and those who believe that it is disposable.\(^\text{41}\) The idea of the Rubicon was originally used by Umberto Eco as a metaphor that demonstrates constant inclination in Western mind to creating boundaries between the sacred and the secular, the known and the unknown, the rational and the irrational, the permitted and the proscribed\(^\text{42}\). For Carlberg, the moral Rubicon can be used to describe the limits of moral order without which moral life cannot be adequately protected. On the other hand, the framework I present can be used to describe that context in which the diverse moral visions can meet each other and provides a warrant for moral obligation in those concrete individual situations in which expediency might oblige us to cross the Rubicon.

Kersti Malmsten in her thesis *Reflective Assent in Basic Care, A study in Nursing Ethics*,\(^\text{43}\) discusses nursing ethics in relation to basic care. The main aim of her work is to present an alternative approach to principle-based ethics based on the models of communicative


ethics, feminist ethics, and virtue ethics. In contrast to her, I present a principle common morality based approach. These are some examples of the bioethical literature by Swedish writers.

To my knowledge, none of these writers have investigated the contribution of non-western culture and values in bioethics. In contrast to these Swedish writers, I present a common morality based approach. My study is situated within the Swedish research tradition. My contribution to bioethics is bringing the insights of African experience to the issues in this field. Internationally, this is an important trend.

The work of Angeles Tan Alora and Josephine M. Lumitao, *Beyond a Western Bioethics: Voices from the developing World* is an important contribution to a common Bioethics. In this study, they contend that Western bioethics does not address satisfactorily bioethical problems that emerge in the context of developing world experience. They explored what elements are needed to go beyond a Western bioethical framework. I will later relate especially in chapter six of this study to this work.

Some Nigerians have written a number of doctoral theses on bioethics. Merry Osemwegie in his dissertation, *Regulating the discriminatory Implications of Libertarian eugenics: the Legal Framework for control*, studies how university students as an enlightened segment of society would accept the new genetics in terms of how they choose the characteristics of their children. He argues for responsible global regulatory frameworks in the area of human genetics. One thing I share in common with Osemwegie is the understanding of the need for bioethical frameworks. In contrast to him, my work is normative, and it is concerned with the ethical aspects of these developments, whereas his concentrates on the need for legal and policy frameworks. In *Legal Analysis of Globalisation and Bioethics in Nigeria*, Icotun Omotonomila carried out an in-depth analysis of the effects of globalisation on bioethical issues in a third world country and proposed legal reforms to protect the polity.

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44 Osemwegie M, 2005, *Regulating the discriminatory implications of libertarian eugenics*, University of Manchester.
45 Omotonomila, 2004, ‘*Legal Analysis of Globalisation and Bioethics in Nigeria*’. 

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Friday Ebhodaghe Okonofua’s\textsuperscript{46} \textit{Female and Male Infertility in Nigeria} is also an important study in this area. This is an epidemiological study of infertility in Nigeria with special reference to the role of genital tract infections and the sexual and reproductive risk factors. Benedict Faneye in his \textit{The Process of Informed Consent in End life Care: Improving care options for Patients and Families} conducted a study on end-of-life care in hospice environment. He argues that terminally ill patients who are in the process of dying are a specific case that calls for empowerment. None of these theses to my knowledge has addressed the question of a general framework for African Bioethics, which is the project of this study. My project deals with the underlying framework, which informs studies and actions in the different aspects of bioethics.

Apart from these theses, some Nigerians and some Africans have written articles in bioethics in general. The project of bioethics requires one to be both globally and culturally sensitive to the particular frame of reference of different people.\textsuperscript{47} These studies are important to the present one since they present and argue for different normative positions in bioethics. This is in itself a mark of moral pluralism in this area of study.

\textbf{Outline}

This study has three major parts. The first part includes the introduction to the study and chapters 1-2. Chapter 1 shows that there are many ethical questions raised by biosciences. It is also to show that there is a plurality of views concerning how these issues could be resolved. In this part theoretical issues are dealt with in a descriptive analysis. Chapter two attempts an analysis of five major theoretical approaches to bioethics. The idea is to show how these frameworks try to resolve ethical issues raised by life sciences. In part two (chapters 3-5), I critically explore three frameworks used in bioethical analyses in the west, namely, elaborated by Tom Beauchamp and his colleague James Childress, Tristram Engelhardt,

\textsuperscript{46} Okonofua, 2005, \textit{Male and Female infertility in Nigeria}, Karolinska University Press, Stockholm.

and John Kekes. Chapter three analyzes the attempt of Beauchamp and Childress to respond to the problems of pluralism of moral visions in bioethics. A critical, analytic and interpretative study is made of their *Principles of Biomedical Ethics*. The fourth chapter is also an analysis of an attempt to formulate ethical theory that could be the basis for a common bioethics in a secular society. In this chapter, Engelhardt’s work *The Foundations of Bioethics* is critically analysed and interpreted. The fifth chapter deals with a theory that is not directly a theory on bioethics but it is important because of its study of the phenomenon of moral pluralism. It is a critical and analytic interpretation of John Kekes’s *The Morality of Pluralism*. The third part (chapters 6 - 8) attempts to formulate a viable bioethics with basis in African worldview and culture. In chapter six, I begin the project of formulating bioethics from an African perspective. The issue here is to explore what relevance culture and worldview have in dealing with bioethical questions. Chapter seven tries to see if it is possible to articulate an ethical theory that could form the background for a common bioethical framework particularly within the African setting. Here, I formulate three common morality principles that I argue could establish a reasonable framework for bioethical deliberations within the African context. Finally, chapter eight returns to respond to the three basic questions introduced at the beginning of this study.

My first approach to honouring the commitment of the work is to show that there are many bioethical problems. Furthermore, it is to show that both in concrete issues and the theoretical framework employed there are many different views concerning their solutions. I will present the different sides of the discussions on these issues as they are today. I make no attempt at an exhaustive treatment of particular problems. Having done that, I will proceed with an examination of the four principles of biomedical ethics by Beauchamp and Childress. It is in this sense that my study is analytic. Then I will go on with a critical presentation of the work of H. Tristram Engelhardt. Having given a reasonable interpretation of his work, I now conduct a study of the evaluative moral theory of Kekes and give a critique of his position. I hope that my analyses of the major perspectives in contemporary bioethics will uncover their
basic thrust and the fundamental similarities and differences between them. Finally, an attempt will be made to formulate a possible framework for Bioethics from an African perspective.

The hope is to provide an insight from the African perspective in this on-going discussion concerning what ways bioethical framework could be formulated in order to give direction in health care, research and policy making services.
1. A Bioethical and Biotechnological Age

Advances in the fields of biological and biomedical research challenge us to re-evaluate our traditional ethical assumptions. There are philosophical, legal and ethical questions about the edges of life and about the possibility and right of human beings to influence these edges. These have made our age a bioethical and biotechnological one, that is, an age in which issues of ethics and life take the centre stage both in social, economic and political discussions. The moral and ethical issues concerning human intervention at the beginning and end of life are real issues for health care givers, researchers and lay people alike.

The task in this chapter is to demonstrate that the field of bioethics illustrates the fact of moral pluralism in our society. The idea is to lay the ground for the investigation of the primary challenge of this study, the possibility and the desirability of a common bioethics for a pluralistic society. Pluralism is understood in this study as a descriptive term, which refers to the existence of different outlooks - moral or religious in a given society. Pluralism in this sense is another word for diversity. Moral pluralism in this work will be understood against a broad cultural backdrop, with three major elements. The first feature is intellectual pluralism, which finds expression in postmodernism and holds that there is no objective truth. The second one is religious pluralism, originating from the fact of the existence of many religions and drawing the conclusion that these religions are equally valid manifestations of the same ultimate reality. The third element is liberal political philosophy, which encourages plurality of beliefs and actions, and places much emphasis upon individual freedom and autonomy of action. In this connection, moral pluralism could be described as the
inevitable consequence of any political philosophy that stresses individual self-determination.

There is lack of consensus in almost all major issues of human life, the significance of human life, human reproduction, early human life, and the significance of suffering, the allocation of scarce resources, dying, and death. There are similarly disagreements on the nature of the good, the right, the virtuous, and the nature of governmental authority. These conflicts show that moral philosophers, ethicists and other players in our cultural life support different moral positions. Some people condemn physician-assisted suicide, euthanasia, and capital punishment while some others support them. There are those who condemn homosexual activities while some others support. The different positions defended in the abortion debate amply illustrate moral pluralism. There is lack of consensus not only on the level of theoretical framework but also at the level of solutions to concrete problems.

Moral pluralism in bioethics will be highlighted by moral and ethical disagreements in certain methods of assisted reproductive technologies, prenatal diagnosis, fetal tissue for research and therapy, embryo research, genetics, stem cell research and therapy, and ethics at the end of life. There will be no attempt to make an exhaustive presentation of any of these issues. It suffices for my purpose to present the dominant positions taken by the proponents and the opponents of these positions. It is hoped that this investigation will enrich and keep the dialogue going.

Assisted reproductive technology (ART)

Infertility is a major health problem in Africa, particularly in sub-Saharan African countries such as Nigeria, where there is a high infertility rate. Okonofua F. E observed that in 1999, 800,000 couples suffered from infertility in Nigeria.48 Nigerian gynaecologists report that problems of infertility constitute between 60 to 70% of their consultations in tertiary health institutions.49

49 Okonofua, Harris D. Odebiyi A. Kane T. & Snow R.C., 1997 ‘The social meaning of infertility southern Nigerian’s Health Transition Review 7: 205-220 See also Okonofua FE,
Although it has been suggested that males and females contribute equally to infertility\textsuperscript{50}, yet, other studies show a disproportionate contribution from the different sexes. Nevertheless, available evidence demonstrates that women suffer much more the social and psychological burdens of infertility in Africa than men do.\textsuperscript{51} ART is a collective-name given to all methods that are used to help infertile couples have children.

According to Osato F. Giwa- Osagie, it is estimated that 10%-25% of adult couples in African countries are sub-fertile and of these female factors account for about 55%, male factors for 30%-40% of the causes while 5%-15% of causes are unexplained.\textsuperscript{52} Infection is the most common cause of infertility in Africa. Two sexually transmitted infections (STIs), gonorrhoea and chlamydia are the most prevalent both in males and females.\textsuperscript{53} Some of the factors that compound the problems of STI in Africa include delayed diagnosis, no therapy, inadequate therapy, and inappropriate therapy. Other factors that represent the next major cause of infertility among women in Africa include infection during or after abortion and childbirth. The latter explains the prevalence of secondary infertility over primary infertility in Africa.\textsuperscript{54}

Childbearing and rearing is an important part of personhood. This makes ART a priority technology especially for the Igbo people. Commenting on the high value procreation has in Africa and the relevance of ART Tangwa writes:

\textsuperscript{53} Osegbe DN, Amakhu E.O, 1985, ‘The causes of male infertility in 504 consecutive Nigerian patients’.
\textsuperscript{54} Giwa-Osagie OF et al, 1984, ‘Aetiological classification and sociomedical characteristics of infertility in 250 couples’.
/.../ assisted reproduction of any putative type would prima facie, be of great interest in Africa and assisted reproductive technologies (ART) could not fail to generate interest and excitement in Africa.\textsuperscript{55}

This text confirms my view that ART is highly relevant to the Igbo people. One of the reasons I have selected ART is to highlight the fact that though infertility may not be a public health priority in Nigeria, it is an issue of life and death in the lives of individuals confronted with this difficulty. It is the source of serious psychological and social suffering for both men and women and does place great pressures on the relationship with the couple.

In her doctoral thesis \textit{Chosen Children? An empirical study and a philosophical analysis of moral aspects of pre-implantation genetic diagnosis and germ-line gene therapy}, Kristin Zeiler, identified infertility as not only a disease but also the worst disease. The reason is that “it did not alter the ability to live but the possibility of choosing to live as one might want”.\textsuperscript{56} Infertility was also described as a deviation from the normal and the response to this deviation was therapeutic: these people could be offered assisted reproductive technology treatment.

Among the Igbo people, different ways are adopted to respond to the challenge of infertility. One of the ways is that the man takes a second wife. Sometimes it is the woman who is infertile who marries a younger wife for the husband. The hope is that the second wife would give children to the family. The first wife sees these children as her own children in every sense of the word. Moreover, most times she is treated so by the children. This practice also still occurs among some Edos of South western Nigeria.\textsuperscript{57}

Where the man is the infertile partner, tradition allows his brother or a close friend of the family to have intercourse with the woman with the hope that she will bear children for the infertile brother or relative or even friend. It needs be said that the consent of the woman is always sought before such arrangements are made. In most cases,


\textsuperscript{57} Nwaevule Martin, 2005, the oldest man in Alike Obowo (born about 1904), personal communication.
the woman would agree. The Igbo with the philosophy of ‘Ibe nyerem aka’ (may my friends help me) try to explain this practice. This could be compared to the modern practice where donor semen is used in insemination. This shows that the concepts of donor insemination and to some extent surrogate motherhood are not so strange to the Igbo culture. The matter is treated with the utmost secrecy among those involved. The children born belong by right to the infertile man and they bear his name. The reason is that in Igbo traditional society any child conceived by the woman while still married to a man, even if separated while the dowry paid on her has not be returned to the man, is recognised as the child of the man. It is significant to note that this extends even to children born by the woman after the husband's death if the man responsible for the pregnancy has not returned the dowry paid by the dead man to his family.58

Virtually all forms of ART are available in the subregion especially in Nigeria namely, artificial insemination; donor insemination; in vitro fertilisation; gamete Intrafallopian transfer; embryo freezing; embryo donation; Intracytoplasmic sperm injection and surrogate motherhood. Artificial insemination, donor insemination and IVF are the most widely used methods. Intracytoplasmic sperm injection and embryo freezing are the least used methods.59 These are available mostly in private clinics rather than in the public sector. There are fertility clinics in Aba, Portharcourt, Lagos, Abuja and a few other cities in Nigeria.60 Other places where they are found in the sub-region include Douala, Lome, Dakar, Harare, Yaounde and Tema. All these centres are in the private or incorporated as foundations. This of course has serious implications for accessibility and equity.61

The development of ART has brought with it ethical, social and political issues that society need to address. Controversies surround

58 Chief Onyekwere, Theodore, 2005, Okangaobiri I of Alike Obowo, personal interview.
60 The first IVF baby in West Africa was delivered at the Lagos University Teaching Hospital in 1989.
nearly all aspects of ART. What restrictions if any, should be placed on methods of ART? It may be said that few other areas in medicine have generated many social and ethical conflicts and have attracted so much public debate as ART. Some of such practices would include manipulation and cryopreservation of gametes, techniques of ovarian stimulation, preimplantation genetic diagnosis, and psychosocial issues, cloning and stem cell research. There is the challenge for health care administrators and policy-makers on what resource to allocate to ART services, on who should have access to them, and on balancing between preventive and curative services.

In this regard, one needs to make a distinction between the technique of ART as a means of helping infertile couples to become parents and the procedures that are involved in each of the methods. One of the controversies surrounding this procedure is the problem of ‘spare’ embryos. Most clinics undertaking IVF freeze embryos and this practice has become an integral part of this technique. The point of issue is that not all couples that cryopreserve embryos use them. It presents potential problems since an embryo can be stored beyond the lifetime of the genetic parents. This possibility raises serious concerns about the responsibility of the parents involved. What is to be done with potentially unwanted frozen embryos is a particularly difficult issue to resolve satisfactorily. It has ignited the issue of the status of embryos. Who do they belong to? Should they be allowed to die? Should they be used in research? Of course, our response to these questions will depend on what we consider the status of the human embryo. The advocacy of sperm banks for geniuses only by William Shockley demonstrates this danger. Only a few studies have addressed the question of what happens to the cryopreserved embryos. According

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62 International concerns about ART and its social and ethical implications were the subject of the 52nd World Health Assembly in 1999. WHO Department of Reproductive Health and Research convened a meeting on the medical, ethical and social aspects of ART on 17-21 September 2001. It is significant to observe that despite the diverse opinions on ART at the meeting, consensus was reached on many points. This is reflected in the corresponding sets of recommendations that those working from different theoretical and methodological frameworks. The participants also agreed on working definitions for ART. This is another illustration of the existence of a common morality.


64 Svanberg, 2003, p. 6. In a recent doctoral thesis she examines the emotional reactions during in vitro fertilization (IVF) treatment among women and men, and the attitude of
to some studies, difficulties with getting in contact with these couples have sometimes resulted in not being able to make use of the embryos.65 There was a great uproar when 3000 cryopreserved embryos their time had passed were destroyed in Britain in 1996.66 Another problem concerns the medical risks associated with reproductive technologies. There are reports from women about dehumanised methods of treatment, pain and emotional stress.67 Childlessness in itself is a very stressful situation. IVF treatment is also highly stressful, with anxiety and disappointments.

**Intra Uterine Insemination (IUI)**

This is the oldest of all modern ART. It is a procedure often used to make it possible for sperms and eggs to meet. When a donor’s semen is used, it is called donor insemination.68 The former refers to homologous insemination while the latter refers to heterologous insemination. In the context of marriage, the child born is the natural genetic offspring of both parents. Nevertheless, problem arises when one of the couples is not able to provide gametes.69 Where the man produces no sperm, there is the possibility for the woman to become pregnant with sperm donated by another man. Egg can also be donated to a woman who does not produce eggs by another woman. For example, question is asked whether it is ethical for physicians to provide artificial insemination to single women. By single women is referred to unmarried women who are either heterosexual or lesbian living with or without a lesbian partner. One of the objections to this practice is the argument that it is harmful to children to create them to be raised in a single-mother household such as those of lesbians

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and unreformed alcoholics. In this regard, many argue that the interest of the child is served best when he or she is born into a loving, stable, heterosexual relationship. One common thing with those who argue this way is that they are often not specific about the supposed harms to children conceived and raised by single mothers. The reason could be that they lack empirical support for their position. In some countries like Sweden, donor insemination is permitted only if the woman is married or living in concubinage with a man or a woman if the partners give their consent.

Whereas some are against insemination for single women, others support it. They argue that it promotes procreative freedom and the happiness of women who desire to experience pregnancy, childbirth, and child rearing and through this be connected with future generations.

**In Vitro fertilisation (IVF)**

It is a term used for a group of procedures designed to retrieve egg from women. These are those who have blocked fallopian tubes that obstruct egg passage. Conception takes place after in a petri dish. After two or three days, one or two of the fertilised eggs are implanted in the woman’s womb. Another variant of IVF is referred to as Intracytoplasmatic sperm injection (ICSI). This procedure is the same as IVF. The difference is that the quality of the sperm is such that there is high risk of fertilisation not occurring when sperm and egg are mixed. This difficulty is overcome by injecting the sperm into the egg. The same evaluation made of IVF thus applies to this technique. There is also the difficulty of posthumous use of frozen spermatozoa.

More than two million children have been born throughout the world using IVF procedure. This technique makes possible embryo

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70 This method is judged by the Catholic Church to be immoral because it does violence to humanity because conception is extra-corporeal. The second reason given is that it eliminates the marriage act. Within Igbo culture, these reasons given for judging IVF immoral are not persuasive enough.

71 On the 25 July 1978, Louise Brown was born as the world’s first test tube baby in Oldham, England. Here in Sweden, the first IVF child was born in 1982. About 2% of all children born in Sweden each year is by IVF, i.e., about 2000 children. Haas John M, 2005,
screening where genetic traits such as sex of the resulting baby, disposition to various genetic diseases and intelligence can be dictated. Although these technologies have capacity for enormous good, yet, many people also fear that they pose great threat to human dignity and life that they presume to help. When IVF takes place through sperm or egg donation, it raises many ethical questions. There are questions regarding the separation of sex from reproduction: sex without reproduction; reproduction without sex, and reproduction with the involvement of a third party. Does it matter how a child comes to be? What is the meaning of parenthood? How far can human beings interfere with nature’s way? What right has the child to know about his or her biological origin?

Some people object to IVF because of the risk of hyper-ovulatory drugs producing faulty eggs that could lead to defective children. Others argue that the possibility to freeze embryos or its loss offered by IVF places a question mark on our conception of human dignity and personhood. In addition to these is the possibility of cloning higher animals and even human beings offered by this technique. Yet others raise objection based on IVF direct link with abortion and procedures such as freezing or using of embryos for research. Yet, others say that IVF opens the door for surrogate mothers, sperm and egg donors and parents who are not the genetic parents of babies they have legal parental responsibility towards thereby contributing to the breakdown of the traditional family arrangements as a social institution. An IVF baby can have up to 5 parents: the biological mother (egg donor), biological father (sperm donor), surrogate mother (the woman who gives birth), commissioning mother, and the commissioning father. As can be seen, this brings serious confusion to the concept or meaning of parenthood and family. This is said to threaten the dignity of family life. Those who argue against the morality of this procedure contend that actions that actually bring about the conception have replaced the marital act. Although conception occurs ‘in vivo’, or in the body, it is argued that the possibility of homologous and heterologous artificial insemination

are judged by these opponents as rendering the procedure immoral.\textsuperscript{72} For these reasons, some people maintain that IVF is ethically unacceptable.\textsuperscript{73}

On the other hand, some people argue that the problem with IVF is primarily that of value conflicts regarding reproductive freedom, respect for life, preserving autonomy, justice and scientific freedom. In this conflict of values, some people argue that there should be a presumption in favour of reproductive freedom.

**Ovum Donation**

Fertility declines in women with advance in years. Sometimes a woman may not be able to produce egg because of genetic reasons and as she approaches menopause. Having eggs donated to them by other women can help women who require IVF but are not able to produce good quality eggs. The eggs could be donated from a sister, relative, and friends or even from anonymous donors. Some people argue against this practice because of the problem of commercialisation. This method has been used for infertile women over forty years of age when IVF with their own eggs has been unsuccessful and there is no other explanation for infertility other than age. There is the issue of whether ovum donation to old women is ethically justifiable, and whether it should be banned. When we ask whether we should permit ovum donation to postmenopausal women, we are at the same time asking whether we should limit the freedom of people to engage in this type of reproductive activity. There are some views that ovum donation to older women should not be permitted because pregnancy and childbirth involve increased risk to older women. Some positions object to this practice because according to them caring for a child is more difficult for older people. Opinions are divided as to the question of whether the child

\textsuperscript{72} Unlike in IVF, which the Catholic Church regards as immoral, there has been no definitive judgement by the Church on this procedure.

\textsuperscript{73} The Roman Catholic Church teaches that any loss of embryos, such as is possible in vitro fertilisation, is morally unacceptable. She argues that the uses of ex-corporeal assisted reproductive technologies are morally unacceptable. This is because they violate the ‘inseparability principle’, according to which procreation, marital love and conjugal act must not be separated, Congregation for the Doctrine of Faith, 1987, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation*, p 4.
born through sperm or egg donation should be told of the donor’s identity.

It is difficult to have an ethical consensus to the specific issues involved in this practice. This raises ethical questions regarding reproductive freedom. Some have argued that ovum donation to older women should be banned, yet others maintain that the reasons for valuing freedom to procreate provide a prima facie right for women that should not be interfered with. Therefore, it is ethically justifiable for older women to be permitted to engage in this activity except where it constitutes obvious serious risks to the life of the woman.

**Surrogate motherhood**

This technique is where a woman carries to term in her uterus a child to which she is not the genetic mother. This method is also referred to as Embryo Transfer (ET). This is an opportunity that is open to couples where the woman has damaged womb or where the womb has been removed perhaps because of fibroids, cancer or other medical conditions. It could be sought when pregnancy might pose a significant health risk to the woman, as in the cases of heart disease or advanced diabetes. In some countries, this method is not permitted while some others allow it.

Distinction is made between commercial surrogacy, which involves the payment of money to the surrogate mother and non-commercial surrogacy, which is often done on filial grounds and does not involve money transaction. Some views argue that all types of surrogacy are ethically justifiable provided those who participate in them are consenting autonomous adults. In addition, no restrictions should be placed on them. There are those who say that all types of surrogacy are ethically unjustifiable. One line of argument against this procedure is that it deprives the child its right

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The first birth of a child through surrogate pregnancy in Nigeria occurred in a Lagos-based private clinic, The Bridge Clinic by Dr Richardson Ajayi et al in 2003. This event raised social and ethical concerns calling on the government to begin to put in place appropriate structures that would deal with moral and social questions emerging from available infertility treatment technology in Nigeria.
to be conceived and born within a marital union to parents who have given themselves exclusively to one another. Opponents to this procedure also maintain that it violates the marital union. It does this by projecting a child as a commodity and a woman as a ‘baby-maker.’ The womb is hired to produce rather than to love child into existence. In this sense, they argue that it is degrading to the woman. In addition to this is the position that surrogate motherhood pose risk of psychological harm to the surrogate that might be caused by separating from a child to whom she has become emotionally attached. Yet there are some others who hold that non-commercial surrogacy done on altruistic ground is ethically justifiable because it is an expression of love and solidarity with couples suffering from infertility. While my purpose is not to take position on these questions, it needs be observed that these issues are difficult to resolve and consensus on them is not easy.

To conclude, this overview of the different technologies in assisted reproduction shows that it is a complex question in which the status of the human embryo takes the centre stage. A disagreement between those who argue that procreative freedom should override other values and those who defend values such as society’s conception of sexuality, the dignity of family life and the marital act. A preliminary point of departure for the ethical evaluation of such technical procedures begins with the consideration of the circumstances and the consequences that those procedures involve in relation to the respect due to the human embryo.\textsuperscript{75}

The Status of human embryo

Opinions are many when it comes to the question of the status of human embryo. It is a widely accepted scientific biological fact that life is a continuum. It results from the union of the male and the female gametes. The relevant question is not when life begins but when the human embryo can be said to possess the status of a full human being. There has been a long tradition of religious, philosophical and legal positions that has tried to answer this question. Some people argue that from the time that the ovum is

fertilised, a new life is begun which is neither that of the father nor the mother; it is rather the life of a new human being with its own growth. More recently, the Charter of the Rights of the Family, published by the Vatican, confirmed that human life must be absolutely respected and protected from the moment of conception.76

Some bioethicists hold that the appearance of electrical impulses in the brain around the eighth week is the crucial point that marks when human life begins. The argument is that since brain activity is used to determine when death occurs, it should also be used to determine when life begins. Such an analogy seems only superficially plausible given the fact that for the brain to be considered dead it has to be shown irreversible. On the other hand, the lack of brain activity in an embryo is only temporary and cannot be said to be irreversible.

Others hold that the point that makes the difference is the moment of implantation that takes place 6-7 days after conception. This is argued to be much more significant than conception. The view is that the human embryo cannot be considered a person until it implants in the uterine lining and can no longer split into identical twins. The thinking behind this is that it is implausible to attribute personhood to a potential human being that has only about forty percent of survival.

Yet, some others believe that the crucial point is the moment when the mother begins to feel the movement of the fetus. This moment has been traditionally referred to as quickening.

Another argument that is often presented concerns when the fetus is considered viable. By viability is meant when the fetus is capable of living independently of its mother. At this point, it is argued that it must be protected and accorded the same rights that are given to human beings. Yet, some others argue that the potential for self-consciousness confers moral standing to the embryo.

There are those who regard the moment of birth as the point at which one can be said to be a human being. Some others say that it is

76 Vatican Instruction on reproductive technologies, Donum Vitae, Issued by the Vatican’s Congregation for the Doctrine of the Faith in 1987. The report submitted by the Christian Action, Research and Education (CARE) Trust, to the Warnock Committee in 1983 states: “the only ethical position is to treat the human embryo at any stage of its development with the respect due to human life at all stages.”
the capacity for rationality. Others believe that it is the ability to experience the past and the future.

We have not exhausted the positions that are argued for in this issue. It is probably obvious from the discussion that the different views regarding when human life begins is not based on factual evidence. One may rightly regard them as representing different views of life, which are often of religious character even when they are presented in the garb of secular thought. We do not really have problem about what we know before and after conception. However, the difficulties arise with the names we give and the moral consequences we attach to the different stages that follow conception. This discussion leads to the question concerning embryo research.

**Embryo research**

The various techniques of assisted reproduction have made possible various interventions upon embryos and fetuses. These interventions are of various kinds: diagnostic and therapeutic, scientific and commercial. Experimentation on embryos has become increasingly widespread and is legally permitted in some countries. Ethical questions arise in connection to these procedures. The central question in embryo research is whether it is ethically acceptable at all. Should we create human embryos solely for the purposes of scientific research with no intention to implant them afterwards? The latter question has been the most contentious issue in the whole embryo research debate. What ethical norms should be worked out to guide these practices? Obviously, the response one gives to these questions depends on the degree of respect that should be given to human life at its different stages of development.

As we have already seen opinions differ on these issues. Distinctions are often made between research that is directly therapeutic and research that is clearly non-therapeutic, i.e., which is not for the benefit of the embryo. In the latter case, distinction is also made between experimentation carried out on embryos that are still

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alive and research carried on dead embryos. An ethical analysis of the issues raised in this area will require the knowledge of the different interests in the need for embryo research. The supposed potential benefits include among others:

a) Research to improve the safety and efficacy of IVF  
b) Increased knowledge about the development of embryos  
c) Enhanced knowledge about the causes of miscarriage  
d) It will enable us to detect genetic and chromosomal abnormalities before implantation.  
e) Increased knowledge about the causes of congenital diseases  
f) Improved methods for cryopreservation  
g) Development of therapies for such diseases  
h) Enhanced knowledge in the development of more effective contraception

These needs and potential benefits of embryo research have made some countries to permit it. At the most general level, ethical advisory bodies in the United States, Great Britain, Canada, Australia, and other Western nations who have examined the ethical acceptability of embryo research agree that research on human embryos for valid scientific purposes, was ethically acceptable. The bases for their arguments were the claims that embryos were not persons or subjects with interests, and were at too rudimentary a stage to be harmed by such research.

There is widespread agreement that embryo research to improve the safety and efficacy of IVF is ethically justifiable. Both religious and civil bodies tend to agree on this point. Most countries agree that embryos should not be kept alive in the laboratory without the possibility of transfer to the uterus for more than 14 days. This is argued to mark the end of implantation and the development of the primitive streak and the first signs of a nervous system, and this would prevent actual harm to more mature embryos and early fetuses. Some other bodies have also claimed that embryos could be created solely for research purposes without any intention to implant them afterwards. This led to the reaction of the Warnock Committee and the prohibition in Australia and in some European countries.
This is probably the most sensitive issue in the whole embryo research question. It is the question of embryo destruction. The central issues in this area can be summarised as follows:

1. Is research on human embryo ethically acceptable?
2. Is it ethically acceptable to create embryos for the sole purpose of research without the intention to implant them after?
3. Is the practice of cryopreservation of embryos ethically justifiable?

These questions are raised, not because of any doubt about the possible benefits of this technique, but because of the costs of harm to embryos that, by definition, cannot consent to the research. John Robertson in his book, *Children of Choice*, sees the problem of embryo research in terms of right. He argues that the fundamental question is whether procreative liberty gives people the right to use their procreative capacity to produce products or materials to serve non-procreative purposes.78 Robertson supports most forms of non-therapeutic embryo experimentation arguing that the loss of embryonic life is profoundly insignificant. In his book, *Life’s Dominion*, Ronald Dworkin points out that the difficulty one encounters in the discussion in embryo research has to do with the way questions in this field are framed as to invite only yes or no answer. He, however, notes that in the midst of the arguments for and against embryo research there is still in principle a common ground. Liberal opinion as well as conservative views presupposes that human life has intrinsic significance, and that it is in principle wrong to terminate a life even when no one’s interests are at stake.79

Most countries prohibit the creation of embryos merely for scientific purposes in the public sector. At the same time, they permit the private sector to create them and ‘sell’ them to the public sector. This is remarkable since it is difficult to explain the ground on which the public sector is forbidden to create these embryos while at the same time permitting the private sector to engage in this. One of the

arguments that is usually advanced for cultivating tissues from embryos for research is that it has potential for application in a wide range of diseases. It thus raises the question of whether its increased demand might lead to the creation of embryos solely for obtaining embryonic stem (ES) cells and creating cell lines, which would eventually lead to the commercialisation of the embryo thus divesting it of its supposed status.

Some persons would still restrict research even if embryo research for reproductive and other purposes were to be ethically acceptable. For some people, embryo research is ethically justifiable if done on ‘spare embryos’ from IVF that will not be implanted to a uterus. Some people argue that there is no compelling reason to make any ethical distinction between the use of a donated embryo for the derivation of ES cells and the use of an embryo created for this purpose. They object to the creation of embryos for the sole purpose of research. This is interesting because it is difficult to reconcile the acceptance of research carried on ‘spare embryos’ and the objection to them being created simply for this purpose. Does this constitute a significant ethical difference? It seems inconsistent to accept the former and object to the latter, since research will be carried on these embryos at the same stage of development. In Britain embryo research is permitted for the purposes of research into diagnostic methods and for reproduction and does not cover research into therapies.80 There seems to be no qualitative difference between the two types of experiment. Because each of them involves using the embryo as a means to an end, since we accept the use in the first case, there seems to be no persuasive reason to disallow it on the second case.

The debate about the moral status of the human embryo as we have seen centres on the question of whether the embryo should be treated as a person, or at least, a potential person. If the embryo is so considered, then it will be morally unjustifiable to use it merely as a means to an end, rather than as an end in itself. This would render impermissible any use of it for other ends other than for its own benefit. Many questions in this field remain unanswered. One form

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80 HEF Act paragraphs 9-11.
of embryo research that demonstrates pluralism of moral and ethical positions is the discussion on embryonic stem cells.

Stem cell research and therapy

One clear example of moral pluralism in stem cell research is the different positions taken by different countries in Europe. Europe is divided into two main groups on this problem. The first group is represented by the position of Britain and Sweden, while the second group is represented by the position of Germany, Italy and France. The first group on the one hand, says yes to embryonic stem cell experiment, on the other hand, the second group says no. Different reasons can be given for the various positions taken by these countries. It is most probable that Germany’s objections to this form of research are historical, precisely in the II world War human experiments and genetic registration. Italy likely has been influenced by the teaching of the Catholic Church on the inviolability of human life from the moment of conception. In the year 2000 Britain became the first country in Europe to permit the creation of human embryo for the sole purpose of experiment. Sweden in the year 2003 followed suit. However, since there is no common position on this question in Europe, there has been a decision from the European Union Parliament that no EU money is to be used to finance any project dealing with embryonic stem cell. This simply illustrates the difficulty one encounters in this area. What then are stem cells?

Stem cells are self-replicating and can generate a number of more specialised cell types as they multiple. They are plentiful in the early embryo. Recent research suggests that human stem cells can give rise to many different types of cells, such as heart cells, blood cells, nerve cells, muscle cells and others. There are two main types of stem cells: adult stem cell and embryonic stem cells (ES cells). The latter is further subdivided into three types. They include totipotent stem cells, pluripotent stem cells, and multipotent stem cells. These

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81 Currently, about 100 persons are involved with stem cell research in Sweden. Major centers of research include Sahlgrenska Universitetssjukhuset in Göteborg and Karolinska Institutet in Stockholm. See Gun Leander, 2002, Livets urcell, källa 54, Vetenskapsrådet.

different forms of stem cells have varying capacities to differentiate\textsuperscript{83} into specialised tissues.

Totipotent stem cells can be defined in two ways: either as cells capable of developing into a complete human or cells which give rise to every cell line in the developing fetus. The fusion of the egg and sperm gives rise to the single cell called the zygote. This zygote divides into many times to produce the different cell types that comprise the entire human being. It is said that the zygote and each of the eight cells created by its first three divisions are capable of developing into a complete human. Such cells are referred to as totipotent.

Pluripotent stem cells are those cells derived from the blastocyst and have the potential to give rise to any cells of the body. When these cells are derived from an embryo, they are called embryonic stem (ES) cells. When they are harvested from primordial germ cells in a fetus, they are referred to as embryonic germ (EG) cells. Although pluripotent stem cells can generate most embryonic cell types, research shows that they cannot generate all the tissues required for complete development into a human. For example, it cannot give rise to tissues, such as the placenta, which are essential for an embryo to develop.

Multipotent stem cells are those cells that can be multiplied and retain in culture but do not have an unlimited ability for renewal. They can be harvested from fetuses and are present throughout life but in progressively decreasing numbers in adults. Their function is to replace fully differentiated cells that are lost by depletion and damage. For example, bone marrow stem cells replenish different types of blood cells. The replacement bone marrow contains blood stem cells, which generate new, cancer-free, blood cells.

One of the main aims of stem cell research is to understand how differentiation takes place, how it is controlled and learn how to direct cellular development. Scientists and society at large are interested in discovering and developing a permanent source of tissue which would be capable of generating cell type and which would not risk the problem of transplant rejection. Stem cells could be used to create replacement cells and tissues to treat many diseases and

\textsuperscript{83} Differentiation here means the process of cellular specialisation.
conditions, such as heart diseases, leukaemia, diabetes, Parkinson’s disease, stroke, Alzheimer’s disease, multiple sclerosis, spinal cord injury, rheumatoid arthritis, and skin conditions, including burns. The availability of stem cells may also change the way drugs are tested. In addition, this research area promises an improved understanding of the complexities of normal human development\textsuperscript{84}. Some scientists believe that research on both adult and embryonic stem cells will contribute greatly to these objectives. There are experiments using both adult and embryonic stem cells. However, some people argue, that the difficulty with experimenting with adult stem cells, makes human ES cell research crucial to the development of stem cell therapies at least until the programming of the cell development is better understood. Those who argue in this way outline the main advantages of pluripotent ES cells as including the ability to generate more different cell types than adult stem cells. They contend that ES cell research has the potential to speed development of adult stem cell therapy techniques; they are relatively much more available than adult stem cells and therefore significantly easier to isolate. It is easier to control growth and differentiation than in adult stem cells.

The second position taken by some people is that adult stem cells have similar if not the same potentials as ES cells and respects the dignity of human life. It is argued that the derivation of cells from somatic cells, i.e., from patient’s somatic cells would have the potential to produce tissue which would permit autologous\textsuperscript{85} transplant of specific tissue type. The advantage is that they would avoid the graft rejection, which will accompany the use of ES cells derived from donated embryos.

The derivation of pluripotent stem cells from donated blastocyst or the creation of an embryo for research purposes, like all other human embryo research raises serious ethical questions. It involves many problematic aspects, both of a scientific and ethical nature. The use of human ES cells and EG cells give birth to important ethical issues, which are primarily concerned with the origin of the cells and


\textsuperscript{85} An autologous transplant uses tissues from an individual’s cells. Such cells do not cause immune rejection, when they are reimplanted.
the way, in which they are derived. The use of human pluripotent stem cells is controversial primarily because much of the current research is focused on deriving these cells from human embryos and cadaveric fetal tissue.

Because of the delicate stage in which the embryo is in its development, some contend that possible experiment on them in the light of current technological advances would involve a very high risk, i.e., risk of causing them irreversible damage and even death. In view of this, it is therefore ethically unacceptable. According to this position, many embryos would be destroyed in the process of trying to develop therapies. This standpoint could be said to build on the argument of the Vatican Congregation for the Doctrine of the Truth, when it contends: “what is technically possible is not for that very reason morally admissible.”

Some issues of Human Genetics

Medical genetics is that part of genetics that deals with the role of genes in illness. The hope is that the completed genome will enable scientists to lay bare the genetic triggers for hundreds of diseases and to device exquisitely sensitive diagnostic tests. It could replace broad descriptions of disease with precise genetic definitions that make diagnosis sure and treatment swift. These sophisticated discoveries about human genetics, and the links between genetic inheritance and susceptibility to disease have important ethical implications. Medical scientists can now identify the presence of some abnormal genes by simple tests.

It can identify individuals who may have, or be susceptible to, a serious genetic disease, or who, though not at risk themselves, as gene carriers may be at risk of having children with the genetic disease. Test can also be carried on DNA for verifying paternity or

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86 Pluripotent stem cells are those cells that have an unlimited capacity to develop into most of the specialised cells or tissues of the body.
87 It is the position of the Ninth General Assembly of the Pontifical Academy for Life on the topic of “Ethics of Biomedical Research For a Christian Vision,” 2003.
88 Donum Vitae, n. 4.
89 Anyone in the USA can today have herself or himself tested. Companies provide this service through the post office.
even solving a homicide case. These raise myriad of questions concerning what uses might be made of the knowledge and who should have access to this information, implications to those having these abnormal gene or genes. “Thus the status of genetic information raises ethical questions that differ significantly from the normal rules and standards applied to the handling of personal medical records.”

Does the person with a defective gene have the right to withhold this information from the family members? Does she or he have a duty to disclose it? What are the rights and/or responsibilities of the rest of the family?

It would require an understanding of some of the ways in which genetic inheritance can cause disease or make people susceptible to a disease, in order to better understand the complex nature of the ethical issues that arise in connection with genetic screening. Genetic tests can reveal information one might not want to know. For example, it can reveal that the supposed father of a child is not really her or his father.

Genetic screening presents three major potential benefits to the individuals, their families and society. They include: the discovery of treatable genetic disorders at an early stage; offers couples the possibility of making informed choices about parenthood; and identifying genetic susceptibility to common serious diseases.

The main ethical problem arises from the conflict between the right of the individual to personal privacy on the one hand and the interest of family members to be fully informed and those who would not want to be aware of the information. There is in this situation a difficult balancing act to be made. Other areas of ethical concern include the use of genetic screening by employers and its use by insurance companies. There is also the threat of eugenic abuse of genetic screening. Furthermore, there is the issue of counselling that is needed as a follow-up to the information revealed by testing or screening. This is not yet part of the primary process of genetic testing in some places. It is a point of extremely importance since it makes a lot of difference when correct information is given in the right manner.

There is another interesting aspect of genetic science that has to do with the prospect of African Americans using genetic technology

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to trace their ancestry to the African continent. Various attempts have been made by the African Diaspora to reconstruct their family history using written and oral sources. Alex Haley’s book *Roots: The Saga of an American Family* is a celebrated account of this attempt. Not many have achieved success using this method. The prospect of using genetic science to achieve this is raising remarkable public interest. Geneticists are promising to identify unique matches that will situate people to their continents, countries, towns, villages, and even their families of origin in far away lands. Scientists hope to achieve this by comparing the order of letters between the DNA sequences of individuals against a reference database. This may then be the New Hope of African Americans wanting to trace their ancestry. However, there is an irony in this development. It has some challenges. What would this mean for the individuals who trace their ancestry to particular communities and what would it mean to the ancestors or communities they link to? One of the risks of such information from genetic science is that of ethnic or tribal discrimination along tribal lines. Equally important is the danger of ascribing genetic meaning to large groups of people such the Igbo, Yoruba, Shanti, Bantus, or Akans. Another issue deals with the desire to see differences between Africans and other peoples such as Europeans. This underestimates the genetic diversity of African people and de-emphasises it. These issues make some people object the use of genetic information in insurance policy, employment and crime resolution.

**Research involving human participants**

Research related to healthcare has been the subject in recent years of several reports and investigations. Particular attention has revolved on placebo controlled studies on the prevention of mother-to-child transmission of HIV (MTCT).

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92 DNA detective story on BBC www.bbc.co.uk/science/genes/dna-detectives.
In order to understand the controversy it is important to be aware of the context within which it emerged. This example is instructive for my studies since it highlights moral pluralism and the conflict that can occur between western articulated framework and the African context. By 1994 medical experiments in the US and France had shown that treatment with Zidovudine (AZT) reduced the risk of mother-to-child transmission of HIV to approximately one-third of what it would have been without treatment, from 25% to 8%. Following from this, a trial protocol referred to as ACTG 076 was developed which then became the standard care in wealthy developed countries for the prevention of HIV transmission from mother-to-child. This drug was expensive costing about US $800 per pregnancy. Obviously, this intervention was unaffordable to developing nations where about 95% of HIV infected persons live, in particular sub-Saharan Africa that unfortunately bears the greatest burden of HIV and where government healthcare budgets are often less than $10 per person annually. The unaffordability of this intervention in poor countries gave the motivation later in 1994 to WHO, UNAIDS, the US NIH, and the US CDC to design placebo controlled studies of short-course treatment of Zidovudine. This intervention would cost $80 per infected woman. The intention was to find out if it would be more effective than the standard practice. Although, this was sponsored by developed nations, the trials were carried out in poor countries targeted to benefit from the project. These countries included: Uganda, South Africa, Thailand, Kenya, Côte d’Ivoire, Burkina Faso, Ethiopia, Zimbabwe, Tanzania, Malawi, and the Dominican Republic. These trials attracted much criticism. Peter Lurie, Sidney Wolfe and bangell criticised these trials in an editorial in the New England Journal of Medicine.

96 Placebo is a treatment without a clinical effect. It is used as a control to be compared against a potentially effective substance or method, which is being, subjected to clinical trial.
and another criticism appeared in an editorial in The Lancet. The argument is that placebo controls are unacceptable when proven efficacious treatment exist. The reason was that the short-course study was tested against placebo rather than the ACTG076 protocol. The argument was that it violated the Declaration of Helsinki guidelines regarding standard of care for human trial participants and the clause concerning ethically acceptable control arms current at the time. In reference to this, the relevant article states: “in any medical study, every patient – including those of control group, if any – should be assured of the best proven diagnostic and therapeutic method.” Elsewhere this Declaration further states that “in research on [human participants], the interest of science and society should never take precedence over considerations related to well-being of the subject.” The aim of these provisions is to protect potentially vulnerable trial participants from being harmed by taking part in medical experimentation.

Besides the accusation of violating the Declaration of Helsinki regarding this issue, internationally accepted largely as the canonical requirements regarding research ethics, the trial sponsors and ethics committees that approved the studies were further charged with employing double standards. The reason is that these studies could not have been approved in the West such as in the US that sponsored them. It is difficult not to conclude in this situation that different standards of research ethics were being applied, one for the rich nations and the other for poor countries.

It is also important to point out that some people defended the use of placebo control in the MTCT trials arguing that it posed potential benefits but no risks to subject participants in the context

where the trials were conducted. They argue that the *Declaration of Helsinki* would be counterproductive if it forbids studies that could benefit and not cause harm to the participants. Against this background, it is argued that the *Declaration of Helsinki* on this regard should be revised. Arguing from both individual and societal points of view, they contend that the trials guaranteed counselling to the individual and the possibility of receiving treatment they would otherwise not have received. Regarding the society, the intention of the sponsors and investigators is to develop affordable prophylactic treatment that would benefit impoverished vulnerable individuals and populations. It is also claimed that comparing the short-course of AZT with the ACTG 076 protocol would not answer the scientific question that informs the trials. The studies were to determine if the short-course of AZT would be better than the normal treatment provided in poor countries to prevent MTCT of HIV. In most cases, the treatment was nothing. While I cannot go into the scientific ramifications of this discussion as that is beyond the scope of this work, it is important to note that historical controls are sometimes considered legitimate in spite of the fact that they may not meet the requirements of scientific methodology perfectly.

According to the defenders of the trials, the clause in the *Declaration of Helsinki* means that research participants in control arm should not be denied proven effective treatments they would receive if they were not participating in the experiments. This line of contention leads them to conclude that the ethically acceptable control arm is one where the participants receive the locally available standard of care for their condition. Given the urgency of the HIV/AIDS situation in the developing countries, they claim that determining the effectiveness of new interventions pose the benefit of saving many lives.

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Bioethics in the last stages of life

Biotechnology has produced a situation where terminally ill and seriously injured persons’ lives can be prolonged beyond the point in which they would have died in the past. This area has been the focus of most of the influential legal cases in bioethics. It raises end-of life issues and has been most responsible for reflection on quality-of-life and sanctity-of-life debates in health-care services. These issues range from brain death and persistent vegetative states to euthanasia and physician assisted suicide to treatment of severely disabled newborn babies. Health care decisions are now engaged in a new framework of advance directives and surrogate decision. People raise the question of provision of futile care, the distinction between ordinary and extra-ordinary treatments and justifiability of killing, and withholding and withdrawing treatments, and the use of the theory of double effect in treating pains. The question of the discrepancy between what is technologically possible and economically feasible needed to be dealt with. There was need to work out a canon for making the difficult discussions on ways to ration scarce resources. The search for this gave birth to different conceptions of the value of human life and what the good life is or should be. This situation has given rise to the debate on euthanasia.

Euthanasia

Traditionally, health-care was aimed at curing and saving life. Today, the attention is primarily on ailments that affect the elderly. About this situation Michael Bury opines:

The growth of heart diseases and some forms of cancer are obvious ones. In many cases effective treatments transform many conditions that may have been fatal into chronic ones, particularly as age barriers to treatment falls, as in the case in Britain. The examples of the expansion of treatment for renal failure, disorders people have to
adapt not only to illness, but also to managing long-term treatment regimens.\textsuperscript{105}

It is now possible to maintain biological life far beyond the point at which death would naturally occur. People want to have control over the way and time they die. Euthanasia is a Greek word meaning ‘good death’. It is a combination of two Greek words: \textit{eu} meaning good and \textit{thanatos} meaning death. In its original meaning, it was a medical way of making the dying process easy for the dying. During the Nazi period it was used as a method for wiping out those who were terminally ill and those with severe handicap.

Sometimes euthanasia is used as a synonym for physician assisted suicide. When a person who is not a physician carries out euthanasia, it is referred to as mercy killing. Euthanasia in today’s debate refers to an intentional act that is meant to kill the patient with or without his/her consent. It is important to make some distinctions. The first concerns voluntary and non-voluntary euthanasia. The former refers to when a doctor assists the patient to die with the full informed and autonomous request of the patient or their surrogate. The latter refers to when a patient is helped to die without his or her fully informed consent or their surrogate. These terms distinguish euthanasia from mercy killing or any other form of killing. My concern here is with voluntary euthanasia.

It can be done through lethal injection, drug overdose, or withdrawal of life support. The demand for euthanasia is based on the desire of patients to escape severe unbearable pains occasioned by terminal or chronic illness.\textsuperscript{106} In most cases, loneliness, anguish, and pains trigger it off.\textsuperscript{107} It can also be explained by the desire of patients to retain their dignity and as much control over their lives as possible during the last phase of their lives. Sometimes it is the cries of terminally ill who want assistance to die because they consider


\textsuperscript{106} The case of Piergiorgio Welby, a 60-year old Italian who suffers from muscular dystrophy, who, sent a video to Italy’s president, Giorgio Napolitano, with a plea to be allowed to die is an example. His case flared up debate over euthanasia in Italy recently. See the newspaper ‘Corriere della Sera’ Sept 23, 2006, and the newspaper, La Republika, Sept 24, 2006.

\textsuperscript{107} Respekts skrifter No 3, 2005, Respekt för människans värdighet, Etisk analyse och katolsk syn på 14 medicinsk-etiska områden, p 46.
their lives no longer worth living, and at other times it is the agonising family members who can no longer cope with the situation.

The issue of euthanasia is a controversial one both for health professionals and for the public. Some are its proponents and some others are its opponents. This can be explained by the diversity of moral views both religious and humanist in this matter. The central ethical issue is whether respect for persons demands respect for their autonomous choices to a personal ‘right to die’ and ‘right to be helped to die’ as long as those choices do not cause harm to others. Some people argue that it does demand that individual choices are respected provided a competent patient or the surrogate makes the choice. This raises the question of whether the death of a person is just a personal matter, or a social and communal matter. Others are of the view that life is a gift to the individual person. We cannot take the place of God by disposing our own lives at will. Opponents of euthanasia argue that if the situations that lead to excessive suffering are reduced or eliminated, the demand for euthanasia would also be reduced. They argue that it is nowadays not necessary for anyone to die while suffering from overwhelming pain because of the availability of better palliative care. They argue that there are grave dangers that a personal ‘right to die’ and the ‘right to be helped to die’ may become a duty to die in which case we run the risk of devaluing human life.\footnote{Derr P, 1986, “Why food and fluids can never be denied,” in Hastings Center Report 16, pp 28-30.} In this connection, it is observed that some old people in the Netherlands who are suffering from neglect are no longer ready to go on living and are requesting for euthanasia. Others say that legalising euthanasia will bring with it the collapse of the traditional trust on the medical professions and change radically our vision and value for human life. Some others reason that there can be no sufficient evidences for us to be justified that a dying person’s request to die is competent, enduring and genuinely voluntary. This means that we cannot be sure that the request for euthanasia comes from the deepest will of the person; it might be the result of a passing moment of suffering. In this regard, they explain that those sufferings from terminal illness, and who want to commit suicide, are often
suffering from depression. The solution for their problem is not, to be allowed to die, but to treat their depression. They argue that most elderly people who commit suicide are in relatively good health, or at least not as ill as they think they are. Terminally ill people sometimes have no family members or close relatives who help and support them in their suffering. In such cases, some of them see no other way out other than to seek a way of ending their suffering since life no longer have any meaning for them. From this perspective, accepting the idea of euthanasia does not mean compassion to them. Rather, it means refusing to help them cope with their needs. Yet others argue that permitting euthanasia will lead to a slippery slope in which case it might become eugenics. These different positions demonstrate moral pluralism in our society.

Since 2001 euthanasia and physician assisted suicides have been legal in the Netherlands. Belgium legalised euthanasia in 2002, and the state of Oregon in the US legalised physician assisted dying in 1994. Colombia is the last in the list of countries where physician assisted suicide is practised. Discussions are going on about this new problem in many countries.

In order to address the moral or ethical problems that arise in issues at the end of life within a particular society, it is important to understand the view that society has about life, suffering, death, autonomy, and dying. Within an African context, a justified policy in this regard would have to include insights from traditional African heritage especially African concept of personhood, individual and communal experience, suffering, death and dying, and the fact of pluralism of moral visions.

**Conclusion**

The purpose of this chapter has been to show the existence of pluralism of moral visions in some bioethical issues at the beginning and the end of life. The issues where we identify and discuss moral pluralism range from those of reproductive technologies, the status of human embryo, embryo research, stem cell research and therapy, ethical issues in genetics, research involving human participants, and euthanasia. In reproductive technology, the ethical issues centre on
the question whether reproductive freedom gives individuals the right to use these technologies as they please. Ethical questions in human embryo research deal with diversity of responses given to the issue concerning the dignity we should assign to embryos. Opinions vary about whether it is ethical to conduct non-therapeutic research on them. In genetics, there is disagreement on how to use the results of preimplantation genetic. There is also diversity of views on how employers and insurance companies should use genetic results. Ethical disagreement in clinical research ethics centre on the use of placebo treatment for those in the control arm of research. It also deals with the issue about what should be the standard treatment for human participants in research. In euthanasia, the disagreement is on whether individual autonomy gives individuals the right to choose the moment of their death, ‘personal right to die’ and a ‘right to be helped to die’. There is diversity of moral views on all of these questions.

In the next chapter, I will attempt to discuss from the perspective of some ethical theories how those issues identified in chapter one are dealt with.
2. Five Approaches to Bioethics

In the previous chapter, I examined some bioethical issues and the various positions that ethicists, bioethicists, moral philosophers and theologians commonly take when discussing them. I also suggested some reasons that might explain why there is such a plurality of positions. One of the main points made was the fact that moral diversity is something that confronts us in everyday life. We observed also that there is no simple solution to many of the problems raised. The main thesis I will attempt to illustrate in this chapter is the fact that bioethicists not only disagree in concrete bioethical problems; they also disagree as to the methods and theories for bioethical analysis.

This chapter discusses and explores five major approaches to bioethics. It is an attempt to explain the various positions that individuals and groups take in these questions from the backgrounds of the different ethical theories or principles such as those of deontology, utility, and casuistic theories that constitute the theoretical framework for their inquiry and analysis. I will classify them into two groups: Principle-based and experience-based paradigms. I will explore two forms of principle-based bioethics and three forms of experience-based bioethics.

Two paradigms and different approaches

Two major paradigms are recognizable in bioethics, namely: principle-based and experience-based. Much of medical ethics has its

109 Bioethical theories can be classified into paradigms. According to Guba & Lincoln, “a paradigm may be viewed as a set of basic beliefs (or metaphysics) that deals with ultimate or first principles. It represents a worldview that defines for its holder, the nature of the world”. Guba E. G & Lincoln Y.S., 1988, “Competing paradigms in qualitative research”, in The Landscape of Qualitative Research: Theories and Issues eds., N. K Denzin & Y.S. Lincoln, pp 195-220.
basis in a principle-based approach, which view rules and actions as based on principles. Experience-based paradigm is the method that takes experience as the defining element in making a bioethical judgement. The principle-based paradigm is the most popular of the paradigms. The reason could be said to depend on its simplicity. I will now explore the meaning of each of the paradigms in detail.

Principles have played a significant role not only in philosophical theoretical medical ethics, but also in clinical applied ethics. This method is analytic in nature and uses principles relying on theories, techniques and methods to create a rationalist, deductive and formalistic approach to bioethics. The advent of this approach to ethics is traceable to W.D Ross’s theory of prima facie principles which physicians adopted and soon became the dominant method of doing ethics.

It is also traceable to the outcry that greeted the many ethical abuses that occurred in human experimentation in North America biomedical and clinical research. Two major factors advanced for these abuses were identified as the imperative to make medical progress and the unquestionable authority of physicians in medical matters. During this period, the concern in human experimentation was on how to control the risks to research subjects. Little or no attention was paid to the research patient’s right to autonomous decision. This need gave birth to the principles of autonomy, beneficence, and justice. Bioethics was at this time concerned with the formulation of ethical principles for research and clinical practice. Relevant principles to a concrete case are identified and, then applied to individual cases.

Theologians played an important role in pushing bioethics in the direction of principle-based approach. Richard McCormick applied Catholic insights and principles to questions such as fetal research. Paul Ramsey combined a theology based on the love of God with natural law theory to argue against technological intervention such as

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in vitro fertilisation.\textsuperscript{114} Charles Curran, in his bioethical writings tried to clarify rules and principles that have emerged in the Catholic tradition.\textsuperscript{115} Some American Jewish theologians working during this period such as Seymour Siegel, David Feldman also contributed toward the principle-based orientation. *The Principles of Biomedical Ethics* by Tom L. Beauchamp and James Childress adopted the approach of Ross and opted for prima facie principles. This refers to principles that should always be respected unless strong reasons exist that should justify overruling them in ethical deliberation.

Principle based paradigm in this study will refer to the approach of bioethics that uses principles to justify particular bioethical judgements. One fundamental question about principles concerns the source of their justification. Traditionally, intellectual justification has been argued in terms of different traditions in moral philosophy. Generally, modern moral philosophy is dominated by two ethical theories namely, deontological ethics and consequentialist ethics. The former is based on reason, intention, and duty usually derived from the work of Kant. Deontologists hold that certain acts are right or wrong per se, for example, lying, killing the innocent, treating persons as a means, never as an end. The latter is based on the effects, or consequences of actions. Utilitarianism is the primary form of it. A principle-based bioethics could be articulated in a consequentialist, deontological or Kantian way. For consequentialists, the central issue is utility and for deontologists or neo-Kantians, it is duty. Experience based paradigm refers to the model of bioethical judgements where justifications can occur in concrete cases without reference to principles, by appealing to experience and intuitions.

**A utilitarian approach**

Utilitarian bioethics is arguably the most popular approach in principle-based bioethics. Utilitarian bioethics concentrates on utility. The principle of utility or the ‘greatest happiness principle’


\textsuperscript{115} Curran C, 1984, *Critical Concerns in Moral Theology.* See also 1985, *Directions in Catholic Social Ethics.*
states that an action is right to the degree that it tends to promote happiness; wrong to the proportion that it tends to produce the reverse of happiness. It is the consequentialist aspect of utilitarianism that maintains that actions, rules, policies, practices, and moral principles are ultimately right or wrong in relationship to their consequences that has made consequence based type of utilitarianism perhaps one of the most controversial moral theories. The core element of utilitarian bioethics could be said to be the view that both individual action and public policy should maximise utility which is defined in terms of happiness or preference satisfaction for the greatest number of people in health care system. The cost/benefit analysis is employed to determine the correctness of a medical or scientific course of action.

Utilitarian bioethicists have discussed and contributed influential works to many problems in bioethics such as reproductive technology, embryo research, abortion, resource allocation, genetics, and voluntary euthanasia. In what follows, I shall discuss utilitarian bioethics as currently formulated by some bioethicists. The idea is to bring out more clearly elements of utilitarian approach to bioethics, its strengths and weaknesses and the plurality of moral views on them.

Joseph Fletcher is of the view that a moral agent’s business is to maximise good. The good in this context is defined as ‘happiness.’ According to him, whatever increases human happiness is good; whatever reduces human happiness is evil. He dismisses the traditional medical reverence for life. Further, he distinguishes between mere ‘human life’ and ‘personal life.’ It is the personal status; he considers critical, not merely human status. This led him into articulating what he referred to as criteria of indicators, which are to distinguish those individuals who possess ‘humanhood’ from those who did not. The former are the truly humans who deserve moral consideration. The list includes minimum intelligence, self-awareness, self-control, a sense of futurity, memory, concern for others, communication and neocortical function. These were given for gauging the quality of human life for biomedical ethics.

Peter Singer, an Australian is one of the most widely known and influential contemporary utilitarian bioethicists of the 21st century. In order to understand Singer’s approach to bioethics, it is important to understand his worldview. Singer may be described as a utilitarian who promotes preference-utilitarianism, an alternative to Bentham’s hedonism in his 1789 *Introduction to the Principles of Morals and Legislation*. Singer’s concepts of personhood, replaceability, and quality of life have serious consequences for people with disabilities, caregivers in general. Singer is of the view that people with severe disabilities such as humans without a clearly shown self-awareness, such as infants and people with severe cognitive disabilities should not be considered as persons and therefore have no rights in ethical matters. The reason is that this group of people is, as he argues, incapable of experiencing pleasure and pain. Singer’s definition of those to be excluded in the category of persons is not clear. However, he suggests those children up to the age at least 28 days and everyone who has severe disabilities. According to Singer, “killing a defective infant is not morally equivalent to killing a person” and “the life of a new-born is of less value than the life of a pig, a dog, or a chimpanzee”. Singer articulates his own Ten Commandments to replace the traditional one, which he considers outdated. The traditional morality of “thou shall not kill” is absent from his list and is replaced by “recognise that the worth of human life varies.” Singer in a similar manner writes that ethical ideals such as individual rights, justice, sanctity of life, purity are incompatible with utilitarianism.

In his *Rethinking Life and Death*, he described the quality of life ethic by writing

> We should treat human beings in accordance with their ethically relevant characteristics. Some of these are inherent in nature of being. They include consciousness, the capacity for physical, social, and mental interaction with other beings, having conscious preferences for continued life, and having enjoyable experiences.

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117 Bentham J, 1789, *An Introduction to the principles of morals and legislation.*
All of these things make a difference to the regard and respect we should have for such a being.\textsuperscript{121}

It should be obvious that there are difficulties with this view of quality of life. The problem arises when the concept of quality of life ceases to be a factor in medical decision making and instead becomes the factor. Singer radicalises Fletcher’s original position to include even animals in the moral community. He would maintain that being human, in and of itself, is irrelevant to the moral status, what counts are whether the being is a person. Rationality and self-consciousness are the essential elements that constitute personhood. Species is irrelevant. According to Singer, by these criteria some animals are persons such as monkeys, dogs, pigs, cats, cattle, sheep, whales, and dolphins.\textsuperscript{122} By the same standards, some humans such as people with advanced Alzheimer’s disease, those with severe disabilities, newborn infants whether disabled or not would not qualify as persons. He compares these humans to fish or fowl and concludes that the wrongs of killing them are not comparable with the wrongs of killing a person. He accused those who value the happiness of humans over the happiness of pigs, goats, and other animals as being spiciest.\textsuperscript{123}

Singer’s conception of disability and those with severe disabilities is difficult to accept for many people. He believes that people with disabilities cannot have worthwhile and rewarding lives. The implication of this would be far reaching if applied to bioethical problems. Every kind of action agreed to by consenting adults could be justified drawing from this position. For utilitarianism, life has a high value but a derivative one. That means that some lives can be traded off for the sake of other lives.

Torbjörn Tännsjö is arguably one of the best representatives of utilitarian position in Sweden. He maintains that happiness is the same as welfare.\textsuperscript{124} In his \textit{Hedonistic Utilitarianism}, he defends hedonism. This is the view that pleasures are the intrinsic good and pains the intrinsic bad. What people want equates in this sense the

\begin{thebibliography}{9}
  \bibitem{121} Singer P, \textit{Rethinking Life and Death},
  \bibitem{122} Singer, 1975, \textit{Animal Liberation},
  \bibitem{123} See Singer P, 2000, \textit{Writings on Ethical life}.
  \bibitem{124} Tännsjö T, 1990, \textit{Värdeitik}.
\end{thebibliography}
ultimate measure of right and wrong. It can be said that all leading bioethicists accept some version of utilitarianism. Much of modern bioethics is largely utilitarian.

Earlier, it was noted that utilitarian bioethicists support “futile care doctrines”. Many hospitals across the world have this in place. This policy permits on-call doctor or treating doctor to withhold treatments that are viewed as ‘futile’ by the treating physician and his or her colleagues irrespective of the wishes of the patients or their family members. One hears such statements as “the patient is not for resuscitation”. From the foregoing, it may be observed that the ethics of health care is embracing or has already embraced a strong utilitarianism.

Utilitarian bioethics fails to give adequate account of how one is to measure happiness and the value of human life. One of the ways it does this is by making the dignity of human life depend on the view of ‘quality of life’. It does not give adequate account of the concept of duty and individual rights. Utilitarian bioethicists reject two distinctions, which are central to deontological approach in bioethics: the intention/foresight and acts/omissions distinctions. These distinctions are important in terms of motives and responsibilities for action. Arguably, euthanasia, both voluntary and involuntary, futile care theory, and the ‘painless’ termination of the lives of the elderly and the disabled are the hallmarks of utilitarian bioethics.

Although there are many arguments against utilitarian pattern of reasoning, yet it is no easy task refuting its claims. Two major factors seem to account for its popularity. First, utilitarianism is not a substantive theory, i.e.; it does not impose a set of thick moral values as monistic theories do. It divests everything of meaning and making them in the end instruments of human satisfaction. Second, it seems to suit perfectly with pluralistic society with its tendency to relativize all values. This means providing no way for assessing the rationality of one’s desires and goals, but enabling one to choose the most effective way to attaining the goal set by desire. Despite its many valuable insights, the failure of utilitarianism to give an adequate and acceptable account of justice and duty has lead to a continued search for bioethical theories that take these concerns seriously.
A deontological approach

This approach to bioethics rejects much that consequentialist utilitarian bioethics affirms. Deontological bioethics is nonconsequentialist. The term deontology comes from Greek ‘deon’, which is a Latin word meaning duty, or obligation. Deontological ethics refers to any system that does not appeal to consequences of our actions, but to conformity with certain principles, rules of duty. Deontological theories have been advanced in different forms. Secular deontological approaches tend to be based on Kantian and neo-Kantian ethical theories. Immanuel Kant, a leading German philosopher of the Enlightenment probably advanced the most influential of all deontological theories with his concept of Categorical Imperative. The two most stated formulations of these imperatives include: “act only according to that maxim by which you can at the same time will that it should become a universal law”. The second states “act so that you can treat humanity, whether in your own person or in that of another, always as an end, never as a means only”.\textsuperscript{125} Kant argued that morality is founded on pure reason, not in intuition, tradition, emotion, conscience, or attitudes such as sympathy.\textsuperscript{126} He made the intention for an act the standards for judging any action right or wrong and contended that duty alone should motivate morally adequate action. One’s duty is to act in accordance with objective moral laws. For Kant, all persons have a distinctive value, a unique worth or dignity. He argues that the worth of a person is not reducible to that individual’s talents or to that individual’s utility or services to others, nor to how others relate to that individual.

There are differences between Kantian and utilitarian bioethical decision-making. Utilitarians and Kantians arrive at different answers to many bioethical issues. Kant’s approach offers a strikingly different interpretation of the meaning of human life, which has implications for applied ethics and especially for bioethics from the one offered by consequentialism or utilitarianism. Kant also

\textsuperscript{125} Kant I, 1976, \textit{Foundations of the Metaphysics of Morals}, trans by Lewis White Beck, p 47.
offers an understanding of the concept of equality different from that of utilitarianism. According to Kant, it is the individuals who are equal in value, whereas for utilitarianism, it is similar preference satisfaction or pleasures that are equal.

Among neo-Kantians emphasis is on rights and duties of a person rather than on consequences. The main ethical principle here is autonomy sometimes referred to as the principle of respect for persons. Neo-kantians hold the view that autonomy is of great intrinsic value because it is the foundation of respect for persons. Utilitarians support the idea of respect for informed consent for a different reason. According to utilitarians, personal autonomy has instrumental value. It is necessary because it enables one to satisfy preferences, desires and interests. It is important to observe that many of the principles in bioethics especially in North America have been defended from a neo-kantian framework. Edmund Pellegrino is a deontologist. He holds the view that human life is a continuum and that every human life has dignity and merits protection. According to him, each stage of that development must be treated as an end in itself, not as a means to other ends, however useful they might be to others.

A common characteristic of utilitarianism and deontological approaches is their emphasis on principles or rules in the observance of moral life. This implies the preoccupation with duty or obligation. In some cases, deontological approach might coincide with those of human welfare and of act-utilitarian ethics. At some other times, it clashes with those of human welfare, such as in situation where it prescribes actions, which may lead to avoidable human misery. There are differences between Kantian and utilitarian bioethical decision making. Utilitarian and Kantians arrive at different answers to the question of whether it is ethically justifiable to sacrifice the life of one innocent person in order to save the lives of two or more people. Most utilitarian bioethicists would answer yes while deontologist bioethicists would argue that it is unacceptable to kill an innocent person. Most Kantian bioethicists reject voluntary

euthanasia, irrespective of the suffering this may cause in individual cases. Utilitarian consequentialist would support euthanasia if it were the desire of the patient provided there is informed consent. Some deontologists are of the view that the human embryo has the right of personhood. It is therefore unethical to destroy them or to create them solely for the purpose of research to obtain stem cells or stem cell lines. In a 1999 report, President Clinton’s bioethics Commission called the National Bioethics Advisory Commission (NBAC), arguing from a utilitarian framework supported the destroying of embryos to obtain stem cells. It should be noted, however, that the endorsement of using spare embryos for research is only supported when the potential benefits exceed the anticipated costs. Generally, utilitarians do not regard the human embryo as a full person. Those who hold the view that embryos are persons reject the report of the Commission. They argue that destroying spare embryos from IVF is still sacrificing human life and, therefore violates Kant’s Categorical Imperative that forbids the use of persons as a means. Yet, some others make distinction between embryos created expressly for destroying them to obtain stem cells and harvesting stem cells from spare embryos from IVF procedures. They argue that only the latter is ethically permissible. Some others do not make this distinction. This shows that even among deontologists and utilitarians there is a diversity of views on many bioethical problems.

An important charge against the principle–based approach is that the latter by emphasizing the abstract features of a universal ethic such as universal rights, equality, dignity, has not identified and adequately accounted for particular moral experiences of the individuals who are involved in concrete moral cases.

How do we then gain moral understanding in bioethics? One important element is the understanding of the contexts or culture within which bioethical issues arise and are dealt with. Against this background, there is need to situate bioethics within personal, social, and cultural contexts. This opens the possibility to many ways of moral deliberation that are not specifically general, impartial, but that includes distinctive histories, relationships and situations that both

129 For the commission’s report, see www.georgetown.edu/research/nrcbl/nbac/stemcell.pdf
engage people’s reason and emotion. Multiple backgrounds structure moral problems and give meaning to moral concepts.\textsuperscript{130}

**An experience-based paradigm**

The second major paradigm in bioethics is what I refer to as an experience-based paradigm. The problems associated with utilitarian and deontological approaches have resulted in the emergence of approaches, which take experience as their major feature. An underlying feature in all of them is the attempt to begin bioethical inquiry and analysis from ‘bottom-up’ and not ‘top-down’ as in principle based approaches. Top-down approaches assume that carefully thought out general principles should frame and direct ethical analysis. The fundamental difference between principle-based and experience-based is the latter’s emphasis on concreteness or particularity. From the foregoing, bioethics is not simply deductively applying general ethical principles to biomedical moral dilemmas. A major characteristic of the experienced-based approaches is often the refusal to acknowledge the existence of an overarching or transcendent ethical framework for dictating how ethical analysis should proceed.\textsuperscript{131} Emphasis is laid on single cases and on context. The difference as I hope to point out between these two paradigms probably lies in their method of justification in concrete bioethical cases. The experience-based paradigm emphasises personal relationships, context, structural analysis that could be both political and social, as well as care, the value of communication and compassion. It is this underlying attention to contextual concern and to particularity that fundamentally differentiates these experience-based approaches from the principle-based approaches.

A striking feature of experience-based approaches is its emphasis on experience and intuition in resolving bioethical conflicts and the great diversity that one finds in its method. Some reasons advanced for this diversity includes the claim that bioethics is still a new field;


that pluralism of moral visions is a sociological fact.\textsuperscript{132} The other reason is the difficulty in applying principles, which opens the way for re-assessment of the way forward thereby giving rise to great diversity. In spite of the great diversity of approaches existing among experience-based paradigm, they all emphasize the need to expand bioethical questions to embrace context, experience, and practice.

The purpose of this section is to describe and analyse three models within experience-based paradigm. The three perspectives are casuistic bioethics, virtue bioethics, and communitarian bioethics. This selection is a reasonable representation of the concerns that have been voiced by these models of bioethical reflection. It might be reasonable to note that a full explication of these approaches to concrete cases is well beyond the limited scope of this study. Nevertheless, I shall at least discuss the essential elements of these perspectives in order to show the existence of ethical pluralism.

\textbf{Casuistry}

Casuistry refers to the style of ethical argumentation fully elaborated by the Jesuit moral theologians in the 16\textsuperscript{th} and 17\textsuperscript{th} centuries. This is an alternative approach to bioethical analysis that avoids the ‘top down’ approach of principles and uses ‘bottom-up’ approach to resolve ethical problems. The best known advocates of casuistry today certainly include Albert Jonson and Stephen Toulmin, who explain casuistry as the art of resolving practical moral dilemmas without appealing to the tradition of principles, rules, rights, or virtues. They trace the origin of this approach to what Aristotle calls ‘phronesis’, or practical wisdom.\textsuperscript{133} Since medicine is both learned and practised through cases, a method of ethics that relies on paradigmatic cases is argued to be best suited for bioethical issues. Casuists are sceptical of the use of the model of a philosophical

\textsuperscript{132} Engelhardt 1999, “Bioethics in the third millennium: some critical anticipations”, \textit{Kennedy Institute of Ethics Journal} 9:3 p 229; 1996, \textit{Foundations of Bioethics}, 2\textsuperscript{nd} edition, pp 3-31. Here he maintains that we must speak of bioethics as a plural noun.

moral science and judgement based in universal principles in bioethics. Casuistry begins with the complex nature of human experience. It refuses to exclude a priori any part of our experience from consideration when generating ethical rules.

Jonson and Toulmin describe casuistry as involving identifying paradigm cases from which moral maxims can be drawn; constructing cumulative arguments that use analogy to extend the applicability of a given maxim to a previously unanalysed moral conflict. In order words, it relies on experience drawn from the history of similar cases, the development of maxims, to resolve present problems. The primary task of this model is to understand differences of paradigmatic cases in terms of morally relevant distinction. Casuists maintain that the way a given case is interpreted, and hence which maxim applies to it, depends on the circumstances of the case and our general perception. A change in the circumstances and perception lead to a change in the maxim that is applied.

Casuists promote the role of experts in bioethical judgments. DeGracia criticising casuists’ promotion of the role of experts writes that casuistry cannot be considered an adequate theory unless it develops ways to get beyond the bias of both experts and our own moral traditions or practices. Jonson and Toulmin point out themselves “more than anything else, where a moral argument ends depends on where it begins.” Given this observation, an important question concerns how casuists justify their decisions on a particular case. The answer is obviously through social conventions and the patterns of judgement traced through their methods. Against this background, one may understand the contention of Kevin Wm. Wildes that casuistry is only possible if there is a commonly agreed upon morality.

Moral judgements are often made when principles and rules cannot be appealed to. When principles are applied inflexibly to cases without adequate regard to circumstances a “tyranny of

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136 Beauchamp & Childress, 1994, Principles of Biomedical Ethics, p 97.
principles” \(^{138}\) is the result. Casuists argue that moral belief and knowledge development proceed by reflection on cases, without appealing to top-down theory. To support this view, they point to an analogy to the case of law. When a jury’s decision becomes authoritative, it sets a precedent for all other subsequent similar cases. The case becomes a paradigm case for other cases that are sufficiently similar in relevant aspects. The moral law develops incrementally just the same way case law does. \(^{139}\) This does not mean that casuistry does not employ principles. What it rather means is that principles are justified by paradigm cases. This is the main difference between casuistry and the method of Beauchamp and Childress, where principles justify judgement on cases.

In his article “ethics and imagination” \(^{140}\), Anders Nordgren develops a type of casuistry which he calls “imaginative casuistry” that is similar to this model. The idea is that with empirical discoveries concerning moral concept formation, morality has to do with metaphors and imagination rather than with precise concepts and deductions. He also stresses plurality of values and case-by-case decision-making. In this paper, Nordgren argues that for normative medical ethics to be psychologically realistic it should take seriously the findings of cognitive semantics \(^{141}\). In this paper, imaginative casuistry is preferred to principlism and other forms of casuistry. Central principles of medical ethics such as justice, autonomy, utility, and integrity are interpreted metaphorically as meaning principles summarising the collective wisdom concerning paradigm cases. \(^{142}\)


\(^{139}\) Jonson & Toulmin 1988, pp 16-19, 66-67, see also John D. Arras, 1991, ‘Getting Down to Cases: The Revival of Casuistry in Bioethics,’ JMP 16: 113-30. Arras claims in this article that casuistry is the product of the middle Ages during which there was consensus on a large issues such as the belief in God, the purpose of human kind and the totality of life pp 29-35.


\(^{141}\) Cognitive semantics, which is a part of cognitive linguistics, begins the analysis of concepts from an empirical perspective. This means that the meaning of a concept is determined by its actual usage by people.

\(^{142}\) Nordgren A, 2001, Responsible Genetics, p 34.
In his book, *Responsible Genetics* he continued to develop this idea. The thesis defended is that responsibility is a metaphorical concept that is supported by findings in cognitive semantics. Nordgren distinguishes between ‘engineering’ and ‘tinkering’ in moral reflection. The former refers to a principle-based moral deliberation. In addition, the latter is nondeductivist approach. Imaginative casuistry is said to be a radical version of this model. The starting point of this model is previous moral experiences. Nordgren’s distinction is similar to the contrast I made between principle-based and experience-based bioethics paradigms. The contrast he makes between agential model of moral responsibility and social models share much in common with the distinction I made between western bioethics and African bioethics. The former is based on an individualistic ontology that does not adequately account for the social situatedness of agents. The latter focuses on the responsibility demanded by one’s social position. Nordgren’s advocacy for a ‘modified social model’ of moral responsibility and casuistic imagination is much like what I refer to as a holistic method in ethical decision. While Nordgren seems to dismiss principlism, he however, employs principles at many points in his studies that are justified by paradigm cases. In his approach, one finds not only an authentic representation of medical morality but also a project that is compatible with the African framework especially in its case-by-case model of decision-making. It could be said in a sense that casuistry uses paradigm cases to generate principles or maxims for application to particular cases. Nordgren’s model of imaginative casuistry is an interesting complement to casuistic approach in ethics.

Casuistry has contributed to bioethics in helping us realise the need to embrace analogical reasoning and paradigm cases in bioethical decision-making. A Casuistic model can help us in assigning priorities to conflicting ethical values. Finally, it is worth noting that a major weakness in the case for casuistry is most probably its ambiguous relationship to theory and principles. My point is that it is not clear, how casuistry makes the transition from paradigm case to concrete decision in a new case. It could happen that when a different set of paradigm is chosen for a particular

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analysis, they could yield different conclusion. I will now turn to another of the alternative model referred to as ethic of virtue.

A Virtue approach

The cultivation of virtues is increasingly seen by some writers as a necessary endowment for a meaningful engagement with dealing with ethical dilemmas in health care setting. Virtues in other words are character-trait of vital importance for physicians and other care providers or for those individuals who are involved in the medical encounter. They are not to be mixed up with technical skills such as making the right diagnosis, giving injections or any other of such skills that are learnt through the period of training. The concept of virtue is probably not a common one in most secularised societies. Nevertheless, virtues still play an important role among such communities where community and family ties are still strong.

Virtue, what it is and how it comes to be possessed by a person has received varying interpretations in moral philosophy. It has always played a crucial role in medical ethics tracing back to the time of Hippocratic, Plato and Aristotle. Living a good life and becoming a good person through the cultivation of virtuous character have been its major emphasis. Aristotle understands virtue as a trait of character that is acquired by repetition of corresponding acts. These acts cannot be described exactly, but must avoid excess and defect. He makes a distinction between moral and intellectual virtues. The latter kind, according to him helps us to reach eudaimonia. He identifies wisdom as the most important cardinal virtue. The good of humans is that activity that is in agreement with wisdom, i.e., the contemplative activity. Wisdom co-ordinates the activities of the other virtues and

144 Malmsten 1999, Reflective Assent in Basic Care, A study in Nursing ethics, p188. In this study, Malmsten, presents virtue ethics alongside communicative ethics and feminist ethics as alternative approach to principled-based ethics that dominate textbooks in medical and nursing ethics. She notes that virtue ethics is presumably an unknown concept for many professionals in nursing practice today.

145 I have in mind most countries in Asia, Middle East, Africa, South America, and those communities in industrialised countries where family names are seen as goods worth preserving, and the honour of the family weighs much in individual actions of the members of such families.
brings them to harmony. Stout has likewise suggested four cardinal virtues for medical care. He proposes ‘phronesis’ i.e., practical wisdom, and embodied intelligence, as justice, courage, and temperance. According to professors Carl-Henric Grenholm and Göran Bexell, five conditions must be fulfilled for any character to be described as a virtue. The character must be a human character, such that can be acquired, it must be a disposition that enables one to act rightly, it must be directed to a holistic view of life, and finally, it must be such a character that is valued. Given this view, morality does not just consist in the ability to perform acts that have certain characteristics; the agent must also have motivations, which lead him or her to carrying out those acts.

Right motives for action tell us more about moral worth than right actions. It is important to point out that this is an important insight, since we normally would want our friends not only to act toward us not purely of obligation’s sake, but more importantly to be motivated from the virtue of friendliness. Without this virtue, the relationship lacks a moral worth.

Nel Nodding and Virginia Held, American moral philosophers have developed a kind of virtue ethics based on the experience of women in patriarchal society. They favour an ethic of caring, which implies a critique of utilitarianism and deontological ethics. They have also made important contributions to various fields of applied ethics. For example, they have developed a relationally based ethic of care that challenges the primacy of the kantian ideal of an ethic of justice.

Nodding argues in her book, *Caring. A Feminine Approach to Ethics and Moral Education* for an ethics of care whose fundamental obligation ought to be care for the other person. The ability to care is in itself a virtue. According to her, what such an ethic could mean in practice is difficult to say. Those who care seek to benefit the fulfilment and welfare of the other. To care, in her view, means to

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146 Aristotle *Nicomeachean Ethics*, BK II.
seek the good of the particular individual in a specific situation. The important element in this type of ethics and what it understands as constituting a right action is not just the consequences of the action. Those who care are characterised by an attitude of kindness and empathy for the other person. Noddings’ form of care ethics leads to a kind of ethical contextualism. The reason one may argue is that care is a cultural phenomenon. Caring often reflects traditional knowledge. Nodding’s hypothesis is that all humans have a need to be cared for. This ability to care about others fosters the ability to take a global view and to develop a sense of social justice. If we are to formulate truly effective social policies, we must acknowledge the central role of an ethic of care.

In her book, *In a Different Voice*, Carol Gilligan argues that women’s moral development is distinct from men’s. Gilligan identifies women’s mode of moral thinking as that of an ethic of cares in contrast to that of men that is an ethics of right and justice. The ethics of care deals with contacts, relationships, and responsiveness. However, it is worth emphasising perhaps that she does not claim that these two modes of thinking are necessarily correlated with gender; neither does it follow that all women or all men necessarily think or speak in the same moral voice. By making this distinction, she is concerned with showing that men and women have a general tendency to speak in morally distinct ways. Gilligan, who is a developmental psychologist, was in the first place criticising developmental theories that are grounded only on empirical studies.

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152 The American feminist, Virginia Held, in her book, *Feminist Morality*, proposes also this form of ethics. A feminist care ethics could be said to be ethical contextualism if it claims that particular moral principle applies to particular context. See Carl-Henric Grenholm, *Bortom Humanismen*, 2003, for a discussion on different forms of contextualism. See also Kronlid David, 2003, *Ecofeminism and Environmental Ethics: An Analysis of Ecofeminist Ethical theory*, Uppsala University, Uppsala.
of boys. Common to Nodding and Gilligan is the claim that an ethic of care is what captures best the moral experience of women. They distance themselves from every form of consequentialist ethics and every form of universalist moral principles.

It is clear that the ethics of care more or less emphasises the personalistic context in which moral decisions and actions arise. In attempting to give a specification for this model of ethics, the relationship such as that existing between parent and child is seen as exemplifying this model.

Michael Slote in his book, *From Morality to Virtue*, makes a case for a general account of a specific form of virtue ethics, a type of virtue ethics that is more interested in virtuous character of virtuous individuals than in the actions of such individuals. It is also a form of ethics that is grounded in the concepts of goodness and excellence rather than in notions like ‘ought’, ‘right’, ‘wrong’, and ‘obligation’. An ethic of character or virtue emphasises the agents who act and make moral decisions rather than the rules or principles by which the decisions are made. Bioethical issues are discussed not just in relation to how we can solve concrete moral dilemmas, but also in relation to what implications the character of the individual(s) might have in their moral engagements. In virtue ethics questions are no longer focused on “what I should do”, but on “what sort of person should I be”. The basic insight is that “as a person is, so that person acts”. Virtue ethicists claim to provide a genuine theoretical alternative to Kantian, utilitarian and deontological approaches to bioethics.

Gunilla Silfverberg has developed a well-articulated position on virtue ethics as it relates to bioethics. In her *Ovishetens etik* she discusses professional ethics in relation to medical ethics. Silfverberg presents a model that is more or less universalistic and valid for all

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159 Slote 1992, *From Morality to Virtue*. Slote proposes a kind of utilitarian and virtue ethics that have ‘self-other symmetry’. By this is meant a form of ethics that treats benefits and harms to the agent as relevant to the evaluations in the same way benefits and harms to other people are relevant to their ethical evaluations of actions.
160 Throughout this analysis, virtue and character will be regarded as synonymous terms when they refer to a form of ethics.
times, for every age, culture and tradition. Silfverberg has also tried to see what could be the relevance of Aristotelian virtue ethics to modern discussion within professional ethics. She holds that a situation-dependent, context-sensitive virtue ethics provides a better way for analysing empirical data than universal principles as present in universalist normative ethical theories. Virtue ethics is a type of experience based paradigm in bioethics. The reason is that experience is a fundamental feature of it. This type of ethics places human character in focus of ethical analysis. Virtues would include wisdom, truthfulness, friendliness, helpfulness, and trustworthiness, flexibility. These characteristics could be desirable and worth striving for in relation to health care delivery. Silfverberg argues that these virtues can help the health professional to make his or her judgements according to the need of the individual and their unique situation. Silfverberg’s virtue ethics is a type of experience based ethics because it focuses on the role of experience of the health care giver in medical decision-making.

Some suggest that virtues should be inculcated through educational programmes, and role models. Gregory Pence argues that what is needed is not a system of rules but a system that trains the health professional’s “desire not to abuse their subjects...”

A person we trust is one who has an ingrained motivation and desire to perform right actions. Not the rule follower, then, but the person disposed by character to be generous, caring, compassionate, sympathetic, fair, and the like, is the one We will recommend, admire, praise, and hold up as a moral model.

This text shows that character is crucial to medical ethics since the health care giver interprets and applies whatever theory or principles are employed. If the foregoing analysis is correct, this makes a good

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165 Pence 1980, Ethical Options in Medicine, Medical, p 177.
166 Beauchamp T & Childress F, 1994, Principle of Biomedical Ethics, p 65f.
case for the inclusion of virtue ethics in bioethics. We should at the same time understand that this does not entail the assigning of an exclusive role to virtue, as if it could completely replace obligation-based theories. The two types of theories although emphasising different points, yet are “compatible and mutually reinforcing.”\(^{167}\) This compatibility, it needs to be said does not mean perfect correspondence. For example when virtues conflict, we need help of principles or obligations to discover the best motivation to follow. In spite of the important role of virtues in moral life, it still has some weak points. First, virtues do not encompass all areas of moral life in every concrete situation. In some setting, it is bound to play a less significant role than obligations and principles. Consequent upon this, virtue is not enough. People of good character that act virtuously can act wrongly sometimes.\(^{168}\) Opponents of this model of bioethics argue that it does not provide sufficient clear action guides. They argue that it is not always easy to define what virtue or virtuous person is. To know this, it has to be based on some apriori notion of right and wrong and of the human nature that forms the reference point for the evaluation of actions.\(^{169}\)

Another point that is connected to this is the unclear relationship that seems to exist between virtue ethics and principles. Whereas it seems to reject principles generally, on the other hand it seems to accept/accommodate the role of some prima facie principles in ethical judgements. We see this in the argument of one of its proponents who maintains that in a defensible ethical theory, action should be principle-guided, rather than always principle-derived.\(^{170}\) These criticisms aside, virtue ethics has provided a much needed and valuable perspective to ethical decisions. It has significantly contributed to humanising bioethics. I now turn to a model of bioethics that highlights the role of the community in ethical reflection.


\(^{168}\) Beauchamp and Childress have helped me to articulate and explain my views on virtue ethics.

\(^{169}\) The reason for this is that epistemology presupposes metaphysics because of the common acceptance of truth as meaning that which corresponds to what is the case, that is what is real. It follows that you have to know what is the case (metaphysics) before you can say what which statements are true (epistemology).

Communitarian bioethics

Communitarian theories maintain that traditional bioethical theories do not adequately address the full range of bioethical problems. This failure comes from the fact that they are grounded in a liberal view that only individuals matter and ignores the fact that group membership and shared cultural practices are important to ethical reflections and the resolution of ethical conflicts within and between people. The ethics of community is that which regards fundamental values in ethics as deriving from communal values and the common good.171 By communal values are referred to those values that express appreciation of the worth and importance of the community. They are those values that underpin and guide the type of social relations, attitudes, and behaviour that ought to exist between individuals who live together in a community, sharing a social life and having a sense of the common good.172 This sense of community has been seen as an enduring feature of the African social system, which distinguishes it from the western system, characterised by liberal individualism.

What is then community? The concept of community describes many human associations. Some communitarians refer to the political state as a community. The roles assigned or acquired by a person define largely what he or she ought to do or not. What seems, however, to distinguish a community from an association, is that in the former, members share an overall way of life. Michael Sandel observing on the positive aspect of communal life notes:

/…/And what marks such a community is not merely a spirit of benevolence, or the prevalence of communitarian values, or even a certain shared final ends alone, but a common vocabulary of discourse and a background of implicit practices and understandings.173

This passage underscores the fact that members of a community most times share similar worldviews and values. This gives them a common moral vocabulary. What communitarians reject in traditional bioethical theories could be summarised by Mill’s defence

for ‘individuality’, Kant’s call for ‘autonomy’, and what liberals refer to as ‘rights of the person’. Communitarians understand these positions as protecting the individual against the state and advocating the neutrality of the state in conflicting values. Following this interpretation, contemporary communitarians reject these positions resting on the ground of liberal theory and the political systems they help to build. Communitarians have often directed their critique at Mill, Kant, and recently, at Rawls. The criticism directed to the later is especially against his claim that the rights of the individual cannot legitimately be offered for the good of the community.174

We could say that communitarians have revived Hegel’s criticism of Kant and applied it to liberals. They accuse traditional bioethical paradigms as not adequately capturing the essence of morality and instead emphasise abstract principles that are removed from concrete individual experience. What kind of theory do communitarians in this respect propose? Communitarians recommend an ethic that focuses on duty and obligation, reciprocity and solidarity rather than on individuals and autonomy. They suggest that we give up the principles, the language of rights in favour of the language of common good, kindness, empathy, generosity, altruism, caring and love.

However, distinction is made between radical and moderate communitarians. The former strongly supports community control and rejects liberal theories. Alasdair MacIntyre and Charles Taylor could be understood as supporting this position. On the other hand, moderate communitarians stress the importance of community and at the same time accommodates some forms of liberalism. Moderate communitarians view social life and morality as being historically founded, principles, and moral rules find their justification from shared community values. Radical communitarians see individuals as finding their meaning and purpose only in the shared life of the community.175

Communitarians have traced the argument that the community should have primacy over ethical theory and individuals in normative ethical judgement to Aristotle. Using the concept of ‘practice’, MacIntyre explains that only by engaging in practice and conforming

to its constraints and standards of excellence can one realise the goods that are internal to a structured communal life. He understands practice:

As any coherent and complex form of socially established co-operative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence, which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.\(^\text{176}\)

For example in the practice of medicine, there are goods internal to its practice, and these determine what it is to be a good physician.\(^\text{177}\) One of the problems with MacIntyre’s view consists in his presumption that there is an established majority culture either in family structure or society level that becomes the standard for every other citizen of the country. It is doubtful whether such majority culture does really exist.

Daniel Callahan, in his communitarian ethics proposes that public polices should be enacted based on a shared vision of the good society, not according to individual rights. For him, bioethics should use communitarian values to articulate or implement social laws and regulation governing every aspect of medical and research practice. The fundamental issue is, “What is most conducive to a good society?” not “Is it harmful or does it violate autonomy?”\(^\text{178}\) He criticises the field of bioethics for its individualism. For liberal individualists, justification rests on autonomy whereas for communitarians, it is established communal values and the conception of the common good.

Emanuel Ezekiel has made a significant contribution to the communitarian position to bioethics. He has proposed a moderate communitarian approach. This kind of communitarian bioethics accepts pluralistic conception of the good life and individual rights. A democratic forum is envisaged for such an approach, as it provides

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the platform for debates and discussions of what constitutes the good life and at the same time helps to enact policies for public good.\(^{179}\)

In my view, the issue of community and the individual is misplaced in most of the literatures of communitarians and liberals. It is not difficult to observe an unnecessary dichotomy that is made between the individual and the community in many of them. The question for most radical communitarians and liberal individualists is that of either/or. Either liberal account of rights and justice has primacy or communal good has primacy. Both of these positions fail to appreciate adequately the intrinsic relationship existing between these two realities. There is enough evidence in the writings of Mills and Rawls to show that they in fact do not defend any theory of atomic, isolated individual, as radical communitarians would like us to believe. By contrast, they developed a theory of the common good and political community and social traditions.\(^{180}\) Mill truly believed that he had in his theory on utility captured the true dynamics of communal welfare. There seems to be a remarkable failure to identify or fully recognise the rights of individuals in communitarian bioethics. The danger seems to be the submergence of the individual in the collectivity of the whole as if the individual does not really exist. Autonomy is in any case an important value especially for the social practice of assigning moral responsibility and for the development of moral responsibility as a virtue. The responsible exercise of autonomy may provide the needed bridge between the individual and community.

The criticism of communitarian approach is not the same thing as refuting its claim that the best life is communal life. The important question then concerns what type of communal life? Communitarian theories have helped us to appreciate more the value of community, the common good, solidarity, even if we today align ourselves with the language of rights and liberal values.

Conclusion

In sum, I have identified some of the major trends in bioethics. Two major paradigms are recognised, namely, principle-based and experience-based paradigms. Within the former, I discuss utilitarian and deontological approaches. This is done in order to highlight the pluralistic nature of these paradigms and approaches. One of the main differences between principle-based and experience-based paradigms to bioethics lies in their methods of justification. The former uses principles to justify particular bioethical judgements whereas the latter employs experience and intuition in justifying particular decisions. The principle-based paradigm is characterised by liberal ideal described by the norms of autonomy and universality. The experience-based paradigm gives priority to the valuation of the concrete case about the working out of the moral rule as it gives up the search for an agreement at the level of ethical theories. Common characteristics found in them are their emphasis on the universalization of moral principles and on their ‘top-down’ approach to ethical analysis. In the latter, I explored and analysed three different models within them: casuistry, virtue ethics, and communitarian bioethics. Common to these models is their critique of a utilitarian and deontological principle based paradigm. An important lesson that could be learnt from the foregoing is the observation that pluralism does not only concern the fact that we do not agree on concrete bioethical problems but also about theoretical framework for our bioethical discussions. We should not prefer solely principle-based or solely experience-based paradigms. Rather, a middle course that incorporates the insights of both paradigms is a better method. The context and the particular bioethical problem must determine the particular approach to be preferred. What follows now is Beauchamp’s and Childress’s attempt to articulate a form of a principle-based approach to bioethics.
In the last chapter, I discussed five different approaches in bioethics. Effort was made to present a critical account of these approaches and to show what it could mean to do bioethics from the perspective of each of these approaches. It was observed that pluralism of moral views does not only concern the fact that we disagree on concrete bioethical problems but also concerns disagreement about theoretical frameworks for our bioethical discussions. I suggested that the framework within which we do bioethics is crucial to the result we get. The challenge identified in the last chapter was that moral arguments in the public square work out of differing conceptual frameworks. Multiple moral positions are argued and defended within each of these ethical frameworks. Within the same framework, we may find two or more positions, which agree or disagree. When there are disagreements within a single framework, the disagreeing parties share basic presuppositions and hence understand one another. However, when it includes multiple frameworks, apparent agreements or disagreements may actually bypass one another.

It is time to turn to the main analytic section of this study. Three authors have been chosen for analysis and the reasons why they have been chosen presented.\textsuperscript{181}

There are several principle-based approaches to bioethics. Nevertheless, this chapter will analyse and assess critically some of the main features of principle-based bioethics of Tom L. Beauchamp and James F. Childress.

I will concentrate on the 4\textsuperscript{th} and the 5\textsuperscript{th} editions of Beauchamp and Childress’s \textit{Principles of Biomedical Ethics} (hereafter PBE). A shift of emphasis is to be observed in the 4\textsuperscript{th} and 5\textsuperscript{th} editions. Entirely new sections have been added in all the chapters of the first edition.

\textsuperscript{181} See Introduction pp 29-33.
They base their argument on ‘common morality’ rather than on the convergence of rule deontological and rule utilitarian ethical theories as were in the earlier editions, although they still recognise and affirm this convergence. In the earlier editions, the principles were argued for by way of elaborating the implications of adequate rule utilitarian and rule deontological approaches and their convergence. These editions are therefore, distinguished from the earlier editions by their strong embrace of common morality as the ultimate source of moral norms. Despite all these, the 4th and 5th editions retain previous chapter structure and positions on major issues. Because of the place of the concept of commonality in African value system, I consider it fruitful to concentrate on these editions as it provides a good contrast with most western approaches. Discussing what this term means, Beauchamp and Childress write.

...the common morality comprises socially approved norms of human conduct. For example, it recognises many legitimate and illegitimate forms of conduct that we capture using the language of “human rights”. The common morality is a social institution with a code of learnable norms.182

This chapter critically examines these editions’ discussion of the four principles, namely: beneficence, nonmaleficence, autonomy, and justice. Before proceeding with this, I shall explore briefly the origins of principles in ethics in general and bioethics in particular.

Advent of principle-based ethics

Raymond J. Devettere in his article, “The principled approach: principles, rules, and actions” attempts to establish that principles and rules have a long history. Thus, it is not a new invention of the founding fathers of bioethics.183 Principles and rules are generated from the reflected experience of the people in their particular moral deliberations and judgements. This would mean that,”principles and

182 Beauchamp & Childress, 1994, PBE, p 6. I will return later to a detailed discussion of common morality in chapter 8.
rules are historically grounded, non-universal and dialectically adaptable”.¹⁸⁴ For my purpose, they will not only refer to this but also to values that in a special way capture the way people understand life and the world around them. That means that principle is understood as “a fundamental standard of conduct from which many other moral standards and judgements draw support for their defence and standing.”¹⁸⁵

Let us look closely at how principles emerge in ethical and particularly in bioethical reflections. During the 1970s and much of the 1980s, deontological and utilitarian ethics had enormous influence on the literature in bioethics. Although utilitarian and deontological patterns of ethical discourses are still common today, it, however, needs to be noted that they no longer dominate bioethical deliberations. The classic deontological theory advocating an overarching principle is that of Immanuel Kant. Alan Donagan’s work [1977], stressing respect for persons and Alan Gewirth’s [1978] emphasising individual rights serve as contemporary representatives of this approach. Characterising principle-based ethics, Kersti Malmsten in her doctoral thesis, *Reflective Assent in Basic Care, A study in Nursing Ethics*, writes

> Principle-based ethics, deduced from universal theories, tend to place their focus on cognitive capacity of single individuals and “outside” the concrete agent and action. In other words, they focus on certain obligations and their justification. Principles are supposed to suggest “right” actions and decisions.¹⁸⁶

Of interest in this characterisation is the highlighting of the important features of a principle. This description seems to capture in an apt way the nature of principles. The language of principles is sometimes mistakenly restricted to deontological theories. Such limitations fail to realise that consequentialist theories also apply the approach of principles.

It may be asked what have made principles attractive in ethical discourse. A possible answer could be the loss of the traditional

sources of moral authority and justification such as natural and divine laws in moral theory. Principle-based ethics has functioned by “identifying what principles are at stake or in conflict and then by rational argument, establishing which principles should take precedence.”187 A principle-based approach must at a minimum, maintain that some general moral norms or action guides are central to moral reasoning. I have been using the terms: principles, rules and norms. For my purpose, these terms will be used in order to specify that some type of action is required, permitted or prohibited in certain circumstances. Principles are understood here as norms that are more general and rules as more specific. Although rules are thought as more specific in content than principles, there is, however, no bright line dividing the two kinds of norm. I will sometimes use norms to refer to both principles and rules.188

**Principle based bioethics**

The story of principle-based approach in bioethics cannot be told without discussing two major developments that made this framework famous.189 The principles of bioethics that are widely used today came as a felt need for a stable and reflective framework that was missing in the bioethics of the early 1970s.190 Principle-based ethics has been especially important in bioethics due to the influence of two publications in the U.S. They are: *The Belmont Report of the*
National Commission for the Protection of Human Subjects and the book by American philosophers Tom Beauchamp and James F. Childress, *Principles of Biomedical Ethics*. Both of them were published in the late 1970s. It is interesting to note that Beauchamp and Childress were both members of the National Commission that produced the Belmont Report.

The National commission came into being following complaints in the U.S. media concerning abuses of research subjects by individuals and institutions. The Commission was to articulate fundamental ethical principles that should direct research involving human subjects. The report defines a basic ethical principle as a “general judgement that serves as a basic justification for many particular prescriptions for an evaluation of human actions.” It developed a general ethical framework related solely to the field of research ethics and identified three such principles: principles of respect for persons (applies to guidelines for informed consent), beneficence (concerning risk/benefit assessment), and justice (applies to selection of subjects). These principles function as framework for resolving problems in research ethics. *The Belmont Report* despite its limitations has had tremendous influence on the development of bioethics. Since I take the view that *Principles of Biomedical Ethics* offers the best expression of principles in bioethics, it is to this version of principle-based ethics I focus my attention. Given the

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191 In 1974, the Tuskegee Syphilis Study (1932-1972) scandal resulted in the United States Congress passing the National Research Act, which required the establishment of Institutional Review Boards to review (IRB) all State-funded research. The ground for this decision was the Belmont Report, which is the articulation of basic ethical principles and guidelines that should assist in resolving the conflicts that arise in relation to research involving human participants. See J. Jones, 1992, *The Tuskegee Syphilis Experiment* for a comprehensive account of this study. The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, April 18, 1979. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. It should be noted, however, that the Nuremberg Code is the first and the most important, international research ethical guideline. This was followed by a document by the World Medical Association called the *Declaration of Helsinki* in 1964. For more information on this, see A.R. Jonson, R.M Veatch & L.R. Walters, 1998, *Source Book in Bioethics: A Documentary History.*


193 Principism will serve as a shorthand expression for PBE. And I will use it in a neutral sense as representing principle-based bioethics. Danner Clouser and Bernard Gert made famous the term “principlism” in an article in 1990, “A critique of principlism” in *JMP* 15:219-236. They used the term to describe all theories comprised of a plurality of potentially conflicting prima facie principles.
remarkable influence of this as a starting point for decision-making in the clinical, technological, and epidemiological professions, it is not surprising that it should be my focus in this study of principles. Further, PBE has for many critics of this approach represented the most discussed form of principlism. 194 Both the Belmont Report and PBE share a number of common features. They seek to formulate general ethical framework that should apply to human subjects participating in research. They are not concerned with the analysis of problems or cases. 195 Further, they propose the same principles that include justice and beneficence. Both the Belmont Report and PBE have used casuistic reasoning in the treatment of cases. According to Beauchamp and Childress, there is no inconsistency between the casuistic form of reasoning and a commitment to principles. These two documents have given rise to the most widely formulations of principles in modern bioethics. 196

PBE makes a distinction between nonmaleficence and beneficence, but quickly points out that the distinction is somewhat artificial. 197 The Belmont report places 198 the principle of respect as the first in its list. It discusses informed consent under this. It should be observed that in PBE “respect for persons” changes to the principle of autonomy or respect for autonomy. This change in nomenclature makes a significant change hence this will play an important role in the understanding of PBE from the perspective of African thought and value system. It is not surprising that my understanding of ethical principles is closer to that of the Belmont


195 Beauchamp & Childress, 1979, PBE, p VII.

196 Since the publications of the Belmont Report and PBE, the principles have featured in many recent reports such as in New York Task Force Reports, 1986, 1987, 1992; in the Guidelines published by the Hastings Center, 1987 and in many other reports and committee statements. All this development has contributed to the influence of principles in bioethics. The four principles are often referred to as the “Georgetown Mantra” because scholars from the Kennedy Institute at Georgetown University have repeatedly formulated them.


report than to that of PBE, which regards principles primarily as action guides for decision making. Later I shall examine closely each of their four principles in the light of African thought and value system, particularly that of the Igbo.

**The approach of Beauchamp and Childress**

At the same time the Belmont Report was being prepared, Beauchamp and Childress were writing their book *PBE*. In this work, they proposed a set of moral principles aimed as a framework to deal with ethical problems caused by rapid scientific, technological, social and biological changes in society. It is intended to be a framework for bioethics that would go beyond research ethics and traditional forms of clinical ethics. It is one of the contemporary attempts to move bioethical decision-making from theory to practical reasoning due to the lack of agreement among ethical theories. This is an example of a principle-based paradigm. Beauchamp and Childress discuss two types of ethical theory, the utilitarianism of Hume, Bentham, and Mill, and the deontology of Kant. They try to show that ethical theory provides a framework within which an agent can determine morally appropriate actions.199 They hold that some rule utilitarian and rule-deontological theories lead to similar action guides springing from the norms of common morality.200 Based on that conviction, they go on to identify four prima facie principles: respect for autonomy, nonmaleficence, beneficence, and justice, and in addition several derivative rules, ‘keep your promises,’ ‘tell the truth’ and such others. These rules are derivative because they are rooted in the principles. Meanwhile, principles are derived from considered judgement in common morality and medical tradition.201 Considered judgements refer to settled moral convictions that are accepted without further argument in order to avoid generating an infinite regress or vicious circle of justification in which no judgement is justified. They derive from beliefs that are acquired,

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199 Beauchamp & Childress, 1994, *PBE*, p 44.
tested and modified over time. On the other hand, explaining ‘common morality’ Beauchamp and Childress write

…Common morality comprises socially approved norms of human conduct…/ The common morality is a social institution with a code of learnable norms.202

The principles and the content ascribed to them attempt to put common morality into a coherent package.203 For Beauchamp and Childress, the project of bioethics is to make the moral system explicit. It involves bringing common morality to bear on bioethical cases and then determine if the answers they yield are justifiable. The principles derived from common morality are prima facie abstract general guides that provide substantial direction for the establishment of detailed rules and direct moral action.

This version of principle-based common morality shares with utilitarian and Kantian theories an emphasis on the principle of obligation.204 At the same time, common morality principles are pluralistic relying on ordinary shared beliefs for its content rather than on pure reason, natural law or a special common sense. In their view, “prima facie obligation indicates an obligation that must be fulfilled unless it conflicts on a particular occasion with equal or stronger obligation.”205 Not withstanding the various common moralities, that is, communal norms, ideals, and virtues that are accepted in various particular communities, the common morality establishes obligatory moral standards for everyone.206 Given this, the moral foundations of principlism are located in public or common morality and are manifest in articulation of public and institutional

204 Beauchamp & Childress, 1994, PBE, p 100.
205 Beauchamp & Childress, 1994, PBE, p 33, 2001, PBE, p 402. Following the method of Philosopher W.D. Ross, in The Right and the Good, 1930 that recognised the prima facie duties of fidelity, justice, beneficence, and nonmaleficence, and Foundations of Ethics, 1939. Beauchamp and Childress distinguish prima facie obligation from actual obligations. The later is determined by balancing the weights of the competing prima facie obligations. The stressed the prima facie principles particularly relevant for actions in science, medicine, health care, and included the principle of respect for autonomy. PBE defines prima facie principle as “a normative guideline stating conditions of permissibility, obligatoriness, rightness, wrongness of actions that fall within the scope of the principle” p 105.
policies. It is this that gives the raw data for the theory of common morality and this explains why we situate the origins of moral principles in the common morality that we all share. It is also in this sense that common morality should not be seen as merely one morality differing from moralities embraced by other individuals or communities. Principle–based common morality refers to “theories that both locate their source in the common morality and use principles as their structural basis.”207 In recent times, the favoured way to represent common morality in public discourse has been the language of human rights.208 Beauchamp and Childress recognise common morality as the basic source of appeal in ethics. They make some distinctions in the use of the term morality.

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The universal principles of the common “morality” comprise only a skeleton of well-developed body of moral standards. “Morality in the narrow sense is comprised of universal principles, whereas “morality” in the broad (full-bodied) sense includes divergent moral norms, obligations, ideals, and attitudes that spring from particular cultures, religions and institutions.209

Obviously, this passage shows that although common moral experience provides the starting points of ethical deliberations, at the same time critical reflection on specific ethical problems may at the end warrant moral judgements that are not widely shared.210 In this regard, one can say that moral principles and rules are not universal in the strong sense of applying to everyone everywhere.211 This discovery supports the view of moral principle as fundamental, but not as absolute principles. In this sense, common morality could be distinguished as strong or weak. The former refers to morality that is particular to societies and communities. In the weak sense, it refers to the core basis of morality that cuts across all people.

As previously noted the earlier editions of PBE developed the four principles and the derivative rules from a convergence or

210Beauchamp & Childress, 2001, PBE, p 403.
overlapping consensus between rule utilitarian and rule deontology in line with rule utilitarian Richard Brandt and William Frankena who held that morality rested on two basic principles: beneficence and justice.212 These principles were regarded as shared requirements of adequate rule utilitarian and rule deontological theories.

Beauchamp and Childress justify particular moral judgement by rules and the rules by principles and the principles by ethical theory. In their account of the nature of the principles, they express an ambivalent attitude to ethical theories.213 On the one hand, they suggest that ethical theories have an important work in justifying principles and on the other, they admit their uncertainty on the question of whether ethical theories are adequate. Generally, their approach consists in uniting principle-based, common morality ethics with the coherence model of justification.214 In this model, coherence is the central condition in moral justification, but not the sole condition.215 This is realised by adopting some central features of John Rawls’s method of reflective equilibrium. They assign no form of priority weighing or hierarchical ranking to the principles. On the contrary, they conceive them as prima facie binding and subject to revision as earlier noted. Since this framework has no overriding principle to justify obligations or adjudicate conflicts between principles or commitments, it relies on specifying and balancing principle to discover where the weight of obligation is stronger.

In the latest edition of PBE, Beauchamp and Childress provide an expanded explanation concerning the ethical framework establishing

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213 PBE claims the same general criteria for theory construction in biomedical ethics as those in scientific or political theory. They include clarity, coherence, completeness, comprehensiveness, simplicity, explanatory power, justificatory power, output power, and practicability. Cf. PBE, 1994, pp 45-47, 2001, PBE, pp339-340.


their treatment of cases in bioethics. Specification and balancing judgements remain central to their method. *PBE* did not develop the ideas of specification and balancing until the fourth edition in 1994 although one may argue that these ideas were already there but underdeveloped. In the area of ethical theory, they have been influenced by two important developments. (1) First is the adoption of Henry Richardson’s account of the specification of moral norms.\(^{216}\) This is significant because it could be argued that *PBE* bears today only a distant resemblance to its first edition. This has strongly influenced their conception of methodology. (2) Second is the development of the idea that the four principles are not philosophical constructs but rather are norms already embedded in public morality. This evidently, explains why in the 5\(^{th}\) edition 2001, Beauchamp and Childress deliberately avoid grounding their approach on any philosophical theory of ethics. Instead, they hold that these principles are rooted in a common morality, which all humans share, and that it offers better prospect for consensus on difficult bioethical questions than any philosophical theory.\(^{217}\)

If this reading is correct, the shift from a convergence model to a common morality coherence model raises some important questions concerning the viability of their approach. A fundamental question in this regard concerns how these two different ways of formulating bioethics relate to each other. The principles of respect for autonomy, nonmaleficence, beneficence, and justice were regarded in the earlier versions as fulfilling the requirement for rule utilitarian and rule deontological theories. They were justified by using a convergence model of justification. From the 4\(^{th}\) edition, the principles began to be justified by an appeal to common morality resulting from the search for considered judgements and coherence. It is not clear how Beauchamp and Childress justify this development. One may ask whether common morality could not yield different principles or even if similar principles but at least much than the principles derived from a convergence of rule utilitarian and rule deontological theories. The reason for this shift can of course be explained as a


response to the many challenges that principlism has encountered. Nevertheless, it is difficult to see how they justify the shift.

With this view of PBE’s version of principles, we now turn to the analysis of these principles. My attention will focus more on the normative significance of the general framework used in the application of the principles and rules to cases. The reason for this is that bioethics has developed a global consciousness and as such, there is need to examine whether its western-dominated methodology that serves as the starting point for practical decision-making in bioethics is adequate and credible outside Euro-American culture.

The principle of respect for autonomy

Obviously, the principle of respect for autonomy is rooted in the liberal moral and political tradition of the importance of individual freedom and choice. In moral philosophy, personal autonomy refers to personal self-governance, which means personal rule of the self by adequate understanding. There is some tendency in Western conceptual scheme to see the freedom of the individual as the human essence.\textsuperscript{218} According to Hirschmann, it is considered to be, “the basic starting point and, not only for understanding human relations and society, but for defining and justifying other concepts, such as justice, obligation, and rights.”\textsuperscript{219} One of the Western philosophers who have defended this view in moral and political philosophy is John Locke. He held that all men are naturally in /…/ a state of perfect freedom to order their actions and dispose of their possessions and persons, as they think fit, within the bounds of the natural law of nature, without asking leave, or depending upon the will of any other man.\textsuperscript{220}

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\item \textsuperscript{220} Locke J, 1988, Two Treatises of Government, Student edition, p 269.
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Furthermore, Locke held the view that “the natural liberty of man is to be free from any superior power on earth, not to be under the will of legislative authority of man, but to have only the law of nature for his rule.” It is significant to realise that these views gave rise to the language of rights that dominate western moral and political system. As earlier noted in chapter three, this language of rights has met with strong criticisms. One can reasonably argue that the language of principles and rules share much in common with the language of rights. The reason for this is that principles are regarded, as being based on the need to respect certain rights considered fundamental to the individual.

The central notion that underlies the concept of autonomy is captured by its etymology: autos (self) and nomos (rule of law). When this was first applied to the Greek city-state it referred to a city that possessed autonomia. From this, it is evident that the concept of autonomy presupposes an ideal of the individual as an independent and rational agent who sets his/her own goals in life. Christine Di Stefano notes that the ideal of autonomy captures in an especially compelling and efficient way, the modern discovery and valuation of freedom, reason and agency housed within a conception of the self as an independent and reflexive rational chooser.

That this constitutes the philosophical bases of the conception of autonomy in the PBE cannot be possibly in doubt. In this light, it is important to note that from the point of view of such individualist autonomy, obligation can be justified only when undertaken without any coercive influence and entered by free agreement, referred to as “consent” or “social contract”. This explains why consent is regarded as the only possible basis for obligation. It also justifies the neutrality of liberal democracies and limits the power of the state to interfere in the life of her citizens.

222 See Chapters three and six. Both feminists philosophers and liberal communitarians raise concerns regarding the adequacy of right language.
This development in political philosophy is paralleled by a similar emphasis on respect for autonomy and free consent in health care and biomedical ethics in Europe and North America. In discussing the implication of this trend, Julia Tao Laipo-wah comments:

> The values of autonomy, individual self-determination and free consent are foundational to the development of patient-centred medicine and autonomy-oriented biomedical ethics in many modern societies […] They are the important driving forces behind policy advocacy movements in support of individual right and freedom of choice in a range of contemporary biomedical issues related to euthanasia, abortion, organ transplant, and procreative liberty involving different reproductive technologies, and including commercial surrogate arrangements.225

Evidently, it is within the foregoing perspective that one can properly understand the four principles by Beauchamp and Childress. The result of this is that the principles articulated by Beauchamp & Childress tried to capture and give expression to this trend. Thus, the principle of respect for autonomy tends to trump other principles in decision-making.

The concept of autonomy as used by PBE functions primarily to examine decision-making in health care. It serves to identify actions that are “protected by the rules of informed consent, informed refusal, truth telling, and confidentiality.”226 Discussing the concept of autonomy, Beauchamp and Childress note that all theories of autonomy agree on two essential conditions. The first is liberty, meaning in this sense the independence from controlling influences. The second is agency, referring to the capacity for intentional action. However, there is no agreement over the meanings of these two conditions and over the question of the possibility of additional conditions.

While some theories of autonomy focus on the autonomous person, the model of PBE focuses on autonomous choice because of their interest in decision-making. This means that the point at issue is

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226 Beauchamp & Childress, 1994, PBE, p 120.
actual governance rather than the capacity for governance. They hold that no theory of autonomy is acceptable if it presents an ideal above the reach of normal choosers. They analyse autonomous action in terms of normal persons who act “intentionally, with understanding, and without controlling influences that determine their action.” The first of these three conditions of autonomy is not subject to grading. The reason is that acts are either intentional or nonintentional. Meanwhile the last two conditions can be a matter of degrees. For example, many children and many elderly people, exhibit various degrees of understanding and independence in their actions. According to them, the conditions required for an action to be deemed autonomous are substantial degree of understanding and freedom from constraint. Adequate decision-making does not necessarily need to be limited to full understanding and complete absence of influence. The line between what is substantial and what is insubstantial can be determined in the light of meaningful decision-making in specific cases. The view in this regard is that substantial autonomy is achievable in many decision-making in health care, such as in decisions to participate in research and acceptance of medical treatments. Autonomous action in health care as elsewhere in life is not incompatible with the ideals of church, state, communities or some other bodies that legislates person’s decisions as some people sometimes believe. The reason is that morality is not a set of personal rules created by individuals cut off from society. Moral principles in this regard have authority over us by virtue of their being situated in a social and cultural setting that is independent of any single autonomous agent. The fact that they are shared by no way prevents them from being individual’s own principles. Although individuals autonomously accept principles, yet these principles are usually derived from cultural traditions. In the same way, rules, codes and professional ethics are not individual’s creation, at the same time they are compatible with autonomy.

The PBE makes a distinction between being autonomous and being respected as an autonomous agent. To respect an autonomous agent is:

227 Beauchamp & Childress, 1994, PBE, p 121.
At a minimum, to acknowledge that person’s right to hold views, to make choices, and to take actions based on personal values and beliefs. Such respect involves respectful action, not merely a respectful attitude.229

As this passage shows, to respect a person could entail going beyond the obligation of non-interference in the affairs of persons as to embrace engaging in actions that positively encourage and empower them to act autonomously. This distinction is necessary because the first two editions of \( PBE \) focused on a ‘principle of autonomy’ rather than on a ‘principle of respect for autonomy’.230 Stated in its negative form, the principle of respect for autonomy says: “Autonomous actions should not be subjected to controlling constraints by others.”231 As can be observed, this formulation asserts a broad and abstract obligation. This is why this principle requires specification in specific cases in order to become a practical guide to action in decision-making. This also partly explains why the principle of respect for autonomy is prima facie and can be overridden by other competing moral values. In its affirmative form, the principle of respect for autonomy obliges us to increase the options available to persons concerning disclosing information and empowering autonomous decision-making.

Nevertheless, the principle of respect for autonomy is not so broad as to cover non-autonomous persons in moral life. This observation makes some room for some intervention in the affairs of persons who are substantially non-autonomous and cannot be rendered autonomous. Such persons would include those who are not competent to make certain decisions for example, infants, children, incapacitated, ignorant, immature, drug-dependent patients, and irrationally suicidal individuals. These cases justify some forms of intervention in the lives of these people.

The concept of consent has important role to play in any adequate understanding of the principle of respect for autonomy.

229 Beauchamp & Childress, 1994, \( PBE \), p 125, 2001, p 63.

230 The former tends to impute high value to personal autonomy and to indicate an ideal to which persons should aspire. The risk is that it presents an ideal that is beyond the capabilities of normal choosers. Such an ideal flies in the face of reality “where peoples’ actions are really, if ever, fully autonomous”, \( PBE \), 2001, p 59.

231 Beauchamp & Childress, 1994, \( PBE \), p 126.
Why? The reason is that the basic paradigm of autonomy in health care and in politics and other contexts is expressed or informed consent. The ethical basis of informed consent is the principle of respect for autonomy. However, there are varieties of ‘consent’. Tacit consent refers to that which is expressed passively by omissions. Implicit or implied consent is inferred from actions. Presumed consent could be based on what is known about the person or because of a general theory of human goods or rational will.

Some states adopt any of these forms in support of specific policies in health care. These consent forms can lack sufficient warrant for action.

Consider this case. A bishop in a diocese on the basis of care for the priests of his diocese enters into an agreement with a hospital that any of his priests, who presents himself for medical care must be tested for HIV without the priest’s knowledge and the result forward the bishop. A priest arrives at a hospital for medical care and his blood sample was taking and tested for HIV together with other routine blood tests. The priest reports back to the hospital for the result of the blood test, and he meets a smiling nurse, who says to him: “congratulations father, you made it.” The priest was stunned when he learnt he had been tested for HIV. This incidence raised a controversy in the diocese concerning the place of informed consent in the medical care of the priests of the diocese. Some people argued that the acceptance of being part of the diocesan medical programme for priests in itself means the acceptance of being tested for HIV. This is the case of implicit or implied consent. Some others held that in the case of HIV specific consent was required. Yet, others maintained that the test must be carried with or without the consent of the priest if the diocese makes this a general knowledge for her priests. This case is problematic because interest in testing patients normally arises because treating HIV-infected patients creates risks for caregivers. In the case of the bishop’s decision, it has nothing to do with protecting care givers. What purpose does such a policy serve for the diocese? Is such a purpose of great moral value as to

232 Four basic elements of informed consent have been developed since the Nuremberg trials: a) capacity to consent; full disclosure of relevant information; adequate comprehension by the participant; and voluntary decision to participate and withdraw from participation at any stage without prejudice to the participant.
233 Beauchamp & Childress, 1994, PBE, p 128.
override respect for the individual persons? In Beauchamp & Childress, 1994, *PBE*, it is doubtful whether this diocesan practice can be ethically acceptable bearing in mind that hospitals are not justified in testing patients for HIV antibodies without specific consent. This is because a positive result carries serious psychological and social risks.

Another concept that is important in this discussion is that of competence. Competence serves as a gatekeeper in health care between those individuals whose decisions should be accepted as autonomous and those individuals whose decisions should neither be solicited nor accepted. The meaning of this concept is controversial and no single definition is acceptable to all. However, a common element present in all contexts in which competence is properly used is the ability to perform some task. In this sense, competence is better understood, as something specific rather than is global. One can be competent at one time and incompetent at another time. It is also possible to have competence for a particular task and not to have it for some other types of task. These elements are significant for an adequate understanding of the concept of competence. The analysis so far suggests that competence in decision-making is closely connected to autonomous decision-making, as well as to the validity of the decision. Although ‘autonomy’ and ‘competence’ differ in meaning, yet the conditions of the autonomous person and of a competent person are remarkably similar. All the same, competence is a threshold and not a continuum concept as autonomy. What are then the standards for the determination of competence?

Beauchamp and Childress hold this view about competence:

../../in biomedical contexts a person has generally been viewed as competent if able to understand a therapy or research procedure, to deliberate regarding major risks and benefits, and to make decision in the light of this deliberation.\(^{234}\)

For Beauchamp and Childress, the lack of any of these capacities makes the claim to competence doubtful. This view has its problems especially in relation to those who possess these capacities in

diminished degree for example religious fanatics and many psychotic patients. Today advanced directives help people to control what happens to them if they were to become incompetent. Yet, this does not remove the issue on what extent a person’s prior autonomous wishes should be binding after the person becomes incompetent or dies. Theoretical issues surrounding issues in this area include the question of personal identity and the continuity of self over time. It is also important to note that standard of competence can be distinguished in two sense. The first sense indicates the conditions under which a person is or is not competent. In the second sense, it denotes the pragmatic guidelines such as age, we use to determine competence.

Beauchamp and Childress accept the view that the primary justification for informed consent requirements is the protection of autonomous choice of the individual. Informed consent has two senses. In the first sense, it refers to when an individual with substantial understanding and in the absence of substantial control by others, intentionally authorises a medical intervention or of participation in research. In the second sense, it means social rules of institutions that must be satisfied for a legally valid consent from patients before proceeding with therapeutic procedures. It follows then that the first sense can be satisfied without the second sense also satisfied in which case the consent is deemed invalid. The elements of informed consent are divided between an information component and a consent component. The former refers to disclosure of information and the understanding of what is disclosed. The latter means voluntary decision and agreement to undergo a particular procedure. However, PBE holds that the meaning of informed consent is better analysed in terms of autonomous authorisation of individuals. The understanding of the principle of respect for autonomy in PBE can be objected to on a number of grounds.

In the Belmont Report, this principle was referred to as the principle of respect for persons. In PBE, the principle of respect for persons changes to the principle of respect for autonomy. In the context of health care PBE went further to reduce the principle of respect for autonomy to autonomous choice of individuals. This is

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236 Beauchamp & Childress, 1994, PBE, p 145.
significant for a proper understanding of this principle in health care and research. Our analysis so far indicates that the principle of respect for persons is now redefined by PBE as a sub-category of the principle of respect for autonomy. This is problematic because the autonomous choice of the individual is what is protected and not the person by virtue of his or her humanity. This view of autonomous choice tends to neglect the fact that the whole person acts and not just his or her autonomous self. The issue is that one possesses a transcendence that goes beyond ones autonomous choices? One often observes that proponents of autonomy “are less concerned with what patients do want than what, from the point of autonomy, they should want”\textsuperscript{237}. This is in agreement with the earlier observation that autonomy is respected for its own value not because of the dignity of the person.

It is interesting that increasing respect for the principle of autonomy has had positive effect in the practice of medicine and in research particularly in checking the excesses of paternalism and unjustified intervention by the state and health professionals. Yet, there are concerns especially in non-western cultures that the principle of respect for autonomy has assumed primary place over all other principles in health care and biomedical discussions and decisions. For many, it is no longer a prima facie principle but functions now as an absolute principle that overrides all others. For others, the principle of autonomy now translates in bioethics into a duty of medical decision-making by patients.\textsuperscript{238} This raises the question concerning what kind of value autonomy has. These and other questions were the concern of Torbjörn Tännsjö in his book \textit{Vårdetik}.\textsuperscript{239} In this work, he defends a form of utilitarianism where autonomy has instrumental value in bioethics. By contrast, autonomy seems to have an intrinsic value in the framework of Beauchamp & Childress.

\textsuperscript{237} Schneider, 1998, \textit{The Practice of autonomy: patients, doctors, and medical decisions}, p xi.

\textsuperscript{238} Robert Veatch and Haavi Morreim seem to hold this position in some of their writings- a duty of autonomy.

\textsuperscript{239} See Tännsjö T, 1998, \textit{Vårdetik}, Bokförlaget Thales, Stockholm, chapter 4. He argues that autonomy has no intrinsic value, but it has great value as a means in health care. He defends a form of hedonistic utilitarianism.
Another problem is the distance the principle of respect for autonomous choice tends to create between people. The danger is that journeying with the sick and dying and finding meaning in life and death are now almost impossible. This principle has also “tended to marginalize family decision-making and to undermine the doctor-patient relationship, reinforcing separation and isolation rather than sharing and involvement.”

Beauchamp and Childress have not adequately answered the difficult question concerning what weight should be given to autonomy in health care and why individuals should be respected instead of the collective will of the people.

It should be noted that autonomy, autonomous choice, and informed consent does not have exactly the same meaning in the context of most African communities as it does in western nations. The risk is that western conceptions of these values could create a tension between autonomy and authority, individuals and their families. Individuals who exercise their autonomy by accepting the authority of their traditions are looked as failing to exercise real autonomy. This presents the view of traditions or institutions as not being legitimate sources of direction for people. It also tends to make morality a creation of individuals.

Yet, another difficulty arises concerning how non-autonomous persons are to be protected since respect no longer pertains to them with the framework of autonomous choice. This problem leads us to the principles of nonmaleficence and beneficence.

The principle of nonmaleficence

There is to be found almost in all cultures and traditions the obligation not to cause harm to other people. It could be said to be part of common morality shared by all humans. Physicians have since the time of Hippocratic taken the oath not to cause any harm to

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241 This norm takes different forms in various communities. Among the Igbo people ones obligation not to cause harm is first and foremost to members of his own community. This is a command of ‘Ala’ the earth goddess. Failure in this regard becomes an abomination calling for severe punishment ranging from banishment to death.
their patients. Until the secularisation of modern culture, nonmaleficence was one of the two hallmarks of medical practice; the other being beneficence. The application of nonmaleficence in concrete cases was in the past the sole prerogative of medical personnel. It is still the case in most of Africa and other poor countries. The modern research ethics was articulated during the Nuremberg trials in 1947. The major characteristics of the principle of nonmaleficence are: focus on avoiding harm to patients, adopts the Hippocratic tradition – *primum non nocere*: “Above all do no harm”, strives to balance against beneficence, which takes the health giver as the decision-maker. A principle of nonmaleficence is recognised in ethical theories for example in both utilitarian and deontological literature.

For some people the principles of nonmaleficence and beneficence are joined and treated as one. For some others, they are distinguished. An example of the former would be the *Belmont Report*, while the latter would be *PBE*. I think there are good reasons to distinguish them. Such reason would include the need to make them more specific in their application to concrete issues. Beneficence often requires positively acting to help or to prevent harm. The concept of harm or injury is a very broad one and extends to setbacks to reputation, property, privacy, or liberty. Meanwhile, nonmaleficence only demands that one intentionally refrain from causing harm or injury. However, it should be observed that the obligation to nonmaleficence is more stringent than obligations of beneficence. The principle of nonmaleficence and its specification in moral rules are *prima facie*. Beauchamp and Childress reject every form of priority to any of the principles and rules in which nonmaleficence is articulated.

Much of the discussion in the area of bioethics at the end of life concerns how to specify nonmaleficence in health care particularly about treatment and nontreatment decisions. Clarification and specification of this principle is important given the fact that many

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controversies in bioethics concern the terminally ill and the seriously ill and injured. A framework for dealing with these issues is therefore needed. Beauchamp and Childress examine the principle of nonmaleficence by trying to see various attempts to specify its implications for biomedical ethics particularly for actions that ends in death. They try to do this by studying the “distinctions between killing and letting die, intending and foreseeing harmful outcomes, withholding and withdrawing life-sustaining treatments, and extraordinary and ordinary treatments”. They also discuss intended effects and merely foreseen effects. The matter at stake for me is to look closely at the general framework they advance for dealing with these cases.

Beauchamp and Childress argue that these traditional distinctions are morally irrelevant and untenable and as such should be replaced by what they refer to as a distinction between optional treatments and obligatory treatments. However, they accept that the distinction focusing on killing and letting die deserves some place in our moral scheme although, the need some reformulation, both in biomedical ethics and public policy. A major feature of the way PBE treats these problems is in terms of benefit-burden ratio. That is to say that the burden of the treatment should not outweigh its benefits. According to this view, “the principle of nonmaleficence does not imply the maintenance of biological life, nor does it require the initiation or continuation of treatment without regard to the patient’s pain, suffering, and discomfort”.

PBE discussion may be said to rest on three key factors namely, ‘quality of life’, ‘cost benefit and risk’ and ‘autonomy for competent patients.’ Central to its analysis is the belief that morality is concerned with the harmfulness of actions per se, and not merely with responsibility for causing harm. This assertion is in turn defended by the distinction between intention and motive. The discussion focuses on motivation for an action. This is important for the understanding of the various positions PBE holds in the issues it treats. This transforms the moral landscape. It shifts the focus from

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247 Beauchamp & Childress, 1994, PBE, p 206.
250 Beauchamp & Childress, 1994, PBE, p 214.
that of responsibility to that of motive. These considerations lead to the classification between optional and obligatory treatments. While these key elements enlighten our discussion in applying the principle of nonmaleficence, yet they are not as precise and conflicts free as PBE would want us believe. Let us for example consider the discussion concerning the ‘rule of double effects.’ PBE discussion of this rule does not give an adequate treatment of three of the four criteria given for this rule namely, the nature of the act, the agent’s intention, and the distinction between means and effects. Most people accept that some acts are intrinsically bad such as murder, some others, goods such as giving food to the hungry and yet, other acts are morally neutral such as playing golf. By focusing on motivation for an act instead on intention, PBE seems to suggest that the end of an act justifies the means. It is difficult to discuss about justifiable intentionality of an act without reference to the act per se, independent of the intention. The inability to distinguish between the nature of an act and the intention of an agent is shown in the position the book defends in two cases it discusses. The first concerns a pregnant woman who has cancer of the cervix that requires a hysterectomy to save her life, which will however, result in the death of the fetus. The second case is about a woman in difficult labour that will die except craniotomy is performed. PBE does not recognise any moral difference in performing these two acts.\footnote{Beauchamp & Childress, 1994, PBE, p 209.} The reason is the belief that rightness and wrongs of an action depend on the merit of the justification for the action, not on the type of action.\footnote{Beauchamp & Childress, 1994, PBE, p 225.} As I earlier argued, the morality of an action cannot depend only on the motive for the action without reference to the nature of the act.

Beauchamp and Childress argue that the same right of autonomy that allows a patient in grim situation to refuse treatment also gives the right to the patient to kill herself with the assistance of any willing physician. This argument reveals some confusion centring on the difficulty they have in distinguishing between a prima facie principle of respect for autonomy of a competent person who wishes that a burdensome and unbeneificial treatment should be withdrawn and the prima facie duty to preserve life. It is this inadequate
distinction that leads them to the concept of life as a machine that
could be stopped in a similar manner as one stops a machine used to
sustain life. The value and dignity of human life call for a more
stringent duty to nonmaleficience than to beneficence in this
particular case.\footnote{Beauchamp & Childress, 1994, \textit{PBE}, p 226.}
In contrast to \textit{PBE}, assisted suicide and voluntary
active euthanasia are incompatible with the role of health
professionals whose goal of practice is preserving life. It is difficult
to defend the argument that the refusal to actively assist one to die is
harming the person.\footnote{Beauchamp & Childress, 1994, \textit{PBE}, p 236.}
While Beauchamp and Childress raise
legitimate concerns in most of these issues, however, they do not
justify mercy killing and assisted suicide. The contrary would make
human life individual property to be disposed at will. Such an
attitude will fail to account for the social and communal dimension
of human life. Therefore, there are morally relevant distinctions
between letting die, assisted suicide, and voluntary active euthanasia.

Generally, Beauchamp and Childress give considerable weight to
quality-of-life judgements in determining whether treatments are
optional or obligatory for a particular patient. However, it is not clear
how the quality-of-life of a particular patient can be measured while
making sure that it is not reduced to individual preferences and the
social worth of the person. Furthermore, it is not clear, how the
distinction they make differs in content with the traditional
distinction they reject except may be in name.

Physicians can and do cause harm to their patients in direct and
indirect ways. It could happen by a failure to give the right medicine
and the right dosage or even wrong decision. Many do not care to
follow professional standard of care. A couple of years ago, Maria
lost her sister because the medical personnel carelessly gave her
injection using an old syringe that was used to inject a tuberculosis
patient. Recently in Delta State of Nigeria, a priest died because the
surgeon used the wrong gas for him when he was being operated
upon. A scissors was carelessly forgotten in the womb of a reverend
sister who had fibroid surgery. Thanks to those who flew her to
Europe, the scissors was discovered and removed.\footnote{The names used in these examples are fictitious but the incidents described are real.}
The list of such incidents caused often times by lack of adequate precaution in
Nigeria could be endless. The unfortunate thing is that the perpetrators of these harms or deaths in most of the cases go unprosecuted and unpunished. They are generally not called to account for their deeds. Whenever at all they admit responsibility, health care givers do so casually by referring to it as ‘medical mistake’. In most of the cases the bereaved do not sue the medical personnel for negligence. The reason for not filing a case as previously noted rests on poverty and ignorance. These cases are significant as they reveal an absence of moral sense and commitment among many health care givers. The greed for money and the non-existence or little of medical ethics and philosophical medicine in the educational package of health care providers could be regarded as the main factors responsible for this. They range from poverty to illiteracy on the part of the people and a failure of government and institutions to be responsible. Absence of any accountability for medical malpractice is another poverty-related fact, which hinders the realisation of a morally viable society. An area that needs serious attention in relation to the principle of nonmaleficence in health care bioethics is the experimentation in the field of clinical trials involving human subjects.\footnote{Cf. chapter one where this issue in relation to HIV/AIDS has been discussed.}

We can see from the foregoing that developing countries face difficulties of exploitation, dehumanisation, abuse and lack of ethical professionalism, to such a degree that developed countries may never dream of nor ever encounter. Nigeria as a developing nation illustrates in an apt way the relationship between poverty and health ethics. It is significant and important to note that in many parts of Nigeria health care professionals often evade both their moral and legal responsibilities to their patients.

The kernel of the principle of nonmaleficence is that we should only not cause harm to others, but we should at the same time protect them from some types and levels of harm.\footnote{Beauchamp & Childress, 1994, PBE, p 249.} It is this awareness that takes us to the principle of beneficence.
Beneficence

The principle of beneficence evidently derives from one of the goals of medicine. There has always been the view that the well-being of patients is the central value in health care. In this sense, what justifies the beneficent act in health care is internal to medicine itself. The American philosophers of medicine Edmund Pellegrino and David Thomasma have expressed this idea in their book *A Philosophical Basis of Medical Practice*.

Medicine is an activity whose essence lies in the clinical event, which demands that scientific and other knowledge be particularised in the lived reality of a particular human for the purpose of attaining health or curing illness through the direct manipulation of the body and in a value-laden decision matrix.²⁵⁸

The concepts of health and sickness or ill-health are understood and defined in different ways by philosophers, social biologist, psychologist and many others. Lennart Nordenfelt, a Swedish philosopher contends that a person is healthy if and only if that person given normal difficulties is able to achieve his or her vital life goals and ill health refers to when this is not achievable. To be healthy in this sense means to have the ability given normal difficulty to actualise one’s minimal happiness. By vital life goals is meant those conditions that are necessary for this particular person’s minimal happiness. The total normal difficulties of a given person at a given time are relative to a specific cultural context. This means that health is both a descriptive and evaluative concept.²⁵⁹ It could be said that Pellegrino and Thomasmas’ understanding of health is in agreement with Nordenfelt’s. The individual and his or her concrete needs seem to be in focus in both cases. However, they differ in an important sense. Whereas the former regards health as the restoring to normality a specific malfunction in the particular individual, the latter considers it fundamentally as the individual actualising himself or herself. This is a more holistic way of characterising the concept of health.


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While Beauchamp and Childress accept that healing is an end of medicine, they will, however, not regard it as the only end as Pellegrino holds. In some other of his writings, Pellegrino maintains that medicine is “praxis and not theory” and “contains its ends within itself.” 268 For the end of medicine, which he claims is healing determines the obligations and virtues of the physician. 261 This account suggests an internalist approach to bioethics as in contrast to an externalist approach where the end of medicine is believed to be external to it. What is the point of this? The idea is to understand how medical professionals have the obligation to act beneficently. What is the source for the justification of a beneficent act? According to Pellegrino and Thomasma, beneficence is internal to the end of medicine. According to Beauchamp, Pellegrino’s vision of medicine lacks a principled basis to exclude alternative accounts and disregards many benefits that physicians can and do provide that are of great importance to society and patients. 262

Although some other goals of medicine exist, such as saving lives and advancing quality of life, health is generally taken to be the central end of health care. Beauchamp holds this same view when he writes that “medicine’s context and justification are found in clinical diagnoses and therapies aimed at promotion of health care or prevention of disease.” 263

This obligation has two parts. First, is the positive obligation to alleviate disease and injury. The second concerns harm to be prevented, minimised, or removed, which in this context are pain, suffering, and disability of injury and disease. 264 How then does

Beauchamp and Childress treat the issue of beneficence that is central to medicine? Beauchamp and Childress identify two principles of beneficence: positive beneficence, which deals with the provision of benefits and utility, which demands that benefits and harms be balanced. The principle of utility as they use it is not identical to the classical utilitarian principle of utility. In their context it is limited to balancing benefits, risks, and costs, and does not determine the overall balancing of obligations. They also make a distinction between beneficence and benevolence. The former refers to action done for the benefit of others; while the latter denotes the character trait or virtue of being disposed to act for the benefit of others. Thus, the principle of beneficence refers to the moral obligation to act for the benefit of others. Distinction is also made between obligatory and non-obligatory beneficence. On one hand, several rules of obligatory beneficence form an important part of common morality. On the other hand, non-obligatory beneficence refers to those beneficent acts that can only be done by severe sacrifice for example donating of one’s kidney for transplantation. Common morality does not contain principle of beneficence that demands non-obligatory actions. Another distinction is made between specific and general beneficence. Specific beneficence is directed towards special relationships such as family members, relations and friends, whereas general is channelled towards all persons. With these distinctions, Beauchamp and Childress try to clarify and specify applications of this principle in clinical medicine particularly as it relates to conflict between autonomy and beneficence, paternalism and beneficence. They also discuss beneficence in relation to the formulation of public and institutional policies that often takes its basis from cost benefits and risks perspectives. Here one advances standard for the value and quality of life.

These distinctions are interesting and raise the problem of the limit of beneficence. How is beneficence related to the claim for the universality of moral principles? Is beneficence culturally or

265Beauchamp & Childress, 1994, PBE, p 259.
geographically relative? Have wealthy nations a positive obligation to benefit poor ones? If common morality holds that moral principles are universal, this could mean that we have a positive obligation to benefit others. The limit for such an obligation is set by what we could do without any danger to our own life. The fact of human observation suggests that these principles though taken as part of common morality, however, are culturally and geographically bound.

The concept of beneficence is especially an interesting one for an articulation of bioethics from an African perspective. The reason for this is that morality in the African context has its basis in the welfare of the community. Beneficence in this regard can be said to be a central feature of African communal life. The members of particular communities for example in Igbo land expect each member to act beneficently towards other members of the community. It is not reducible to the analysis of benefits and harms in a specific problem, as PBE seems to suggest. Rather, it is better understood in relation to benevolence, a disposition to act for the benefit of others.

The principle of beneficence seems to be in conflict with that of autonomy theoretically and as well as practically in both moral philosophy, ethics in general, and bioethics in particular. This appears to be more evident in the context of African life. This problem raises issues of justice.

**Justice**

The view that the concept of justice is a broad and difficult one is uncontroversial. When is a person treated justly? What criteria must be satisfied for such a treatment? How does one relate risk to probable benefits? A study of the principle of justice reveals that like the principle of beneficence, it has several principles each requiring specification in particular contexts. In Vårdetik Tännşjö points out that issues of justice are present in at least three different ways in bioethics: (1) scarcity of medical resources, (2) how these resources should be shared between the various forms of care, and (3) how health care should be structured. These problems have brought to the frontline debate about the nature of justice.
Philosophers have developed various theories such as fairness, desert that refers to what is deserved (Alasdair MacIntyre), and entitlement (Robert Nozick), which refers to that to which one is entitled to explicate the meaning of justice and thereby resolve issues, raised by it. These theories concentrate on the discussion of how people are to be compared and what it means to give people what they deserve. A condition of scarce resources and the competition surrounding access to it has given rise to questions of distributive justice. This term refers to “fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social co-operation.”

Several theories of distributive justice have been articulated in an attempt to specify our principles, rules, and judgement. These include egalitarian theories that emphasise equal access to primary goods. Utilitarian theories favour social programs where public and private utility are maximised; libertarian theories emphasise rights to social and economic liberty; and communitarian theories emphasise either the responsibility of the community to the individual or, in policy formulation, the responsibility of the individual to the community.

Interestingly, in treating these philosophical approaches to justice, Beauchamp and Childress do not defend the adequacy of any one of them for constructive reflections on issues of health care. Their position is evidently informed by their acknowledgement of limitations of ethical theories. Obviously, these four theories of justice understood as equal access to primary goods of life, maximisation of private and social programs, rights to social and economic liberty, and the responsibility of the community to the individual and vice versa resonate with some aspects of our intuitive ideas about justice.

271 John Rawls defines justice as fairness. This is understood as norms of co-operation agreed to by free and equal persons who participate in social activities with mutual respect. Such and idea of justice presents an egalitarian challenge to libertarian and utilitarian theories. In line with his views about reflexive equilibrium, he maintains that, “what justifies a conception of justice is not its being true to an order antecedent and given to us, but its congruence with our deeper understanding of ourselves and our aspirations, and our realisation that, given our history and the traditions embedded in our public life, it is the most reasonable doctrine for us.” See “Kantian Constructivism in Moral Theory”, Journal of Philosophy 77(1980): 519.
Each influential general theory of justice is a philosophical reconstruction of a valid perspective on the moral life, but one that only partially captures the range of diversity of that life.273

Common to every theory of justice are the formal and the material elements. The former requires that all equals must be treated equally and unequal unequally. It is formal because it provides no criteria for judging when it is applied. The latter specifies the relevant conditions for applying the former.

From the foregoing, what conception of justice do they defend in their framework? They favour a framework that recognises “an enforceable right to a decent minimum of health care within a framework for allocation that coherently incorporates utilitarian and egalitarian standards.”274 What this means is that justice of a social institution of health care is justified by its capacity to confront lack of opportunity. This difficulty arises from “natural and social lotteries over which individuals do not have control and by their commitment to efficient and fair procedures in the allocation of health care resources.”275

The experience of poverty and the marked disparity between people in the developing countries lead to a different concept of justice in the provision and distribution of health resources. These inequalities of wealth not only create the pre-conditions for disease, but it also limits the economic power of developing countries to purchase basic Western Pharmaceuticals and medical supplies. It can be observed from this that diseases of poverty dominate the medical needs of most people in developing nations.276 Against the background of scarcity of medical resources in the developing world, some have proposed an ethics of scarcity for them, which do not deal with cutting-edge technologies. In this framework, autonomy is not given priority, but distributive justice and the equitable access to minimal levels of preventive and curative services. I admit that issues of distributive justice is crucial in the health needs of developing

273 Beauchamp & Childress, 1994, _PBE_, p 387.
275 Beauchamp & Childress, 1994, _PBE_, p 387.
nations, yet cutting-edge technologies such as reproductive technologies, ethics at the end of life, and problems of research ethics are global issues that confront many today whether in rich or poor nations.

**Critical Voices**

The major criticisms of principlism in health care and research bioethics are by now well known. Clouser and Gert, as well as Green have argued that the framework provided by *PBE* does not provide a theory of justification or any kind of general moral theory that systematically unifies and integrates the principles in such a way that conflicts among them can be reconciled. On the other hand, principlism has also its defenders in the persons of B. Andrew Lustig and David Degrazia.

The criticisms levelled against the principles by Clouser and Gert rest on three main charges: (1) The principles function more like chapter headings in a book than clear directives for morally right action. (2) The principles lack systematic relation consequently fails to present a coherent theory of justification. (3) The prima facie principles often conflict and there is no clear direction given to reconcile these conflicts. The fundamental problem seems to be centred on the notion of a moral theory and on whether principlism is an adequate replacement for moral theory in resolving biomedical conflicts. This conclusion is confirmed by their definition of the term principlism. For Clouser and Gert, principlism is the term, which denotes “the practice of using ‘principles’ to replace both moral theory and particular moral rules […] in dealing with the moral problems that arise in medical practice.” Clouser and Gert point out that the deficiencies of principlism are especially pronounced in the field of justice. The reason is that no specific guide to action or any theory of justice is formulated in the principles. We are instructed by principles to “be alert to matters of justice,” and to “think about

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justice and nothing more. Clouser and Gert hold that the same problem afflicts all general principles.

In 1990, Henry Richardson examined what principlism needed to be capable of giving normative directives in specific cases. Richardson identified three major ways to respond to this difficulty. (1) Deriving the right action from general principles; (2) concerns the balancing of principles to ascertain which has priority in a given situation; and (3) process which proceeds by adjusting the circumstances of application of the relevant principles or rules. Thus came the idea of specification and balancing of principles and derivative rules. Specification notes, is a way of resolving problem by deliberation, but no proposed specification is justified without a showing of coherence. The reason for specification as Richardson points out is that, “the complexity of moral phenomena always outruns our ability to capture them in general norms.”

Starting from the fourth edition and continuing with the fifth edition, Beauchamp and Childress responded to many of the criticisms that have been levelled against their approach to bioethics. In their responses, they reveal a number of things of great interest quite illuminating concerning the nature of the problems of decision making in moral life. Beauchamp and Childress admitted that these criticisms merit attention but refuse to agree with certain assumptions, which they accused Clouser and Gert of. This has to do with the view that there should be a single, clear, coherent, and comprehensive decision procedure for arriving at answers. They admit the second criticism, which contends that the principles lack

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systematic relationship. But they regard it as irrelevant. This response confirms our earlier observation that they have an ambivalent attitude to ethical theories. As for the third criticism, they admit that the principles compete in ways that conflicts among them cannot be resolved a priori. Beauchamp and Childress point out that no theory can escape this problem in moral life. It is important to note their brief defence against Clouser and Gert critique. They have not denied the important points made by Clouser and Gert. What they have simply done is to claim that the critics’ preliminary assumption on which the whole criticism rest is wrong. While I do not agree with Clouser’s and Gert’s arguments in their entire ramification especially in their insistence for a single canon for moral judgement, I must also note that they raised legitimate issues in their critique. This reading is confirmed to be correct by PBE adoption of the ideas of specification and balancing. The question remains whether principles lack clear directive and are not systematically related. This claim one may say is most plausible in the case of unspecified principlism. PBE specified principlism could be understood as blend of Lustigian and DeGrazian specification presented to meet the charge of lack of coherentism exhibited by the principles. Even this has its own difficulty as confirmed by Beauchamp and Childress. These principles are liable to several interpretations and principlism provides no way of choosing among competing interpretations. Beauchamp makes this point clearer by clarifying that the four principles:

> Were never intended to form a full moral system or theory, only to provide a framework through which we can identify and reflect on moral problems. The framework is abstract and spare, and moral thinking and judgement must take account of other considerations as well.  

This admission is interesting and very important for my project. These principles have been interpreted from a Eurocentric

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283 Beauchamp, 2003, “Origins, Goals, and Core Commitments”, p 27 In connection to this they write: “Principles are general guides that leave considerable room for judgement in specific cases and provide substantive guidance for the development of more detailed rules and policies. This limitation is no defect in principles; rather, it is part of the moral life in which we are expected to take responsibility for the way we bring principles to bear in our judgements about particular cases.” PBE, 1994, p 38.
perspective. In other words, the application of the principles will be subject to other values held by the society. The truth of this is that people act in ways that are more consistent with the values they profess, rather than following any particular bioethical principles. No wonder then that the values that are held in a particular cultural, social or religious society or community informs the development of laws, bioethical principles, and practices.

As earlier noted, this framework focuses on the individual, ignoring the interest of others who are intimately affected, such as family and community. This focus on the individual is evidently based on the concept of autonomous self that regards the self, and only the self, as the end per se. This framework embraces Kantian ethics that requires universal norms and impartial perspective, which is inattentive to relationships and community. Africans believe that we morally constitute ourselves not only through free and rational choice but also through our families and community. Since a viable bioethics must not only be based on the needs of the individual but also on that of the community, we must, given this explore the possibility of bioethics that equally recognises the needs of the community and the individual self.

For Beauchamp and Childress, the success of their framework depends partly on whether their principles, substantive rules, authority rules, and procedural rules can be specified and the specification justified. Of course, this view is in line with the point of Richardson when he notes that the success of specification has to be evaluated in terms of its coherence and mutual support of the whole set of moral norms. As earlier pointed out, what is required for this is a coherence standard of rationality that applies the Rawlsian idea of ‘wide reflective equilibrium’ to the level of concrete cases. A question that one needs to take account of concerns how one justifies a particular choice of specification since there may be many ways of specifying a particular norm.

Whereas specification focuses on the meaning, range, and scope of principles, balancing is about how much weight or strength a

284 Beauchamp & Childress, 1994, PBE, p 30.
particular principle has especially when they conflict in a specific situation. Discussing the importance of balancing, Beauchamp and Childress point out that, “principles, rules, and rights require balancing no less than specification.”

Balancing principles or rules is another way to try to resolve moral dilemmas and conflicts. It is important to realise that balancing presupposes a certain conception of moral norm’s weight and strength. Generally, four main conceptions are often involved in this method: (a) conceiving moral norms as absolute principles and rules, (b) holding principles and rules of thumb as merely recommending, (c) ranking principles and rules in hierarchical order and (d) regarding them as prima facie binding principles and rules. There can be no doubt that all these conceptions play some role in bioethics. Beauchamp and Childress view the fourth conception as an intermediate conception regarding the weight and strength of moral norms. They argue that the four principles along with the derivative rules are only prima facie binding. In line with this view they identified several conditions for justifying trade-off of prima facie principles and rules. In the fifth edition, they offered a longer list of conditions that constrained or restricted balancing of prima facie principles. This came, of course as a response to persistent charges that the model of balancing earlier presented remained too intuitive and open-ended. All the same, Childress admits that it is difficult to determine the exact nature and function of the constraints they propose on balancing. One possible way to interpret this is to say that the account of balancing of judgement is not satisfactory. Beauchamp and Childress’ application of this betrays the degree at which intuition functions in their act of

287 Beauchamp & Childress, 1994, PBE, p 32.
288 See Joseph Fletcher’s 1966 Situation ethics as an example of this conception.
289 Veatch’s A Theory of Medical Ethics, 1981, is one good example of this conception. He gives all deontological or non-consequentialist principles, such as honesty and promise keeping, ‘lexical priority over the principle of beneficence. Nevertheless, when deontological principles conflict, Veatch uses balancing to resolve the conflict. See also Engelhardt, 1995 that assigns the principle of autonomy priority over that of beneficence.
290 Beauchamp & Childress, PBE, 2001, pp 19-20. PBE draws a parallel between the just war tradition and the process of balancing in bioethics. The reason is that several criteria for assessing wars and other human actions infringe some prima facie obligations and therefore, are in need of justification just as the conditions of ‘constrained balancing’
balancing. Evidently, they do not offer reasons justifying their balancing in particular issues.

An important issue that requires attention concerns the nature of moral reasoning or how we make moral judgements. Morality in my view deals with how to take the interest of the other into consideration along side with ones own interest in such a way that each gets his/her due. There has been a lot of debate on how this can or should proceed. Some people hold that moral judgements need to proceed from some fundamental principles or mid-level principles. Others are of the view that it should begin from reflection on concrete cases. A problem that arises in this connection is that these two approaches are often espoused in form of either/or instead of both/and. An adequate moral system should embrace this fundamental moral concern of the well-being of the people. Its articulation could take different forms. It need not be articulated in form of the four principles of Beauchamp and Childress. Even when they are so formulated, they need not be deductive in such a way that specifying and justifying particular bioethical issues have to proceed by deduction from the original principle.

Earlier we noted that people do not often begin their moral reasoning from principles. The issue at stake is that people generally tend to proceed by a conscious or unconscious reliance on the web of moral beliefs or values they profess. In most cases principles come into moral deliberations when there is conflict of values. Much like Beauchamp and Childress, I believe that common morality forms a compass with which we negotiate daily moral choices. In my view, moral reasoning proceeds not from principles and rules that are independent of the totality of life in a given concrete situation.

The framework of PBE does not meet my criterion of coherence concerning different societies and their worldviews. Beauchamp and Childress focus on the individual and his or her right to the principle of respect for autonomy. This reflects more the American society

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292 Consider their evaluation of policies for the mandatory pre-marital screening of HIV infection required for a while in several states in the U.S. They justified their argument on the ground that there are better alternatives. Their arguments do not tell us what should be the right course of action when other better alternatives are lacking. Cf. PBE, 1994, pp 414-415. At the same time, they maintain “balancing…is a process of justification only if adequate reasons are presented.” PBE, 1994, p 34.
than the African society. This focus fails to give adequate account of the individual as both a social and a communal person. By contrast, I hold that the needs of the family and community must be given adequate consideration, not just the need of the individual self in decision-making in health care context. The reason for this is that moral agents do not stand-alone in the world. They live in a web of relationships. Because moral agents are relational and interdependent persons, it is not sufficient as PBE does to regard moral agents as single autonomous persons with a sound intellectual capacity. If this understanding is correct, then to be capable of ethical deliberation in concrete situations one must be understood in wholeness. There is also need for an understanding of the interdependent nature of vulnerability and power in human relationships and how the impact on moral decisions and judgements.

It also fails to meet the requirement for plurality of moral visions. The reason is that it does not take the fact of pluralism of moral visions seriously, not even pluralism within the western context. Beauchamp and Childress contend that the essence of common morality can be reduced to their four principles. This suggested assumption means that only these four principles are applicable at all times in every cultural context. Objection could be raised to my criticism by arguing that PBE is pluralistic since it has four principles and not just one principle and that these principles are specified and justified differently in different cultural contexts. Yet, this fails to refute my criticism. The reason is that their starting assumption that the principles provide an adequate alternative to our common notion of morality is misleading and false. Some other principles such as solidarity exist and can be more appropriate in some cultural settings.

Within my framework, the number of principles is determined by the concrete moral problem at hand and the cultural setting. This is because moral principles can both be conceptually relative and culturally bound in time and space. Even if the four-principle approach can be shown universally applicable, there can be more to be said about bioethical issues from a distinctively African perspective. The reason is that none of these four principles implies a substantive moral position by itself. They have an instrumental value and not an intrinsic value.

293 Malmsten K, 1999, Reflective Assent in Basic Care, p 219.
Conclusion

In this chapter, I have explored the method of bioethics proposed by Beauchamp and Childress. They advocate a principle–based common morality framework. Within this approach, four main bioethical principles are articulated. They include the principles of respect for autonomy, beneficence, non-maleficence and justice. They are defended as prima facie ethical principles. Coherence method of specification, wide reflexive equilibrium, and balancing are essential elements employed in addressing conflicts between these principles. Beauchamp and Childress help us to see that there are common elements of moral life. Nevertheless, they seem to exaggerate these commonalities thereby overlooking diversities that are often encountered in moral reasoning. They argue that their four principles capture and replace our common notion of morality. I have argued that these principles and the conception behind their formulation fail to address adequately the issue of pluralism of moral visions. Responding to this challenge is the point of the next chapter of this study.
4. The Foundations of Secular Bioethics

I shall in this chapter discuss H. Tristram Engelhardt’s argument for the principle of permission as the only foundation for a secular bioethics. The reason for analysing Engelhardt is that he takes pluralism seriously recognising that ours is a morally diverse, culturally plural world and the need to come to moral decisions by involving all of society in the discussion. In this regard, he offers a better understanding of our moral scene than PBE that resonates with our moral experience. This represents a particularly appealing approach. Engelhardt’s method can be classified both as a principle-based and as an experience-based paradigm of bioethics. This is a pragmatic or procedural method\textsuperscript{294}, which leads to the formulation of a single principle, namely, permission, although this approach much like PBE is obviously inspired by Kant. On the other hand, it shares with experience-based paradigm the search for what humans share simply as humans that could become the foundation for a common bioethics. In this sense, the principle of permission can be said to be the result of human experience and is justified by it. This combination of the two paradigms is obviously an advantage to this approach. Yet, it is more a principle-based paradigm because it is still the principle of permission that justifies concrete bioethical judgements.

The Foundations of Bioethics (1996), and Bioethics and Secular Humanism: The Search for a Common Morality (1991) are the primary sources for my analysis of Engelhardt’s bioethics. The Foundations was first published in 1986. I have chosen the second edition instead of the first one because I take the argument in the second edition to be more compelling than that of the first edition. Commenting on the first edition, Engelhardt writes: “I had held back

\textsuperscript{294} Procedural bioethics refers to that method that seeks to establish moral authority through agreement that all participants can freely abide by, even if they do not share fundamental ethical vision.
from stating many positions as forcefully as I could.” These two books direct attention to various aspects of Engelhardt’s philosophy of medicine and bioethics. In these books, he considers the implications of the failure of the modern philosophical project, the role of reason in ethics, and the resolution of conflict among communities of moral strangers. Engelhardt has written enormous works. Nevertheless, I have chosen these two books and not the other works of Engelhardt because he has specifically and comprehensively focused on the issue of the search for a common bioethics in these two books. *Bioethics and Secular Humanism* is in many respects important for the understanding of *Foundations*. In addition to these two books, other works of his will be used.296

**Bioethics, a philosophical perspective**

My point of departure in this section is that Engelhardt’s theory can be placed in the context of the philosophical debate involving the claim of universal ethics and the critical relativist response. Some bioethicists contend that there are fundamental ethical principles that ought to be applied transculturally and transnationally. For example, Ruth Macklin offers two concepts that could become normative ethical universals in medicine: humanness and compassion for the pain and sufferings of others; and humanity, i.e., the recognition of equality and autonomy of every human. According to her, these principles form the basic elements hidden within the world’s seemingly moral visions. Critics of this system argue that ethical universals like that of Macklin’s actually originate from the European Enlightenment. They contend that non-western civilisations have different, but equally encompassing ethical systems.

Engelhardt defines the subject and the goal of secular ethics as

> An ethic that aspires to provide a logic or grammar for speaking across a plurality of ideologies, beliefs, and bioethics […] one

296 *Philosophical medical ethics, Bioethics and moral content*, monographs, and articles written by him.
reaches for this sense of ethics precisely because one needs to justify a viewpoint that can span divergent communities of moral conviction.²⁹⁷

The reason is that appeals to ethics of ethos, law, ideology, religious beliefs and all other forms of moral convictions are not accepted in secular pluralist context. Crucial to this definition is the identification of the two senses of bioethics, which is guided by their discoverability of a content-full morality. In the first sense, bioethics is elaborated as a rival to and a possible replacement for religious bioethics. In the second sense, bioethics is viewed as a neutral framework through which advocates of various religious bioethics can negotiate.²⁹⁸ It is the latter sense that is fundamental to Engelhardt’s response to the challenge of pluralism in bioethics and healthcare delivery. He is not defending a secular pluralist ethic through agreement between moral agents. On the other hand, he is concerned about its inevitability. It is about a bioethics for moral strangers.

Moral strangers are persons who do not share sufficient moral premises or rules of evidence and inference to resolve moral controversies by sound rational argument, or who do not have a common commitment to moral controversies.²⁹⁹

Engelhardt’s definition of secular ethics is understandable when viewed from his concept of the two senses of bioethics, his concept of moral strangers, and his interpretation of humanism.³⁰⁰ Already in his definition, we see the root of his procedural method. Engelhardt identifies nine clusters of meaning around the term humanism, which are later classified into three broad divisions. It is the ninth sense ‘humanism’ as a philosophical basis for common moral understanding and negotiation between moral strangers that is most important to Engelhardt’s secular bioethics. According to him,

²⁹⁸ Engelhardt, Foundations 1996, p 17; Bioethics and Secular Humanism 1991, pp. 17-18. Engelhardt identifies seven senses of secularity and it the first of these senses that is the focus of his project. Here the secular is viewed as a morally neutral framework through which believers and non-believers can collaborate with one another. This distinction is related to the distinction often made between what reason can establish and what revelation can teach. Cf., Bioethics and Secular Humanism pp 22-23.
humanism encompasses (a) concerns with humane or philanthropic actions, (b) the scholarly possession and command of a critical literary tradition, and (c) the development of a moral philosophy grounded in what humans as such share.301 A further classification is also made in order to show the philosophical and moral issues these senses of humanism raise for bioethics. These various senses of understanding humanism are evidently dependent on different visions of human well being and how it is to be achieved. Each of them makes possible a different justification of how health care that could achieve human well being. The three clusters of senses of humanism are interwoven and have an influence on contemporary health care policy.

Engelhardt further distinguishes between secular humanism with upper case (Secular Humanism) and secular humanism with lower case (secular humanism).302 The former identifies beliefs or opinions linked to organised humanist movements such as ‘Secular Humanism’. The latter refers to a cluster of philosophical, philological, moral and literary ideas, images, commitments that have been identified with a historical phenomenon of humanism independent of any attachment to a particular religious or ideological tradition. In order words, the latter identifies a body of moral, political, and philosophical claims that can be justified as integral to a moral language for individuals and groups who do not share common moral perspectives. In this sense, it is an attempt to justify morality by appealing to what we share as humans. This underlies most contemporary understandings of bioethics and health care. Secular humanism in the first sense sometimes construes itself as a rival to religion. By contrast, the second sense is only a means of peaceable collaboration between people with different moral visions and does not presuppose the denial or destruction of differences in belief. The two secular humanisms differ not just in their metaphysical claims but also in terms of their social structures in being atheistic and agnostic respectively.

**Bioethics and secular humanism** attempts to provide a basis for health care on the ground of rational arguments anchored in a critical

account of human nature and human condition. The two senses of humanism identified are related to the contrast made between secular bioethics as a rival to other bioethics and secular bioethics as a mediator among rival bioethics.

In order to understand adequately Engelhardt’s secular bioethics, it is equally important to understand his analysis of the concept of secular. He identifies seven senses of secularity. The first of these ‘secular as a morally neutral framework, through which believers and non-believers can collaborate one with another,’ is the sense that is most important for his work. In this regard, the intellectual challenge for secular bioethics is to fashion a bioethics that speaks with moral authority across the various types of content-full bioethics, i.e., bioethics that is independent of particular traditions. The crucial question is that of finding out if there are enough that humans share simply as humans, simply as persons, so that bioethical controversies could be resolved with moral authority, even where participants do not share the same particular faith tradition. The idea of the normatively human is, therefore, vital in this project. This search becomes not only for secular humanism but also that of secular moral philosophy, and bioethics. In order to situate the common characteristics that human beings share, Engelhardt turns to the secularisation of society since the Middle Ages and the humanist tradition. In his reflection, he understands appeal to humanism as representing a reaction to the secularisation of the West.

Engelhardt regards the project of finding a neutral framework for moral participants in pluralist societies as an urgent task. The need to avoid the danger of force is a driving and a necessary condition of his secular bioethics. The response to the question of the normatively human has been various. Suppose, humans were to agree to a list of important human goals and ideals, yet it is unlikely that they would all agree to a particular canonical ranking of these goals. Consequently, Engelhardt identifies the principal difficulty in ethics as the impossibility of establishing a canonical ranking or rational account of values.303 This suggests that the difficulty is not the absence of, or acknowledgement of values but that of their respective relevance in moral judgement. To the question, can a humanist vision

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or any other vision for that matter justify a common bioethics? Engelhardt maintains that:

...as long as particular understandings of humanism remain in principle parochial, there appears to be no way by appeal to human nature and the human condition to justify a universal morality, a morality for moral strangers, a morality through which individuals with different views of human excellence and human community can speak to each other, lay claim to a common moral fabric, and justify intellectually a common understanding of bioethics.304

As this passage shows, Engelhardt denies the possibility of rationally establishing normative human nature. From a secular perspective, the will to morality distinguishes moral individuals from immoral individuals and creates a common language for moral participants. This will to morality does not involve any particular moral content.305 Moral content must be sacrificed, Engelhardt argues, because it is inseparably bound to a ranking of values no longer recognised by moral strangers. In this sense, Engelhardt’s moral negotiators must be ideal individuals uninfluenced by any particular moral, religious or ideological traditions. This is why these negotiators could only collaborate on the ground of the principle of permission.

Engelhardt makes a distinction between secular bioethics and bioethics of content-full moral commitment. The first type is the focus of Engelhardt and can only provide a procedure for dealing with the challenge of pluralism in moral conflicts. Meanwhile, the second kind can only be realised in concrete moral communities.306 In order to understand what Engelhardt means by secular bioethics, it is important to understand what he means by secular humanism. What are the salient points in this definition? These distinctions lead him to the identification of two levels of morality, namely: content-full

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305 Engelhardt, 1991, *Bioethics and Secular Humanism*, p 122. This ‘will to morality’ may be compared to *PBE’s* discussion on common morality whereby they contend that those committed to the project of morality share a common framework. This commitment may be the same as the ‘will to morality’, which is the engagement of a moral community or peaceable community.
morality of moral friends and procedural morality binding moral strangers.307

Bioethics aspires to provide logic for pluralism of beliefs. The reason is that grounds for conflict resolution of moral controversies are of crucial importance, for they are the basis for public policy. In this sense, justification of particular conflict resolution does not appeal to any external other worldly creature for its validation. Here, bioethics becomes a lingua franca, i.e., a language of speaking. It is important to realise that Engelhardt articulates bioethics in a qualified sense, namely, as secular bioethics. What is this all about? It is a bioethics for the post-modern society. As such, the central tenets of postmodernism308 such as neutrality and autonomy are the bases on which a secular bioethics is articulated. The plurality of moral positions in post-modern society is real. It is not a sort of ethical dysfunction. Engelhardt rightly points out that the current situation within bioethics calls for an acknowledgement of the reality of plurality of moral visions and the acceptance that bioethics is a plural noun. There is no one bioethics.309

What Engelhardt says about bioethics is informed by his philosophical perspective on some fundamental issues such as the concept of the human person and the philosophy of medicine310. Our perspectives inform our perception of whatever we are saying. James M. Gustafson underscores the fact of this statement when he writes: “The perspective of the investigator has a bearing on the

307 Engelhardt, 1996, Foundations p. 7. “Contentfull morality provides substantive guidance regarding what is right or wrong, good or bad, beyond the very sparse requirements that one may not use persons without their authorisation” Foundations, 1996, p 7. What in this sense renders individuals moral strangers is the different ranking of fundamental values. The reason is that these values may be comprehensible to moral strangers who may recognise each other’s moral commitment but at the same may see them as misguided. In order to explicate on the distinction between moral strangers and moral friends, he employs the concepts of community and society. The former identifies a body of people bound together by common moral traditions or practices around a shared vision of the good life. Society, on the other hand, refers to an association that encompasses individuals who have diverse moral commitments.

308 Post-modern refers here to criticism of absolute truths, theories of objective truth and any such grand narrative. Postmodernism describes attitudes sometime aimed at critical theories such as relativist, nihilist.


310 These same factors play important role in African value system and her response to issues of health care.
development of the natural and biological sciences; this is even more the case in the social, behavioural, and policy sciences.”

Philosophy and medicine have close relationship and the philosophical bent of a bioethicist determines largely how he or she responds to concrete bioethical issues. Philosophy has a direct implication on doing and teaching bioethics. Kant, Hegel and the scepticism that pervades the secular society have deeply influenced Engelhardt as a moral and political philosopher. He explores in the *Foundations* several philosophical justifications of contemporary secular bioethics. When one examines the issues that the study of bioethics includes, it is not difficult to see that in addition to ethical and legal questions, bioethics raises social and policy issues.

Engelhardt’s response to the project of bioethics is also informed by his identification of this task with that of the Enlightenment project to employ reason to justify what a good life consists in. By contrast, PBE identifies its task as that of analysing benefits and harms of a particular course of action in order to ascertain its ethicality or permissibility. Engelhardt contends that the Enlightenment attempt was a failure and the modern philosophical project of providing a justification for a canonical secular ethics is beset with difficulties. The success or the failure of the task of fashioning a secular morality is tied with that of the project of justifying a general secular bioethics. The *Foundations of Bioethics* focuses on the implications of the failure of Enlightenment project to discover a canonical, content-full ethics for bioethics to apply. It is an attempt “to save something from the failure of modern philosophical project.” Furthermore, it is an indication of “the enduring remnant of the Enlightenment hope to disclose for moral communities the possibility of authoritative collaboration.”

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313 Engelhardt, 1996, *Foundations*, p viii. Alasdair MaIntyre in his book *After Virtue*, paints a similar picture of moral fragmentation in the post-modern society. Although there are important insights in this claim, yet it is arguable whether one would accept fully the implication of this presentation of the apparent failure of reason.
Bioethics as a moral lingua franca

In describing the project of bioethics in the preface to the Foundations, Engelhardt writes:

The account offered in Foundations does not provide a content-full ethics by which men and women can live their concrete moral lives. […] It offers a moral perspective that can reach across the diversity of moral vision and provide a moral lingua franca.316

Such description of bioethics probably presupposes certain conditions or state of affairs. This view underlines two important accounts of ethics. First, ethics is conceived as a search for concrete, content-full moral authority. Second, ethics is regarded as founded in rational moral dispositions, intuitions, and theories that generate moral authority. For Engelhardt, both accounts suffer in the hands of secular scepticism. It is not possible for people sharing different moral perspectives to agree on either authority or intuitions.

According to Engelhardt, there is no longer any common value for today’s society. We meet as moral strangers. This means that we belong to different traditions and cultures and have different moral visions and moral languages. Moral fragmentation is in this sense a social and historical fact, which any serious contemporary ethic must reckon with.317 In this light, secular bioethics can be understood as a process for dealing with this pluralism. An acceptance of pluralism is crucial for a secular bioethics to function. By assuming a neutral position, secular bioethics tries to engage this problem. Fundamental to a secular bioethics is, therefore, the principle of informed consent. This means that the individual decides what to do when he or she faces a moral dilemma. No one else has any moral authority over the individual. Secular bioethics does not recognise any universal reason. It is not only that ‘God is dead’, but also human reason is equally dead. Secular bioethics is in this sense a form of epistemological relativism. That means that human reason cannot justify any moral position in such a way that it becomes acceptable to every one

irrespective of whatever moral tradition the individual belongs. From this standpoint, there are no universal content-full bioethical principles that ought to be applied across national and cultural boundaries. Something that is considered justified in one particular tradition may not be in another tradition. Engelhardt argues for this form of bioethics in *Foundations of Bioethics* and *Bioethics and Secular Humanism*. The moral authority that is at stake in the two books “is not that of God, reason, or human nature, but the sparse authority of permission.” In these books, he contends that modern society is both characterised by fragmentation and individualism. Outside of a particular moral community such as that of devout Jews, Protestants, and Orthodox Catholics, Roman Catholics and similar communities, there is no canonical content-full moral guidance, or content-full bioethics. Notwithstanding, outside of such concrete communities of belief, Engelhardt contends that procedural morality can bind moral strangers and establish a procedural bioethics.

How may we further understand the context of Engelhardt’s articulation of secular bioethics? He provides us with some insight on how we could appreciate his perspective. Reading the *Foundations* from the background of the perennial debate between what reason is able to know and what revelation can teach might shed light to the understanding of bioethics as a procedural project. The distinction he draws between faith and reason leads him to the conclusion he reaches concerning the limit of human reason. However, it is doubtful whether there are no core values on which all reasonable people might agree and apply to different practices and cultures. It might be argued that John Rawls’s “veil of ignorance” demonstrates in a powerful way the possibility of establishing core values that humans might rationally agree upon, although it might be less successful in being applied to specific controversies. Engelhardt’s concept of incommensurable values seems to deny that such an identification of a rational core is possible.

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Why there is no secular bioethics

Engelhardt began his task of formulating a secular bioethics by analysing and criticising several philosophical justifications of contemporary secular bioethics such as: intuitionism, casuistry, ideal observer, natural law, rationalism, middle-level principles, consequences of moral choice and a group of unbiased contractors.\(^{322}\) Obviously, this refers to the two paradigms and approaches discussed in chapter two, classified as principle-based and experienced based. One general thing to be noted in his criticisms of these positions is that they are formulated in the same way.\(^{323}\) He rejects these theories on the charge that they all appeal to a higher-level moral sense that cannot be done \textit{ad infinitum}. Defending this he writes: “secular accounts beg the question, arbitrarily affirm a particular point of departure, or invoke an infinite regress.” \(^{324}\) Having rejected all the options offered, he then engages the reader in a dialectical account of what should be the goal of secular bioethics. Engelhardt argues systematically why his theory about bioethics is the only possible one available for moral strangers in a pluralistic society. He holds that content-full views of the good fail because they “attempt to justify a particular moral vision (which itself) presupposes exactly what it seeks to establish so that theoretical arguments are at best expository, not justificatory.”\(^{325}\) Engelhardt believes apparently that objective standards of morality do exist. He does not deny the possibility of a secular bioethics. On the contrary, he allows for a thin or as he calls it, content-less secular bioethics. For Engelhardt, the failure of this project means that the possibility of a secular morality, which can be justified in general rational terms, does not appear feasible. However, one may question the validity of this account, it would seem that there is no room for moral truth and no way could moral controversies be rationally resolved in this framework. If this understanding is correct, Engelhardt faces a serious challenge. The question is whether one can even make sense of his argument that there is moral disagreement.

First, he criticises intuition, a theory put forward by among others David Little, which represents the view that human beings have a basic sense of the wrongs or rightness of certain actions for example tortures. This would mean that certain human abilities exert a moral claim that should be developed. Engelhardt raises the question of what happens when one intuition conflicts with another. Such a conflict as he sees it can only be resolved by appeal to a higher level of moral judgement. Intuition cannot resolve another intuition. Engelhardt criticises casuistry for resolving ethical conflicts by reliance on a guiding framework beyond the cases they appeal to. This problem is not encountered between moral friends. In this regard, paradigm cases can be recognised. The case is not the same with moral strangers. Casuistry in this connection, as advocated by Albert Jonson and Stephen Toulmin, as I discussed in chapter two cannot resolve the problem of appeals to intuitions.

Consequentialists have the difficulty in choosing one course of action and justifying why that particular one is preferable to another. The difficulty is that there is no correct way of ranking consequences, knowing which ranking of benefits and harms to be preferred. Against this backdrop, he concludes that:

Consequentialists accounts (including utilitarian accounts), which compare outcomes, are no better advantaged than intuitionists accounts with regard to being able to demonstrate which ranking or comparing of benefits and bane are to be preferred, since both presuppose an antecedent, indeed authoritative means of judging, ranking, or comparing benefits and harms. 328

This understanding of consequentialist ethics is a direct refutation of PBE in its focus on determining which action is ethical by benefits and harm based on quality of life. This critique refutes also Peter Singer’s quality of life ethic. Engelhardt seems to think that there is a way of deciding on two or more things in conflict that does not involve the calculation of their consequences. Engelhardt’s point probably could have been better made if he had reformed it as to imply that it is not always that the consequence of an action

326 Jeffrey Stout, 1988, *Ethics After Babel, the languages o moral and their discontent.*
327 See chapter two for casuistic account of bioethics.
determines whether it is justifiable or good. Even here, one needs to point out that the concepts of justification and good are not always the same. Engelhardt is, however, correct in maintaining that, “consequentialist ethics presupposes a nonconsequentialist ethics.”\textsuperscript{329} The reason is that to evaluate consequences one needs independent moral criteria. This difficulty is not resolved by interest or preference accounts of consequence.

Hypothetical choice theory advanced by among others John Rawls,\textsuperscript{330} Roderick Firth\textsuperscript{331} and Richard B. Brandt\textsuperscript{332} was rejected. These theories invoke what an impartial observer or disinterested observer would affirm as being morally correct. An impartial observer could be classified under the experience-based paradigm. The reason is that such an observer probably appeals to what would be seen to resonate with human experience to determine what would be ethically proper in a given case. For Engelhardt, the success of this argument depends on a number of factors. The rational agent must be fully informed, impartial in choosing alternative courses of action. He would also need to appeal to a moral sense to know the canon of impartiality. Drawing from this, Engelhardt identifies the difficulty with this position and rightly when he argues that if the observer is fully morally disinterested and truly impartial, then that observer will have no moral sense whatsoever, and as such would be incapacitated in identifying preferable outcomes.\textsuperscript{333} In order that these observers could be effective in their work, one must assign to them some moral sense. However, since what is at stake is how to establish the preferability of one moral sense over alternative moral senses, then this position suffers from the same problem as the earlier ones. Engelhardt, therefore, concludes that appeals to hypothetical observer fail for the same reason as the others. Given this, appeals to

\textsuperscript{330} Rawls offers his account as a “theory of rational choice” resolving conflict among different conceptions of the good. See his book, \textit{A theory of Justice}, pp.396-97. Engelhardt argues that Rawls multiplication of impartial observers does not free Rawls hypothetical contractor theory from the problems he raised. This is because the contractors in their choice depend on a particular idea of the good.
\textsuperscript{332} Brandt, 1976, \textit{A Theory of the Good and the Right}.
hypothetical choice including hypothetical contractors do not give contentfull direction in formulating healthcare policy.334

Engelhardt similarly argues that appeals to rationality, neutrality, or impartiality to establish a concrete view of the good life suffer from the same difficulties as hypothetical choice theories.335 In this connection, Engelhardt is probably arguing against some utilitarians as I discussed in chapter two who are of the view we ought to produce agent-neutral goods, that is, goods that would be accepted by every rational individual. Engelhardt contends that it is impossible to achieve this aim without a particular concept of morality. Bruce Ackermans principle of neutrality336 and Jungen Habermas’s ‘Theory of Communicative Action’337 were presented as good examples of such attempt. He accuses Habermas of smuggling in considerable content into his discourse.338 For Engelhardt, in either way, one inevitably endorses a particular ranking of values or canon for ranking of values. True to his sceptical mind, Engelhardt rejects Habermas’s position that sufficient reason is able to bring divergent moral points of view to agreement. Immanuel Kant’s appeal to a contradiction in the wills to establish obligations of charity which argues that one cannot speak of oneself as worthy of respect without regarding similar entities with similar respect is also rejected for the same reason.339 It is argued that content is smuggled at some point in the notions being discoursed.

Having rejected appeal to reason to resolve moral dilemma, he now explores appeal to the game theory, which he similarly dismisses because it too requires some common ranking of values and harms as well as some common understanding of rationality.340

336 Ackerman, 1980, Social justice in the Liberal State. Ackerman smuggles in the concept of entitlement into his principle of neutrality in order to reject privileges due to natural lottery and social lottery accepted by Robert Nozick in his 1988, Anarchy, State and Utopia.
337 Herbamas’s contention that sound rational arguments can resolve moral controversies is one of the main arguments Engelhardt tries to refute in Foundations. See Habermas, 1984, The theory of communicative action, trans Thomas McCarthy, Vol. 1 p 42.
Next, he argues against appeal to natural law in secular moral controversies. According to Engelhardt, it is unclear how one could derive normative moral content from the structure of reality or nature. According to him, within a secular perspective, nature is “merely the products of physical processes,” and, as such has no moral significance outside a context of moral interpretation. It is difficult to discern what true human goods are that would enable us to establish a secular bioethics that would be the basis of the goals and purposes of good medical practice and justifiable health care system. Since there is no shared vision of the good, Engelhardt tells us, as such, it is not possible to establish a normative human nature that could form the ground for agreed human good. Even the acknowledgement of a creator God does not guarantee a normatively human nature. There is the problem of how one chooses with moral warrant among competing accounts of the moral implications of nature. Engelhardt argues that nature will not have moral claim on our conduct other than through shaping the consequences of actions. Besides being determined by the consequences, one implicitly would have presupposed a particular interpretation of nature. Following from this, a secular theory of nature though possible would fall into the same difficulty as the metaphysical approaches.

Using the same approach, Engelhardt rejects appeal to moral facts since it is not clear how one could explain the failure of two people to recognise the same moral fact. Finally, he argues against appeal to middle level principles of autonomy, beneficence, non-maleficence, and justice. This is in contrast to PBE. Engelhardt does not refer to this approach as principle-based, rather, he calls them middle-level principles. By adopting this classification, he suggests a distinction between these principles and his own principles. Engelhardt probably makes an important point when he distinguishes conflicts due to different moral visions and conflicts due to different theoretical frameworks. Obviously, this is vital to understanding the distinction he earlier made between moral strangers and moral friends. One important question is to what extent

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appeals to mid-level principles help in reconciling people with different moral visions. Engelhardt admits the importance of principles when it has to do with conflicts arising from similar sentiments, those that share a moral vision but are separated by theoretical reconstruction. However, when there is not only theoretical difference but also difference in moral perspectives, the case is not the same. All concrete moral choices presuppose a particular moral perspective, hence their failure in establishing secular bioethics. This is the case because moral content is achieved at the price of particularity. Since there is no particular way of choosing which moral content should be accepted, there can be no particular moral vision of bioethics in general secular terms.345

With the failure of these frameworks, how does one escape moral relativism and nihilism? Although, one may accept his analysis of these principles, it does not follow that one would also arrive at the same conclusion as he did. Drawing from his claim for the failure of secular humanism, which represents for him the failure of western philosophical hope to establish the objectivity of morality, Engelhardt does not see how reason could now succeed in resolving moral controversies and justify particular moral visions. It needs be pointed out that he, however, recognises the important role of reason and its limits and dangers in the project of articulating a secular bioethics when he writes, “the content of moral vision cannot be discovered by appeal to reason alone.”346

Having explored these philosophical moral theories and found them wanting, he now begins to consider other possible sources of moral authority in a pluralistic society. Engelhardt searches for a neutral foundation free from particular moral vision. It was this seeking that led him to the humanist tradition. How then does Engelhardt think the project of secular bioethics could be undertaken?

Bioethics for moral strangers

Having shown the inadequacies of the theories explored, Engelhardt was left with four alternatives to choose from, namely: force, conversion, sound rational argument, and agreement.\textsuperscript{347} Force, conversion and reason are all rejected as ways by which moral conflicts could be resolved. Engelhardt recognises two major principles, namely, beneficence and permission in dealing with the problems of moral judgement in bioethics. They provide ground on which interaction between moral strangers can be justified. They are also the answer to the challenge of secular pluralism.\textsuperscript{348} The first of these two principles is conceived as the morality of welfare and social sympathies. It deals with the question of what is good or bad to do. The second sets limit to the first of these two principles. By this is meant the criterion for specifying the good to do and the evil to avoid. I will now turn to a discussion of these two major principles and an exploration of the place of informed consent in Engelhardt’s general scheme.

Engelhardt takes the principle of beneficence as having to do with the core of moral judgement. This concerns the issue of what is the good to do.\textsuperscript{349} How does one then understand this principle? Beneficence focuses on the morality of common welfare and social sympathies. In this respect, it is simply the principle of doing good. Unlike the principle of permission, which is a negative principle, beneficence is positive. To accept the principle of beneficence is to recognise the project of common good. Talks about the good necessarily deal with issues of values. In this sense, this principle cannot function the same way as the principle of permission since it cannot be explained without including content and contentfull morality is only possible in particular moral communities or traditions. Comparing these two principles, he states:

\begin{quote}
Unlike the principle of permission, which justifies the process of for generating content, the principle of beneficence identifies the content of the practice of morality. The principle of permission shows that patients may not be used as a means merely; the principle of beneficence
\end{quote}


supports the concrete moral goals to which medicine ought to be directed.\textsuperscript{350}

Engelhardt argues that beneficence acquires content when individuals affirm it. Implicitly, this would mean that permission given by individuals is important. The implication of this for bioethics is that the requirement for permission sets the boundaries to what could or could not be morally acceptable. Still, a commitment to beneficence characterises the project of morality. Meanwhile, the basic argument of Engelhardt is that secular bioethics must be content-less. Therefore, he maintains that the difficulty with the principle of beneficence is that of establishing the ranking of values that its application presupposes. Since this principle depends on a particular moral vision, it has difficulty in negotiating across moral communities. The problem is that one cannot offer a conclusive view concerning the justification of any moral perspective since accounts of the good varies and different individuals accept different rankings of benefits and harms. How one justifies a particular view of beneficence is the point at issue.\textsuperscript{351} One possible way to understand this is that since there is plurality of moral understandings of the good life, beneficence being content-full must be acknowledged within a given moral community in order to be practical. If I have understood and interpreted Engelhardt properly, namely, that content-full secular morality to which all would accept is impossible, then the good in this sense can only come about by mutual agreement.\textsuperscript{352} Therefore, the principle of beneficence is not basic to Engelhardt’s secular morality. This is in line with his conclusion when he writes that the principle of beneficence is not required for the very coherence of the moral world. It is in this sense that this principle is not as basic as the principle of autonomy. One can be nonbeneficent without contradicting the minimal notion of morality.\textsuperscript{353} In this connection, one could say that the principles of permission and beneficence are not of equal importance in Engelhardt’s framework. The reason is that the principle of

\textsuperscript{353} Engelhardt, 1986, \textit{Foundations}, p 68.
beneficence suffers from the same difficulty as those philosophical theories Engelhardt rejected earlier. The former does not depend on any ranking of values but requires only an interest in resolving issues without the use of force. However, it is less clear how this could be the case.

The principle of permission is crucial to Engelhardt's secular perspective. It may be said to be a reworking of Kant's thesis of autonomy as the essence of the moral life. In recognising permission or the importance of freedom of those participating in moral deliberations, Engelhardt identifies with Kant who underscores freedom as the presupposition for morality. The principle of permission forbids the use of force against the un-consenting innocent. Engelhardt maintains that this principle does not rely on any particular vision of the good; hence, it is content-less and procedural. One necessary condition for participants in moral controversy is the requirement to respect the freedom of the participants. Implicit in this conclusion is the re-conception of ethics as a means to peaceably negotiating moral disputes. Of course once this view of ethics is accepted, permission as a necessary condition for participants in a moral controversy becomes inevitable. Within this context, Engelhardt sees consent or agreement as the only alternative to coercion in the resolution of moral conflicts. Those who act forcibly without regard for the principle of permission abrogate any reciprocity with respect to their own freedom. They are disqualified as participants. Engelhardt concludes this thought by asserting that no moral fabric can exist between moral strangers without respect for freedom and the principle of permission. Engelhardt is quick to explain that the principle of permission does not focus on freedom as a value. It rather focuses on moral agents as the source of secular moral authority.

It is worth noting in this connection that appealing to the principle of permission, as a source of moral authority does not involve any specific moral understanding. In other words, permission is the

content of the will to morality. “It is a negative principle”. This is the case because it is only a principle of forbearance and only requires, for example, institutional bodies such as the state to be neutral towards these types of decisions. In this view, the interaction between the state and the individual is libertarian. For Engelhardt, this condition is morally unavoidable for peaceable secular pluralist societies. The moral authority and the neutrality of the state are justified in the same way, i.e., the principle of permission and the “right to be left alone”. This authority emanates from those who participate. It does not require any foundational moral understanding. The state is not to commit itself to any particular vision of the good. Rather it should enable individuals and communities to pursue their own vision of the good. Furthermore, the state has no authority to forbid what individuals agree to do with themselves and others who consent. What does this imply in practice for the state? The state may use force to protect the unconsenting innocent from being used without their permission. It should also enforce contracts and determine how common resources are to be used. One may say that what apply to states also applies to institutions and equally to moral strangers. The only difference it would seem is that people who join institutions do so of free accord whereas governments de facto and not necessarily de jure. The principle of permission is invoked before the discussion of what constitutes the good. As long as they are peaceable, individuals and society may employ manipulation, persuasion, enticements and market forces, all of which are morally permissible within secular morality.


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The principles of beneficence and permission contrast as a general principle of authority and a general principle of the good. These two principles are not justified in terms of their consequences. The reason is that they disclose unavoidable areas of personal conduct. They give priority to non-consequentialist principles particularly respect for freedom of individuals, over consequentialist and utilitarian considerations. In this sense, they are deontological principles. Yet, “concrete rules of beneficence are likely to be teleological in being justified in terms of their consequences.” In contrast, specific applications of the principle of permission bind not minding whatever consequences they have. Within this context, there exists a tension. It gives birth to a health care setting where the morality of mutual respect expressed by the principle of permission and the morality of welfare expressed by the principle of beneficence conflict. No wonder, he regards the tension between autonomy and beneficence as the conflict at the roots of bioethics.

Personhood in Engelhardt

Engelhardt’s bioethics stands on his view of human beings. Margaret Monahan Hogan and John C. Moskop have pointed out that the concept of person is central to Engelhardt’s project. What is then the nature of persons who give consent? "Persons, not humans, are special" argues Engelhardt. This is based on his conviction that not all humans are equal. Persons are important because they are the only constituents of a moral community. Therefore, moral concerns focuses on person, not on humans. By implication, belonging to a particular species is of no importance, unless membership also makes one capable of participation in the moral community as a moral agent. This suggests that all humans are not persons, and all persons are not humans for example angels. Consequently, “fetuses, infants,

the profoundly mentally retarded, and the hopelessly comatose provide examples of human nonpersons”.373 The reason for this is that such humans cannot blame or praise, or be worthy of blame or praise. “They cannot make promises, contracts, or agree to an understanding of beneficence.”374 The reason is that only persons have that status.

Those considered as persons must be self-conscious, rational, have a minimal moral sense, and regard themselves to be free. Engelhardt regards these as the characteristics that give persons the rights and obligations of the morality of self-respect. The principle of autonomy applies to persons. Non persons fall outside the parameters of this morality. Distinction is made between human personal life and human biological life.375 The fundamental question in this regard is not when human life begins but when a human being becomes a person. This categorisation of human life has serious implication in assessing the moral significance of each level of human life. This point is especially relevant for the articulation of African bioethics where this sharp distinction between humans and persons or nonpersons does not exist. This distinction is important in understanding what is allowed or prohibited in Engelhardt’s bioethics.

One may then wonder what the fate of those nonpersons is in Engelhardt’s framework. Why does Engelhardt choose rationality, self-consciousness and minimal moral sense as criteria for personhood and not such others as sentience, community or solidarity? Contrary to Engelhardt, these seem to mark the morality of welfare and social sympathies rather than the capacity for autonomy. Animals are protected by the morality of beneficence that is by nonmaleficence.376 This varies with the ability to feel, suffer, and have affection for others. What happens to those entities that will most probably develop into persons such as embryos, fetuses, and infants? Will appeal to potentiality secure rights for them? Engelhardt answers no. What about infants, the profoundly mentally retarded, and those suffering from very advanced stages of

Alzheimer’s disease, those who were persons, but are no longer capable of minimal interactions, those who never were and will never be persons in the strict sense? Engelhardt justifies the respect shown to them on what he refers to as “social sense of person’ that in turn is justified in terms of the various utilitarian and other consequentialists considerations.377

Critical assessments

Engelhardt’s secular bioethics has received many interesting objections. At the same time no one who has read Engelhardt’s argument would be left in doubt about the force of the arguments he presents. There is no doubt that Engelhardt’s work is a powerful contribution to bioethics. One of the major strengths of Engelhardt’s theory, is its ability to take seriously the secular pluralist nature of modern society. It is fashioned solely for moral strangers. There is also a worthwhile attempt to be connected to the humanist tradition. One major way my work differs from that of Engelhardt is in our views concerning the ability of human reason. In contrast to Engelhardt, I believe that one can offer justifiable reasons for the beliefs one has. In order words, I do not share his unbridled scepticism concerning the capacity of reason to justify its standpoint. However, we do share the acknowledgement of real diversity among moral perspectives and the weakness of secular reason which in no way in my own case translates into impossibility of establishing by reason justifiable moral positions. We share also an interest in connecting to the humanist tradition.

My evaluation framework will include the following: First, I will argue that Engelhardt is unable to establish the central concept for his own secular bioethics i.e., the notion of person. Second, I will maintain that Engelhardt’s definition of the project of bioethics is unpersuasive and unsatisfactory. Third, I will argue that his approach fails to account for the role of community in the individual person’s moral life and as such lacks correspondence to the existential experience of human persons in society. Fourth, I will contend that Engelhardt’s account of the nature of human reason is inadequate.

a. Personhood

The concept of personhood is obviously Engelhardt’s point of departure. Why is the concept of person important for my purpose? First, because the way it is understood has a lot to do with how concrete bioethical problems are handled in a pluralistic society. Second, it is central to Engelhardt’s principle of permission. Engelhardt takes the higher-brain capacity as his criterion for personhood. For Engelhardt, all persons are human beings, but not all human beings are persons. The reason is that some humans lack the rationality necessary to participate in agreement. Consequently, all those human beings lacking rationality are outside the boundaries of persons. In this sense, foetuses, infants, young children, irreversibly comatose, vegetative patients and severely retarded individuals are not persons in the strict sense.

What could be the implications of this view? One can conclude that how these groups of people are treated is a matter of agreement among those who are strictly rational. This account encounters difficulties. The question is whether society as we have it allows us to define in and out of existence a particular group of people. Engelhardt’s answer would likely be no. How then does he take care of his ‘nonpersons’? He develops the idea of ‘social personhood’, which allows these nonpersons to be ascribed symbolic personhood. Meanwhile, those who possess real personhood are those with rational powers. The inadequacy and ambivalence of Engelhardt’s concept of person is shown by the concern for the inclusion of human beings who are at the margins of life such as the senile, severely retarded, irreversibly comatose and others like infants, fetuses and embryos. In addition, it fails to account for the most important dimension of human nature, namely, its self-transcending abilities. Such a conception does not fully account for the different dimension of the human psyche such as memory, emotion, imagination and subconscious’s, which are all integral aspects of human beings.

Engelhardt’s project is internally flawed since one of his fundamental concepts, the person, is not properly accounted for. I am concerned that Engelhardt does not care much to define the person
who must give consent in his permission game. This lacuna in Engelhardt’s theory is what must form the bases of bioethics.

Anthropology, that is the study of the human person and his specific nature, is therefore the basis of bioethics; it is the obligatory starting point for any further reflections, and a reference to those questions man has always posed about the meaning of life by using his intellect […] 378

Obviously, the different ethical visions arise in the ideas about the person, giving birth to the many bioethical perspectives. Health care system equally arises in the context of the value attached to the human person and the well being of the society. One can in this sense say that one of the major tasks of bioethics is to help deepen the understanding of the human person. And in that light it should propose guidelines that will help policy makers frame a health care system that is true to the truth about the human person and the society in which he or she lives.

There is no doubt that persons who take part in secular morality are an important source of authority for secular morality. Nevertheless, it is doubtful if that is the only source or sufficient to establish secular moral authority. Engelhardt tells us that the principle of permission must be content-less. That means that Engelhardt’s moral participants must act as ideal types rather than real, contextually and historically located people. I do not see how these individuals can give their consent if they no longer see the value in giving consent for a common goal. Surely, there can be no pure procedures. The reason for this is that “for the procedures of consent to work there are necessary commitments to particular views of rationality, the value of peace, and the value of persons.” 379 It worries me that they are not valued for their humanness as this passage shows

Within the sparse morality of moral strangers, one cannot talk about persons being valued or as having moral worth. They, and their consent, are simply necessary for a morality of moral strangers. 380

What is disturbing is that the individuals in Engelhardt’s game of permission are stripped of their humanness; they are not valued for their humanness. Engelhardt is correct in saying that permission is necessary for participants in secular bioethics. However, Engelhardt is incorrect in maintaining that it is the only foundation available to pluralistic societies. For Engelhardt, the best one can do with the principle of beneficence is to articulate it in such a way that it would mean: “Do to others their good, in the concreteness of particular moral communities.” Yet, it cannot be denied without self-contradiction that individuals who freely give their consent as participants are not devoid of self-goals. These individual goals are in turn value-laden. This is underscored by the fact that Engelhardt himself has strong content-full personal ethics, which contrast greatly with that articulated in The Foundations of Bioethics. One can state with certainty that what he offers in his theory is not the morality that guides his personal content-full life as he confirms. This could not be more strongly expressed,

...I indeed affirm the canonical, concrete moral narrative, but realise it cannot be given by reason, only by grace. I am, after all, a born-again Texan Orthodox Catholic, a convert by choice and conviction, through grace and in repentance for sins innumerable […] My moral perspective does not lack content. I am of firm conviction that, save for God’s mercy, those who wilfully engage in much that a peaceable fully secular state will permit (e.g., euthanasia and direct Abortion on demand) stand in danger of hell’s eternal fire.

It is not clear, how the game of permission could work without a commitment to certain values or principles. Hauerwas makes a similar point when he maintains that the principle of permission “provides only an empty process for generating moral authority.” I am inclined to grant him right in this observation. This rings true

381 Engelhardt, Bioethics and Secular Humanism, p.44 describes humanism as an “extraordinarily vague but still fruitful notion.” Engelhardt’s treatment of humanism has been compared to that of Gianna Vattimo in The End of Modernity, 1985, p 35. This line of reasoning stems from Continental phenomenology and claims that a crisis of humanism necessarily means the failure of metaphysics.


383 Engelhardt, 1996, Foundations p. xi. For example, Engelhardt supports Lockean view concerning the universal ownership of property that permits a two-tiered health care system.

particularly because every choice presupposes a recognised value, which the individual making the choice considers worth striving for. Every individual is situated at a particular environment in the world and at certain point in time. Every act of deciding is therefore contextual. In addition, there cannot be content-less ethics since there is no context-less way of deciding on a particular issue.

Engelhardt’s theory does not give any clear answer why agreement with persons should be kept. Nevertheless, it is clear from his work that he believes the agreement to be morally binding on those who have freely entered it. Furthermore, no blame is assigned to those who would reject peaceable negotiations in favour of force. For Engelhardt, those who reject peaceable negotiation cannot be said to be immoral. However, they have forfeited their reciprocity to be treated peaceably. Could this not imply that the application of force would be appropriate and justified to those individuals? If this is the case, what then could be the ground for using force on them other than that certain common values shared by those peaceable negotiators are being protected.

Engelhardt’s humanism does not focus on humanitas, but on personitas. In this sense, it ceases to be humanism and turns out to be a general morality that does not require humanity for its foundation. Human emotions seem to receive little or no space at all in Engelhardt’s theory. In bioethics we are concerned with issues that are fundamental to being human, issues that are emotive such as life, suffering, disease, and death. The richness of human emotion in the context of value is indispensable to humanism. Yet, he defends his project in the light of the humanistic tradition. His humanism does not acknowledge the fact that humanism is contextual. By this, I mean that humanism gives us the opportunity to make informed judgements in particular cases without having to make one value absolute and universal over all other values. Such a project, even where it is possible, might not be desirable in a pluralistic society. Even when we rank values, they may change depending on the context, place and time. If my interpretation and criticism of Engelhardt is right, it means that we must look for an ethic of value, this becomes a necessary condition for any application of procedural ethics. Paul Ricoeur believes that such an ethics is necessary. Engelhardt’s concept of person with its bases in the higher brain
capacity and his principle of permission both fail to satisfy my criterion on coherence with the worldview of the people.

b. The project of bioethics

The next issue concerns Engelhardt’s account of the project of bioethics. Engelhardt employs the distinction between the ‘good community’ and the ‘peaceable community’ to explicate on the project of bioethics. He claims that the latter is the core of secular bioethics. Evidently, this means that the project of bioethics is to form a peaceable community, not necessarily a good community. This community is formed through the negotiation of standards that are acceptable to participating moral agents. Therefore, the project of bioethics is that of generating ground for moral authority. Within Engelhardt’s secular framework, everything is permitted such as abortion, cloning human embryos, harvesting of totipotential cells from human embryos, euthanasia, and physician-assisted suicide, at least among consenting adults. I suggest that this notion of the project of bioethics is poor. Etymologically, ethics deals with how to do the good and avoid harm. It is primarily about good acts. In the second sense, it deals with the right. How does one act in ways that are good and right? Engelhardt’s principle of permission seems to be concerned only with a theory of the right and not with the good. This is clearly demonstrated with his answer to the question of when one can engage in another’s life. Permission, he argues, is the only thing that allows one to do that. In the same manner, others can only engage in my life only with my permission. This way of accounting for the project of bioethics seems flawed and inadequate. It fails to recognise the distinction between ethics and law. The former seems collapsed in the latter. In addition, an important oversight concerns Engelhardt’s failure to distinguish between public morality and individual morality. Morality is an informal public institution. It arises as a result of human interactions. The presence of the ‘other’, that is another ‘self’ seems to be what invites one to be moral and establishes the morality of self-respect and the morality of welfare.

It is impossible to talk about the principle of permission without the concept of free and informed consent. The issues of free and informed consent have their difficulties. It is not clear what the
notion of free and informed consent means in Engelhardt’s philosophy. What is claimed to constitute this validity is the moral agent being able to choose freely. This would require an understanding and an appreciation of the consequences of the contemplated action. Following from this understanding, an action must be chosen and willed by the moral agent for it to be imputable to him or her. How patients in health care context achieve informed consent has been problematic. For example, there is the issue of how much disclosure is necessary for them to achieve an informed consent. Furthermore, an equally important question arises in the context of how informed consent is understood and interpreted in non-western societies such as Africa.

One needs to realise that the conflict in bioethics is not just about giving permission to others. There is also need to recognise that it is a conflict that concerns fundamental and substantial values that express the greatness of humanity that are in conflict with one another. It concerns how we can integrate these issues concerning the nature of human beings into our moral life. The relevant questions should concern such issue as, what kind of humanity are we becoming? What kind of humanity do we wish to become? What kind of humanity should we be promoting?

c. The role of community
It is with the peaceable community and not the good community that secular bioethics engages itself. The idea as Engelhardt argues is that the former does not depend on any notion of value or the good, whereas the latter depends on a particular moral sense. It is not clear, how the concept of peaceable community can be used without subscribing to some kind of moral sense. ‘Peace’ and ‘community’ are normative and evaluative terms. The word peace is value-laden as well as community. As I argued earlier in this work, community has values intrinsic to it independent of individual members of it. Engelhardt fails to account for human beings as social and communal persons.

How can Engelhardt’s theory be understood and interpreted from an African perspective? In most western societies, morality is seen as a personal thing. A person is autonomous and free to live his or her
moral life the way that seems fit. In most of Africa, this would only be partially true. Morality is never completely an individual matter. It has a community dimension. Engelhardt’s response to the challenge of pluralism of moral visions is influenced by his interpretations of the concepts of community/society and individuality. This is in turn influenced by the North American society that forms the matrix for his project of bioethics.

PBE embodies a particular moral tradition as well as several value commitments characteristic of the contemporary United States such as privacy and contractual social relations, its liberal democratic culture and the liberal health-care system. It is its values, attitudes, and convictions with its unbridled emphasis on individual freedom that the theory mirrors rather than a tenable foundation for a secular bioethics.

Within African culture, the person is regarded as a relational self, a self in social relationship. Given this, bioethics in global context must highlight ethical pluralism, i.e., the co-existence of alternative and competing ethical frameworks. Engelhardt’s claim that we are moral strangers has serious implications for his medical morality. This is to be governed by principle-of-permission-based understanding of moral values. His medical morality includes elements both internal and external to medicine.385 These two notions refer to that end for which medicine is practised and those norms and values that supplement and modify the former. Engelhardt maintains that because of the intractable secular moral pluralism, that form the landscape of the modern world, moral commitments can only be implemented in different ways in different traditions. Therefore, each community or tradition is to determine standards external to medical institutions that determine its end and not some universal end of medicine or some medical profession.

Engelhardt and Wildes contend that communities define concepts such as medicine and healing. From this perspective, what is permissible in medicine derives from the community, not from universally shared ends of medicine. The basis of this view is

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385 Internal standards for medical morality refers to the ethic derived from the ends of medicine or professional practice standards. External standards refer to an ethic which basis its justification by external standards such as law, public opinion, or philosophical ethics.
Engelhardt’s claim that there are no substantive foundations of secular bioethics. Arising from this, there are no foundations of any sort of bioethics other than historical roots in communities.\textsuperscript{386} If we should accept Engelhardt’s position, social justice and medical beneficence have no place in our society unless individuals in community agree upon them. For example, a person who helps an unconscious bleeding accident victim on the highway would be performing an impermissible act unless given permission to act by the victim. Engelhardt is right in recognising that moral judgement may differ from one community to another. However, it does not necessarily follow that people from different communities cannot agree on moral matters through reason because of their different conceptual and theoretical perspectives. What is universal needs not necessarily be general at the same time. Morality does not need to have a single foundation in order to be universal, reasonable or justifiable. The reason is the relevance of context to the justifiability of moral judgements.

d. Human reason
Underlining Engelhardt’s secular bioethics is what I call his unbridled scepticism concerning what human reason is able to establish. Engelhardt’s scepticism concerning secular ethics exposes the difficulties in employing reason to justify a universally binding ethics for all people at all places and at all times. Engelhardt’s conclusion concerning human reason could be attributed partly to the distinction he makes concerning what human reason is able to establish unaided by the light of divine revelation. This sharp distinction is not persuasive and correct. Why should we reject his sharp distinction between faith and reason? First, there seems to be an indirect and simplistic assumption by Engelhardt that religion or faith has nothing to do with ethics and morality in a pluralistic society on the one hand. On the other hand, he seems to believe that only religion could guarantee content-full morality. His argument that moral matters severed from a rightly ordered relationship to God cannot disclose any evil in actions such as physician-assisted suicide, euthanasia, cloning of human embryos, abortion, harvesting of

\textsuperscript{386} Engelhardt, 1996, \textit{Bioethics and Secular Humanism}, pp 105-124.
totipotential cells from embryos confirm this conclusion. This cannot be completely acceptable. For example, Catholic moral theologians and ethicists argue quite correctly that religious sources to morality in principle only give further justification for human valuations that can be justified simply by human reason without any appeal to religion. Therefore, it is incorrect to think that those in concrete moral communities justify their moral positions just by appeal to their moral traditions or religion. In African thought and value system, for example, among the Igbo of South Eastern Nigeria, morality although believed to be religiously motivated is often justified not by religion but by its contribution to the well-being of the community. Engelhardt establishes by reason that which he claims cannot be established by reason, i.e., a canonical ethic for post-modern society, and a minimalist and libertarian general secular morality. One needs to note as well that Engelhardt writes about reason as if there were, ever a time reason produced irreducible first principles. Engelhardt seems to have understood the notion of reason only from the conception of European thought and culture. The arguments in the *Foundations* and in *Bioethics and Secular Humanism* show that they are dependent on the presuppositions of European history. The arguments do not appreciate enough the fact that European and North American reasoning pattern are not just the only ones that are relevant to an articulation of a common bioethics.

What does it mean to do bioethics in cultures outside the western system? This question seems to have received sparse mention if not completely neglected. This is the main purpose of this study. What could it mean to do bioethics within the framework of African thought and culture? If it is correct that Engelhardt’s understanding of human rationality is shallow, then the whole structure erected upon it by Engelhardt also collapses. This strategy for dealing with moral conflicts does not stand. One of the central tenets of Engelhardt’s bioethics is his claim that humans no longer share any common vision of the good in pluralistic society. This is obviously


388 A reading of Alasdair MacIntyre, *After Virtue: A Study in Moral Theory* amply shows that even before the Enlightenment, there was plurality of moral visions.
doubtful given that there are many constitutive and authoritative human values, feelings, and notions of positive good such as the value of family. These belie the rationalism of Engelhardt’s bioethics. He seems to implicitly acknowledge that many of the values we hold as humans are shared among most humans. The difficulty lies with the ranking of them.

…Large elements of contemporary American bioethics are not just a reflection of a particular moral vision, but the unavoidable intellectual consequence of not being able to justify in general secular terms a concrete morality that transcends various traditions.389

As the passage shows, Engelhardt recognises that the difficulty is conceptual and not epistemological. I like to contend that Engelhardt underestimates the level of agreement on the good in our society even among his moral strangers and overestimates the level required for us to reason with each other on issues of common concern. It appears to me that Engelhardt underscores the fact that secular society as it may be still share real and significant vision of the good no matter how limited this may be. The empirical survey of the RAMP (Religious and Moral Pluralism) demonstrates that pluralist societies such Scandinavian countries still share many things in common with respect to history, politics, economy and social life. The process of internationalisation and ‘Europeanization’ is even making them more alike than in the past.390 The commonality shared by Scandinavian peoples is also illustrated by the empirical analyses conducted by Thorleif Pettersson and Göran Gustafsson.391 In this respect, Engelhardt fails the coherence criterion of my study. Engelhardt’s attention seems to be particularly focused on those areas of our life where we lack agreement, i.e., the TEYKU type.

390 The RAMP is an international empirical research conducted in several European countries from 1998 to 1999. The basis for it is the interview of 2700 people between the ages of 18 and 79 who were interviewed in their homes. The study shows only small differences between the populations.
392 This is the Talmudic notion, which describes dispute regarding the law that does not admit of resolution, because the arguments in favour of both sides balance each other. Cf. Foundations 1996, pp 129-130.
From the foregoing, a contentfull morality is possible. What seems not to be possible is the project of establishing one single contentfull morality or seeking for a single foundation for morality. Even if this is possible, is it desirable?

Conclusion

How is the challenge of plurality of moral visions to be met? Engelhardt response is the concept of permission. He explains this by using the principles of beneficence and that of permission. He argues that the only answer left for people living in a pluralistic society is the principle of permission. The analysis of this argument discloses a number of important things. First, Engelhardt has successfully exposed many of the difficulties in employing reason to justify an ethics binding on all humanity. Second, his principle of permission and concept of person have far reaching implications for concrete bioethical conflicts. The principle of permission can justify any kind of action agreed upon by two consenting autonomous agents. In this sense, his argument for the principle of permission is internally flawed. Third, Engelhardt has not established one of his central concepts, that of person. The distinction between persons and nonpersons is highly problematic. His theory excludes from the moral community the unborn, infants, terminally sick, those who have lost their rational powers as they are regarded as nonpersons whereas it includes some non-human animals. I have argued that this concept of person is foreign to common human experience and that his principle of permission does not resonate with the day-to-day moral practice of individuals in pluralistic societies. Fourth, the problem between society and individuality that obviously, formed the context of his understanding of person is not clear. In his theory, bioethics is concerned with generating authority for moral actions. This makes his project for bioethics questionable in many respects. I have maintained that the fact that morality is pluralistic in nature does not remove the fact that there are values that are commonly shared among humans as the RAMP project confirm. Furthermore, I have equally maintained that good lives are plural. However, given
the nature of the issues in health care system, we are required then to demonstrate how such a conception of morality and good life can ensure an obligation to protect human life. John Kekes’s defence of the morality of pluralism is important in this regard. In his theory, he discovers something that eluded Engelhardt. In him, we see how good life could be plural, how pluralism does not necessarily lead to moral scepticism and nihilism.
5. A Secular Ethics of Value

In the previous chapter, I argued against the conclusions of Engelhardt. I raised objections concerning his claims that reason is not able to justify a particular moral position; and against his project for bioethics as that of generating moral authority for individuals in pluralistic society through the principle of permission. Engelhardt argued for a content-less secular morality. Contrary to this position, I maintained that a justifiable secular theory of value is possible.

John Kekes argues that the present moral and political uncertainties are due to a deep change in society from dogmatist to a pluralistic view of values. Dogmatism is committed to there being only one justifiable system of values. By dogmatism or absolutism I understand Kekes as meaning ethical universalism, understood as the view that there is only one standard of rationality that in principle can be accepted by every one irrespective of their cultural and social contexts.393 Pluralism, on the other hand, acknowledges the existence of many such standards and regards them as positive and desirable, and yet it avoids the pitfall of relativism and value nihilism.394

Engelhardt identified moral pluralism395 and diversity in modern societies as the primary causes why reason fails to justify the good life in pluralistic societies. Moral pluralism, for him, created an atmosphere of confusion and loss of faith that exist about the issues of values. Following from this, modern societies no longer have the resources to resolve moral conflicts. This failure rested on the inability of modern society to locate the source of moral authority.

393 From this point the term dogmatism or absolutism would be understood as being synonymous with ethical universalism or universalistic ethics.  
395 Moral pluralism refers to the view that there are moral truths, but they do not form a body of coherent and consistent truths as those found in sciences e.g., mathematics.
He highlighted the limitations of secular ethics and pointed out that a content-full secular ethics is impossible.

However, some fundamental issues raised by Engelhardt need to be closely explored. Such considerations would include a justification of rationality, a case for the pluralism of moral visions, conceptions of the good life, the source of moral authority and the reasonable resolution of conflicts of value. Do we content ourselves with the claim of Engelhardt that a common view of life is impossible in a secular society? Do we need an ethic of value, or an axiology i.e., a theory of value? Such an ethic will be true to the life-world of human beings. This presupposes a satisfactory worldview that combines a reliable account of reality and a system of ideals or values. Having such a worldview would give meaning and purpose to life, and creates the conditions under which life can be good.\(^{396}\) Participation in a rationally justified worldview provides a necessary condition for the achievement of good life. If we cannot recognise some common values in human life, we are cut off from all knowledge of who we are, and would be unable to make sense of anything in our life. To make meaning out of our present experiences requires that we have a conception of who we are and who we think we should be. This project can only be accomplished by an ethics of value. Assuming for the moment that one is attracted to such a project, the question arises, how one can articulate such an ethic given the diversity in moral understandings. These concerns are those that John Kekes attempts to address in most of his books especially in *The morality of pluralism*.\(^{397}\) Kekes advocates an ethic of value contrary to a content-less one argued for by Engelhardt. Central to the understanding of Kekes’ theory are his conceptions of pluralism, the good life and the source of moral authority, human nature, and relativism.

This chapter is an attempt to explore Kekes’s value theory in order to understand what could be its implications for bioethics. I intend to


\(^{397}\) John Kekes is professor emeritus of philosophy at the State University of New York at Albany. His is author of about 135 scholarly articles and thirteen books in moral and political philosophy. He is an important contributor to the literature in ethics and social philosophy. Some of his books include: *A Justification of Rationality, The Nature of Philosophy, Moral Tradition and Individuality, Moral Wisdom and Good lives, Pluralism in Philosophy: Changing the Subject, The Art of Life and so on…. It is to be noted that the same themes especially pluralism and the good life run through all the books of Kekes.*
explore how Kekes shows that not only can one justify a content-full theory in particular tradition, but also how one can equally do so in pluralistic society. To realise this goal, I will attempt to elaborate Kekes’s discussions on reason, universalism, relativism, pluralism, conflict among values, and a critique of his value theory. My aim is not to explore let alone discuss all that Kekes has written about moral pluralism in his books. I will only concern myself with the issues he raised in especially The Morality of Pluralism as they relate to the arguments advanced by Engelhardt in the preceding chapter concerning the impossibility of secular content-full morality. Kekes has written several books on ethics and he seems to make similar if not the same claim in all the books. The common themes running through all of them include the good life, pluralism and the justification of rationality.

Understanding some of the common and contrasting elements between Engelhardt and Kekes is vital for my goal. A starting point for this understanding could be drawn from the formers’ definition of secular bioethics as “an ethic that aspires to provide a logic or grammar for speaking across a plurality of ideologies, beliefs and bioethics….” One can reasonably say that the common elements in their works would include among others, an interest in formulating normative secular ethics, an interest in exploring the meaning of pluralism of moral understandings, an interest in conflict resolution and an interest in articulating a common view of the good life. Both of them advocate some form of contextualistic ethics in a pluralist society. In contrast to Engelhardt, Kekes would argue for a secular theory of value. While Engelhardt’s moral contractors would be strangers to one another, those of Kekes would be moral friends because they share some basic characteristics by virtue of their common humanity.

**On the failure of reason**

Engelhardt argued that the modern philosophical project of providing a justification for a common secular ethics is riddled with

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difficulties. The problem stems from the inability of reason to justify what is the good life. Kekes calls this position the disintegration thesis. It refers to the view that we have conflicts among values “because we have lost a rational foundation for our moral convictions.”\footnote{Kekes, 1993, \textit{Morality of Pluralism}, p 7.} We are, therefore, confronted with the question concerning whether or not we could really declare reason a failure. In my view, the answer to this question could be both yes and no. Yes, because we no longer enjoy the kind of certainty and agreement that characterised the past because of diversity of moral visions. Although pluralism has always been a phenomenon of life, it was only recognised in the course of time. In this sense, it is to be understood as the product of historical, cultural, social and political processes. One may answer no by contending that what has failed is a particular notion of morality.\footnote{Kekes, 1993, \textit{Morality of Pluralism}, p 8.} Engelhardt, in spite of his argument that the Enlightenment project was a failure, gives us a clue to how we can approach this question. He did this by being concerned with the question of whether there was anything that could be retrieved from the ruins of secular humanism. He embarked on this project by employing reason. Although, he concluded that reason could not establish a content-full secular bioethics; he was nevertheless able to establish a ground for generating moral authority by which moral controversies could be resolved. It is remarkable that he arrived at his conclusion by employing reason.

Engelhardt argues that it is not rationally possible to justify our actions because the criterion, by which we justify them, needs itself to be justified. He maintained that this justification is not possible. The difficulty, he claims is that the process of justifying one standard by another leads either to infinite regress, or to non-rational commitment to some standard. I think in a sense he is correct depending on how one understands justification and what is being justified. This could be true if one is seeking to justify a single system by which other beliefs are in turn to be justified. By this we mean an absolutist system, all encompassing, timeless, and cultureless system. Such a conception of justification as we shall lately discover is far from Kekes’s position. Kekes is not looking for a timeless universalistic theory, principle or norm. This was the case
when much of our moral language was anchored in a religiously constituted moral realism. It was easier to maintain such a system when moral reality was rooted in God’s reality. Now, the centre no longer holds, as God is no longer accepted as the justifying factor. Now, humankind has to look for a moral foundation to stand on.

In *A Justification of Rationality*, Kekes aimed to debunk the idea that rational moral justification is an impossible project. On the contrary, he argued that rational justification of beliefs and actions is possible. Part one of Kekes’s book maintains that scepticism especially in its strengthened version is a serious challenge, which cannot be ignored. In the third part of the book he shows why standard philosophical arguments fail to refute the strengthened version of scepticism. In part three of this book, he develops a theory of rationality that responds adequately to the challenge of the failure of reason claimed by Engelhardt.

Kekes argues that sceptics attack the possibility of knowledge, certainty, or justified belief only indirectly. According to him, the sceptics’ primary target is the process of reasoning which allegedly yields the reliable conclusions. A belief in this sense would be rational if it is held as a conclusion of a reliable method of reasoning. Following from this, reason is reliable if it conforms to one or another standard. The difficulty for the rationalist arises when he or she discovers that the standard of rationality must itself be shown rational.

Kekes goes on to identify many standards of reason such as deductivism, empiricism, phenomenology, inductivism, positivism and a host of others. The one thing these standards share in common is that appealing to them poses the same difficulty. Since rational justification involves appealing to a standard of rationality, the problem is how the standard can itself be justified. Epistemological scepticism is the most fundamental kind of scepticism and it is directed against the standard of rationality. For Kekes, the rationality of the theory of rationality depends upon its capacity to

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403 Epistemological scepticism refers to those varieties of scepticism, which attack one or more epistemic concepts such as knowledge, belief, understanding and justification. They operate by taking a concept and deny the existence of any instance of it.
conform to its own standards. With the concepts of internal and external requirements of a theory, he tries to explain how this is possible. By internal requirements, he means logical consistency, conceptual coherency, explanatory power and criticizability of the theory. External requirement concerns the problem solving capacity of the theory.

The role of theories is to provide solutions. Understanding a theory means understanding the problem to which the theory offers a solution. Kekes concludes that the problem-solving feature of theories must constitute the foundation of a successful theory of rationality. This whole issue surely concerns the justification of moral beliefs. It may be argued as some have done that moral beliefs are just social constructions. It may be reasonable to agree with such a claim only on the understanding that justification of moral belief is relative to epistemic context, because all epistemic justification is relative to context. It is important to point out here that doubts about explanations or criteria for moral truth are not necessarily about moral truth. Moral truth does not in this sense mean justified belief or warranted assertibility or the dependence of justification on epistemic context. The fact that all justification is relative in no way means that the truth of a particular proposition is relative.

Kekes makes problem-solving the context-independent and objective standard of rationality. Accordingly, Kekes theory of rationality defends the standards, which guarantee the rationality of a theory that conforms to them. Moral conclusions are justified not so much by our common rationality, as by the satisfaction it gives to the individual and the moral merits it possesses.

A view of pluralism

Influenced by Michael Oakeshott and Isaiah Berlin, Kekes developed a theory of pluralism through a systematic and careful defence of six theses. The are namely, the plurality and

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405 These authors share the common belief that philosophy should transform its practitioners rather than simply aiming to inform them. Berlin’s *Two Concept of Liberty* (1969) has contributed to the development of what we can call today value pluralist movement in moral philosophy. John Kekes is one of the leading contributors in this area.
conditionality of values, the unavoidability of conflicts, the approach to reasonable conflict-resolution, the possibilities of life, the need for limits, and the prospects for moral progress. It scarcely needs an argument to show that Kekes’s primary aim in *The Morality of Pluralism* is to show that good lives are plural. In this book, he delineates some of the most distinctive perhaps even the defining attributes of pluralism. It is a theory that claims that there are different conceptions of what is required of life for it to be said to be good. It offers an account of the relevant features of a good life. A distinction is made between good life and moral life. Conception of good life is regarded as broader than that of moral life. Good lives for Kekes are lives that are both personally satisfying and have moral merit. Goodness of life can be judged subjectively and objectively. The subjective content must rest on the ground that lives have moral merit. The explanation to this is that good life has both moral and non-moral components. Kekes attempts to show that pluralism need not lead to relativism in moral deliberations. He contends that plurality of moral values need not compel us to accept the relativistic conclusion that all values are ultimately subjective preferences. The basic claim of pluralism is that good lives require the realisation of radically different types of values, both moral and non-moral that may sometimes conflict with each other.

Pluralism has many versions. In all its forms, it is committed to the view that there are reasonable beliefs about the true and the good. However, it insists that they have a plurality of forms. Kekes defends a form of pluralism that is a mixture of epistemological and axiological components. Its epistemological component maintains that our lives, circumstances, and the disruptions that we face occur in an irreducible plurality of modes. On the other hand, the axiological component claims that each of these modes of reflection provides a perspective that is believed to make an important

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406 Kekes, 2000, *Pluralism in Philosophy*. Some of these versions include ontological, anthropological, political, p.5. Pluralism can be strong or weak. These two major forms are in turn subdivided into different types. We will see the meaning of these forms of pluralism later in this chapter. Pluralism could be understood in various ways. It could be understood as a political consequence of moral and religious diversity in modern societies. Philosophically, pluralism takes moral diversity as being imbedded in the nature of moral concepts.
contribution to good lives. This brand of pluralism believes the existence of a context-independent morality of which we can be aware. Kekes has tried to articulate pluralism in such terms.

It should be noted that the concept of pluralism in Kekes differs from that in Engelhardt. Kekes understands pluralism as a moral theory in the broad sense of a theory about good life. Pluralism in this sense does not deny the existence of values whose denial led Engelhardt’s moral strangers into a moral jam resulting in normative inclusiveness. In the theory of Engelhardt, it appears that pluralism is understood and interpreted as a negative value that is responsible for the loss of coherence and unity of an earlier age. In other words, it is an undesirable phenomenon of life.

In *Pluralism in Philosophy: Changing the Subject*, Kekes confronts the relativism that undermines our beliefs concerning what is true and good, and thus our capacity to lead good lives. According to Kekes, there are different “modes of reflection” by which humans try to explain disruptions in the quest to live good lives. These modes include religious, moral, scientific, aesthetic, historical, and subjective. The main difficulty is that different modes attribute different significance to the same facts. The result is a conflict in which meta-questions i.e., philosophical problems are given birth. This kind of problem presents serious theoretical difficulties. One could reasonably see this as another way Kekes attempts to deal with the challenge of pluralism. In this book, Kekes maintained that modern society fails to answer these philosophical questions because it is asking the wrong question. He tried to show that philosophical problems if correctly asked could be solved. For Kekes, the way to overcome this problem is to abandon the assumption shared by these rival modes of reflection that the solutions of this problem could be rational only if they apply universally to all lives in all contexts. Kekes believes that solutions may vary with lives and contexts and still be rational. In Kekes’s words “philosophical problems have rational solutions, but they are not general solutions because there is no such thing as the one true account of the significance of facts.”

In *The Morality of Pluralism*, Kekes identified two traditional approaches to coming to terms with this difficulty namely:

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universalism and sceptical relativist approaches. The former is the view that there is one and only one reasonable system of values. It holds that this system is the same for all human beings, always, and everywhere. How good human life is becomes a question of the extent to which it conforms to this system.\(^{409}\) This universalistic ethics can be formulated in different ways. By ethical universalism, I refer to the position that maintains that it is desirable and possible to articulate ethical argument that can be accepted by humans who belong to different social and cultural traditions. Professor Carl-Henric Grenholm in his *Bortom humanismen: en studie i kristen etik* holds the same view.\(^{410}\) Ethical universalism claims that humans share the same moral language that can be understood in every culture and social contexts. Kekes’s criticism is directed in the first place to a kind of universalism that maintains that it is possible to establish normative criteria without consideration to contextual factors. On the other hand, relativism, in Kekes’s words, is “the view that ultimately all values are conventional.”\(^{411}\) In other words, it is the claim that all values are social constructions and, therefore, cannot be justified on objective grounds other than on subjective appreciation. Furthermore, there are no foundational values and principles, which are shared by different cultures and traditions. Different cultures and traditions give different criteria for the justification of different moral positions. Kekes is also against a strong epistemological relativism as well as value ontological relativism.

\(^{411}\) *The Morality of Pluralism*, p 8. The risk of relativism and upholding the value of moral principles against the modern tendency to relativism has been one of the major concerns of Joseph cardinal Ratzinger, who is now Pope Benedict XVI. In a homily on April 18, during the Mass celebrated before the start of the conclave, at which he was elected pope, he pointed out that there is ever changing trends in contemporary thought that he referred to as “a dictatorship of relativism that recognises nothing as absolute and which leaves the ‘I’ and its whims as the ultimate measure.” This criticism of relativism is firmly in line with what John Paul II taught on many occasions when he warned of the dangers of a society without ideals. Arguing from a religious perspective, Ratzinger, points out that relativism which is the starting point of secularist mentality, often becomes a kind of dogmatism that believes it has reached the definitive stage of awareness of what human reason really is.
Relativism can be formulated in at least four principal forms. The first one is descriptive relativism, the view that human beings in different cultures have different moral understanding. It holds that what is considered right in one cultural tradition could be considered wrong in another tradition. Descriptive relativism shares a lot in common with ethical contextualism, the view that whatever moral understanding one has depends on the social and cultural context of that individual. A second form of relativism is normative relativism, which maintains that what is regarded as right in one social context may be wrong in another context. Primarily, it means that whatever a particular culture says is right remains right even if it is wrong in another culture. The third form of relativism is epistemological relativism, the position that claims the reasons given to justify a particular moral action varies and they depend on social and cultural contexts. A fourth form of relativism is value-ontological relativism, that holds that a particular moral judgement can be true in one social context and false in another. All these forms can be described as post-modern critique that insists that universalistic ethics is neither possible nor desirable. Moral pluralism is seen as an unavoidable feature of life and a desirable phenomenon. However, ethical universalism rejects all forms of relativism at least in some meaning. I will later explore how Kekes’s pluralism of moral values relates to these different forms of relativism and universalism.

Kekes examines the arguments of universalists and relativists and finds that neither of them meets the challenge posed by the disruptions of every day life. The former is not able to defend their claim that only one system offers the true understanding of the significance of all facts. He accepts the view that there is no universal standpoint from which we can arrive at absolute moral truths. Universalists believe that the diversity of values is apparent, not real. They admit the existence of many values, however they insist there is a universal and objective standard that can be appealed to in evaluating them. Universalism has a rationalistic basis. Particular standard is justified if it conforms to the moral order of

\[412\] Carl-Henric Grenholm’s classification of relativism in *Bortom Humanismen* in pp 18-19 has been of much help.
reality. This is the reason given in favour of universality and objectivity. However, the difficulty is that the candidates for universal and objective standards are also plural. Universalists are aware of this and attempt to explain this problem. They argue that human weakness prevents people from recognising the one true standard.

Relativists acknowledge the diversity of values. They maintain that there are many values and many ways of combining and ranking them. For relativists, there is no universal and objective standard of resolving conflicts among values. Epistemological relativists claim that we are limited by our own worldviews, unable to make judgements on any of them. It means that there can be no rationality as such, but only rationality relative to the standards of some particular tradition. It is interesting to note that Engelhardt shares much in common with this position. According to relativists, what is considered as valuable and important depend on the consensus of society. In this sense, a value is what is valued in a particular context, all values, therefore, are context-dependent. This would mean that values could not be reasonably criticised or justified. In this way relativists overreact to the universalists’ position by arguing that we abandon reflection on facts. It is doubtful if one could abandon reflecting on disruptions of everyday life. Kekes rejects a strong epistemological relativism and insists on common human nature, which he regards as the basis for reasonable conflict resolution among values. On the descriptive level, Kekes would argue for a weak form of epistemological relativism. He insists on the possibility of rational justification of morality.

The alternative to universalism and relativism, in his view, is the philosophical theory of pluralism,

\[\ldots\] a theory about the nature of the values whose realisation would make lives good. The primary concern of pluralism is with the relation in which these values stand to each other; the identity of the values is of interest to pluralists, qua pluralists, only in so far as it is relevant to understanding their relations. Pluralism thus is a theory only about one aspect of good lives.\[414\]

It should be observed that this understanding of pluralism differs from the contemporary philosophical understanding of it. In the latter sense, pluralism is a descriptive metaphysical theory. Pluralism in the sense Kekes uses it is at once descriptive and evaluative. Its evaluative feature derives from the fact that “it is not an uncommitted analysis of the relations among various types of values involved in good lives but a theory motivated by concern for human beings actually living good lives.”\textsuperscript{415} It not only offers a description of conceptual and factual features relevant to good lives, but it also attempts to evaluate these features on the basis of their contribution to good lives. Kekes’s *The Art of Life*, shows that certain common features characterise good lives and that it is possible to learn what makes some lives good and others not. According to Kekes, good lives necessarily take different forms, are lived in vastly different contexts, and are guided individually by different dominant styles. By identifying and exploring some representative examples, he explicates those essential qualities constitutive of good lives in a pluralist society.\textsuperscript{416} Following from this, he rejects the search for solutions that holds one and for all. He instead looks for rationality and truth in particular solutions for particular problems.

In his book *Bortom Humanismen*, Carl-Henric Grenholm examines another alternative to universalism and relativism, which he calls ethical contextualism. This is the view that our moral understanding is dependent upon the different traditions and social contexts in which we live. Ethical contextualism differs with ethical universalism in its relation to the four different forms of relativism discussed earlier especially in relation to epistemological relativism and value ontological relativism.\textsuperscript{417} Jeffrey Stout in his book, *Ethics after Babel: The languages of Morals and their discontents* argues for ethical contextualism. Stout contends that there is moral diversity and disagreement between different cultures and traditions. Our moral understandings are culture-based.\textsuperscript{418} There are no moral principles accepted universally. We must therefore accept that the justifications of our moral actions are context-dependent. Within this

framework, it is also possible to give rational arguments for our moral convictions.419

Kekes wishes to introduce us to his claim that good lives require the realisation of both moral and non-moral values. By moral values, Kekes refers to humanly caused values for example common good, justice, love, friendship and by non-moral values he means those values that are either naturally or humanly caused for example, beauty, playfulness, career plans.420 As Kekes points out, the plurality of values are not merely caused by the different sources and recipients but also by the different reasons there are for seeking or avoiding them.

The descriptive element of pluralism is that good life is best understood in pluralistic terms. These features maintain that we are motivated by both moral and non-moral values. We encounter conflict between values. Given this, we sometimes sacrifice important values.421 From the evaluative point of view, the claim is that notwithstanding the conflict we encounter because of our commitment to various moral and non-moral values, plurality of values is a positive and desirable thing. It enriches the possibility for our living good lives.422 It is this characteristic of pluralism, namely, of its conception of plurality as something positive that clearly distinguishes Kekes’s theory from other theories for example that of Engelhardt’s where pluralism is regarded more or less as undesirable.

Engelhardt in recent articles has continued to argue that content-full bioethics is only possible in particular traditions or communities.423 Such an understanding of moral justification can be described as a form of descriptive relativism and an epistemological relativism. He continues to argue that postmodernism is characterised by inability of human reason to justify particular moral positions.

423 Engelhardt “Critical Care: Why there is no global Bioethics”, JMP 23: 643-651. In this article he contends that in developing countries it is financially impossible to provide all with the standard of care accepted by law, policy, and convention in developed countries. Furthermore, he claims that the American bioethics that has been exported to the rest of the world represents a morality for a community that is weak and whose family is fractured. He strikes an important cord on the last assertion. Cf. Anjos “Medical ethics in the developing world: A Liberation Theology Perspective” JMP 21: 629-37.
Kekes shares some form of universalism. However, his form of universalism is a weak one. Kekes’s work is important in that he shows that moral conflicts in a pluralistic society are not found only among communities having different visions of the good. It is also found among individuals who despite the fact of possessing much in common with regard to ideological affinities and belonging to the same tradition are still forced to choose between incompatible values. Pluralists’ conception of morality is broad and takes seriously the roles of feeling, imagination, and the will as well, as reason in ethical discussions. It is significant to note this if we are to classify Kekes’s pluralism as a cognitive theory. Pluralists are in partial agreement and disagreement with both universalists and relativists.

In agreement with universalists and in disagreement with relativists, pluralists claim that a conception of good life must be reasonable if it is actually to yield a good life. Moreover, that means that the plurality of values and their comparative rankings that the conception embodies must be not only subjectively accepted but also objectively justified. In agreement with relativists and in disagreement with universalists, however, pluralists deny that there is a uniquely reasonable conception of a good life embodying something like the one true system of values. Good lives are plural because they are constituted of the realisation of different valued possibilities as well as differently valued possibilities. Pluralists stress that good lives embody the conjunction of these two essential elements: the available possibilities and their being valued.

Pluralists accept an objective and universal standard, but it is only applicable to some values. This standard is enough to apply to some values. It is, however, not sufficient to apply universally to many other values. One can say in a sense that the standard in question accommodates part of the universal concerns of universalists and part of the context-dependent values of relativists. The source of this standard is of course human nature. Obviously, the issue of contention between universalists and relativists concern the source and method of conflict resolution among different values. Contrasting universalists and pluralists, Kekes points out that what sets them apart is their contrary interpretation of the significance of the plurality of values. For pluralists, the plurality of values implies

conditionality of values while for universalists plurality does not imply that. Pluralists deny that there are authoritative systems of values. On the contrary, universalists believe that they exist. The fundamental reason for the disagreement between pluralists and universalists, one may argue, rests on whether or not there are overriding values. Drawing from the foregoing, it will then become obvious that good lives depend on the satisfaction of basic physiological, psychological, and social needs. The satisfaction of these needs is a universal and objective requirement of all good lives, whatever the social context may be in which they are lived. Pluralists side with relativists in their rejection of the universalist’s claim that their universal and objective standard applies to every one in the achievement of good lives. In relation to politics, pluralists think that the political arrangement of a society ought to protect the minimum requirements of good lives and encourage a plurality of good lives. Societies can be reasonably compared and evaluated based on how well they protect these minimum requirements of good lives.

Kekes sees the task of ethics as that of constructing a good life out of the available possibilities. But the difficulty is that reasonable possibilities often do conflict with each other. Some ways are not acceptable as methods of realising these possibilities. Given this experience, limits are imposed to exclude unreasonable possibilities and unreasonable ways of pursuing them. Relativists argue that no objective justification can be provided for imposing limits on the different possibilities. Kekes thinks otherwise. By formulating an axiology of human values within a secular context that escapes the pitfall of relativism, he shows that we do not need to deny the existence of moral values in order to establish a secular ethics. We need, however, to understand the way Kekes understands values. According to him, they refer to benefits and harms affecting human beings. The former refers to the minimum requirement for a good life and this is said to be plural. It needs be recalled that this is also the view of values held by PBE. What kind of axiology does Kekes provide?

425 In this regard, Kekes differs from Engelhardt who believes that the state should be neutral except in protecting the innocent.
Kekes distinguishes between primary and secondary values. He makes this distinction by appealing to human nature. The former embraces physiological needs such as food and shelter as well as social needs such as respect and security. These values have their foundation in human nature. The latter refers to values that vary with persons, societies, tradition and historical periods. This happens for two reasons. First, what is valued often depends on the conceptions of a good life that reason allows, but does not require us to hold. Second, benefit and harms in primary values are normally universal, but the forms and ways in which they are sought or avoided allow for great differences.

Kekes recognises hierarchy among primary values. However, he is not prepared to admit any authoritative system of values in which there is any value that is always overriding. He claims therefore that all values are conditional. According to Kekes, a value is overriding, first, when in conflict with any other value it always takes precedence over it. The second is when it is absolute or prima facie. That is, when the only justification for its violation would be to realise its objective. Third, when it is universal. Fourth, when it is permanent and invariable-holding in all contexts. In contrast to overriding values, Kekes recognises conditional values. This means that when in conflict with each other any of the values can be justifiably defeated. They are all subject to a trade-off in order to realise the person’s conception of a good life. No single good, value, or set of goods or values is overriding in all cases for the purpose of guiding action. In other words, there is a multiplicity of genuine goods. These are qualitatively heterogeneous and cannot be reduced to common measure of value. In addition, these qualitatively distinct values cannot be fully rank-ordered; there is no sumnum bonum that enjoys a rationally grounded priority for all individuals at all times and in every context. The advocates of overarching systems do not regard conflict among values as central to moral life since they allow overriding principle to prevail. How then can we resolve conflict among values within Kekes’s framework?

428 Kekes, The Morality of Pluralism, p 19. The view can be compared to the North American’s moral philosopher, William Frankenas’s argument in his book 1976, Ethics where he argues that different persons are capable of living different good lives.
Conflicts of values intrinsic to moral life?

Given the fact that pluralism does not recognise any highest value such as happiness or pleasure that can override others when they are in conflict, question is raised as to its capacity to judge objectively the moral property of these values. The foregoing shows that conceptions of good life and the values on which realisation of good lives depend are plural and conditional. Some of these values are incommensurable and incompatible. They are the types of conflicts that interest pluralists. Incommensurability means that the values are so unlike as to exclude any reasonable comparison among them. Values are incompatible due to qualities intrinsic to the conflicting values and because of human nature. The reasons for this depend on there being no highest value, no medium of expressing values, and no canonical or categorical principles. A reason given for the interest of pluralists in conflict is their thinking that conflict confirms in a strong way their claim on the plurality and conditionality of values. What makes Kekes’s theory pluralistic is precisely because it recognises all values as conditional, incommensurable and incompatible. Although Kekes recognises conflict as unavoidable feature of the moral life, at the same time he believes that most conflicts are rationally resolvable. There are not only reasonable ways of settling conflicts among values, but there are also reasonable ways to resolving conflicts about ways of settling them reasonably.

The recognition of the extent of real disagreement and the difficulty in resolving conflicts among values by establishing a standard that every rational agent would accept led Engelhardt to deny that reason can succeed in resolving them. Some pluralists insist on the centrality of conflicts as the central problem of pluralism while some others do not regard conflict among values as being central to their theory. Kekes belongs to the latter group. Resolving conflicts is thus not the central problem of his theory. The essential claim for these two groups is that morality makes different claims on reasonable moral agents that may be located on duties, rights, and virtues, personal, and social ideals. All these claims are believed to

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be good and are irreducible to each other, because they are incommensurable.432

By contrast to Engelhardt, Kekes believes that many conflicts can be resolved by appealing to some reasonable ranking of the values in conflict. However, he is quick to add that rankings are only reasonable in given situations because they depend on the variable and individual conceptions of the good held by those participating in the conflict. By this, he seems to argue both in theory and practice that there is no context-free order of epistemic dependence.433 The system of moral precepts derives its content and justification not from any one single moral criterion. The question may be asked what the approach to a reasonable conflict-resolution could be in Kekes’s framework.

In order to respond to that, two basic questions must be answered: What are the merits of the values in conflict? What things depend on the resolution of a conflict? Conflict can either occur within people or among people. In the first case, the framework of values is the conception of a good life of the individual facing the conflict. For the second case, when the conflict occurs among those who share the same tradition, it is to be realised that “conflicts occur against the background of the whole system of values that partly constitute the tradition.” 434 We find similar insight else where in one of his works where he recognises that conceptions of a good life are not defined by autonomous agents but are products of the moral traditions into which the individuals are born and grow up.435 Given this understanding, the approach to resolving conflict is by articulating the shared important values of those participating in the conflict and judging the effect on them of various methods of resolving the given conflict.436 In this context, it is worth observing that the stress is here on the manner of resolving conflict and not on the conclusion reached by employing this particular means. This

433 One may argue that Kekes advocates a kind of contextualism, which holds that whether an act is morally proper or not is related to circumstances around the moral agent and the object in question. It needs to be noted that this position does not solve the epistemological question whether we can have moral knowledge, nor, the ontological question about the truth or falsity, right or wrongness of the act.
approach transforms the problem from that of conflicts of values to conflicts about means of resolving conflicts. Kekes is quick to note that objections can be raised against this method because some conflicts may not be resolved by this method simply because they occur among those who do not share a system of values. Recognising that the values of a particular tradition or a particular conception of the good is not always greater than a particular value as this method claims reinforces this objection. The reason being that values are not only means to good lives but are also constituents of them. Nevertheless, these objections can be met by arguing that such occasions are exceptional and can only occur in circumstances where barbarism rules. To avoid this, the system strives to be sufficiently agile and flexible. Whatever happens there is always some common ground to begin.

Even if we are moved by utterly different systems of values, we are still human beings, and hence we are going to prize, if we are reasonable, the primary values. There will normally be some commonly shared values that may be appealed to in settling at least some conflicts.437

In some fundamental ways our physiological and psychological needs permit us to speak of a universal and unchanging human nature.438 In this sense, Kekes shares something in common with natural law theorists and humanistic ethics. In this respect, Kekes’s theory and humanistic ethics are both anthropocentric. Human nature is the norm for morality. An act is, therefore, said to be good if it contributes to the actualisation of human nature. This presupposes that there are characteristics shared in common by all human beings. Accordingly, conflicts among values can be resolved by appealing to the context-independent ground provided by the minimum requirements of all conceptions of a good life.439 If I understand Kekes, he seems to be insisting that every conflict in fact make sense only against a background of shared tradition, which the contestants can appeal. Kekes is probably right in maintaining that there is a

reasonable limit to moral conflict, i.e., a limit beyond which talks of conflict becomes unintelligible. Such limits are established by primary values and by substantive and procedural secondary values that represent the concrete forms primary values take.\textsuperscript{440} It is on this note that Kekes differs from strong epistemological relativists who take the context to be morality as a whole.

What distinguishes Kekes from others who share his sensitivity to pluralism of values is his context independence and insistence on non-overriding values, principles, theories, or traditions. Stanley Hauerwas formulates a form of ethics that can be called narrative virtue ethics. The central ethical question in this regard is what kind of human being we should become. The social context and tradition to which we belong determine the answer to this question. In his book, \textit{The Peaceable Kingdom}, he contends that all ethical judgement is relative to time and space. This means that ethics is culture, tradition, and time dependent.\textsuperscript{441} Against this backdrop, it is doubtful whether there is a common human nature that helps us decide what is morally good. James M. Gustafson has argued for a kind of ethics that is ecocentric. He is critical of anthropocentric culture, religion and ethics, where human being is the measure of all things. By contrast, he proposes a teocentric ethics, where God and not human being is the norm for morality.\textsuperscript{442}

From the foregoing, we can say there is no fundamental moral criterion that all other criteria depend upon such as human nature. In reality, there is no single fundamental criterion, although there may be fundamental criteria. It is not clear how we could be justified in accepting a given criterion without relying upon the acceptability of some other criteria. Given this, It is difficult to know when objective norms informed by human nature as acknowledged by Kekes can help us formulate objective criteria in a pluralist secular theory. Since pluralists acknowledge the fact that exceptions are possible with regard to deep conventions\textsuperscript{443}, and do not recognise any overriding

\textsuperscript{440} Kekes, \textit{The Morality of Pluralism}, p 119.
\textsuperscript{443} Some conventions are said to be deep because they protect and inexpressible conditions of human welfare. Because they are said to give content to morality, their violation is seen as unreasonable. What actually make a convention deep is its connection with the facts of
values, the difficulty that arises is how one can avoid the slide to relativism, which begins with the rejection of universalism.

Kekes attempts to show how this is possible using the example of life burial performed by the Dinka, a tribe in southern Sudan. The custom concerns the live burial of the most important and respected religious and political leaders of the Dinkas. The Dinka believed that the death of the spear-master in this way was necessary for the transmission of life from the spear-master to his people. The spear-masters were thought to possess more life in them than was necessary to sustain them only. In his interpretation of this tradition, Kekes cites some considerations that must be borne in mind if one is to properly understand the Dinka’s action. This tradition is motivated by the respect the people have for the spear-master. It is carried out with the full consent of the spear-master, at the appropriate time chosen by the leader. Furthermore, it is because they value life that they participate and celebrate the master sacrificing his life so that the life of the tribe may be sustained. We have in this context no reason to find the Dinka guilty of intentionally murdering their spear-masters. From the foregoing, Kekes concludes:

The live burial of the spear-master should be seen therefore from both as a morally commendable sacrifice made by good people and as a possible case where there may be good reasons for violating the deep convention protecting life.

This passage is significant because it shows that a distinction is made between moral agents and their particular actions. However, Kekes argues against this custom by contending that the Dinka’s practice was informed by ignorance of the meaning of reverence for life. These men died willingly, believing that their dying breath revitalised the life of the tribe. Nevertheless, neither the action itself nor its symbolic interpretation produces the effect it claims i.e. that of benefiting life. This makes the action a violation of the deep convention protecting life. The point at issue is not whether the

the body, self, and social life and not that it is a strongly held view. See Moral Traditions and Individuality, pp 12, 31.


Dinkas regard human life as a primary value but what they consider as reasonable for violating the deep convention protecting life. It is on the latter level that objections can be made concerning this custom. This disagreement is made possible only on the ground that we agree with them that life has primacy over all other values. It remains an open question if life was protected in this particular case by depriving some one his own life. For Kekes, therefore, the important question is whether live burial is a reasonable way of protecting life. Kekes answers this question by appealing to the objective and context-independent criterion provided by human nature. It is the deeper agreement that human beings share about the primacy of the value of life that establishes the objective and context-independent criterion we appeal to in answering what qualifies as reasonable in our deliberation. Obviously, the moral situation of the Dinka’s was that they believed that they had good and justifiable reasons for acting as they did. But the fact of the matter remained that they were seriously mistaken. Kekes points out that the sustenance the Dinkas derived from this was psychological in nature than physical and could have been derived by other means. He concludes that the fact that the people of Dinka are still flourishing many years after its abolition by the Sudanese authorities illustrates the fact that it was not a reasonable way to protecting life.446

Implications for bioethics

The ethical implication of Kekes’s theory for bioethics can be understood by exploring his understanding of the nature of values especially his answer to the question of what it is in human life that is valuable. In chapter two of this study, I explored different approaches to doing bioethics. It was noted that the particular approach or framework that is employed in dealing with particular bioethical issue determines the result one arrives at. Drawing from our analysis so far, there are ample reasons to identify Kekes’s ethical framework as falling under the natural law ethics. This is an alternative from both Engelhardt and the PBE. Human nature is the criterion for morality. Yet, the approach can be said to be

446 Kekes, The Morality of Pluralism, p 130.
consequentialist utilitarian as well. We have seen that Kekes regards value as meaning benefits and harms that arise from performing a given action. Although, Kekes recognises other factors as important in evaluating the morality of an action, yet, it is clear that the consequence of an action is given pride of place in evaluating its moral worth. In this framework, the consequence of a particular action may not have overriding function, but there is no doubt that it is ranked higher than any other values. By taking this position, pluralists are to be understood as making consequence of an action the criterion of moral evaluation. Pluralists are comfortable admitting the moral relevance of consequence of an action. However, consequence is not the only criterion, they insist, for judging the morality of an action. To this effect, Kekes admits, “pluralists are committed only to rejecting the ultimacy and exclusiveness of consequences as the standard of moral evaluation.”

Interestingly, one observes that human life is understood as having an extrinsic or instrumental value in spite of it being an ultimate value, i.e., value on which the enjoyment of all other values depend. In this sense, it has no overriding value. Therefore, it is subject to a trade-off. For example, in the case of the Dinka, we know that the dying spear-master’s breath has no effect on the people standing at the graveside. Suppose that it did actually revitalise the life of the community, in this sense, the taking of the spear-master’s life could be justified and the value of human life in this particular case would be overridden.

It seems reasonable to add at this point that the way one engages bioethical problems is equally dependent on the life view or the notion of human value adopted by the participants in the conflict. Now, I need to examine closely the question of what it is in human life Kekes considers valuable. Earlier in chapter two, we saw that

448The term worldview or what the Swedes call “livsåskådning” is an interesting and important concept in ethics, moral philosophy and bioethics. Many Swedish writers in these fields have explored meaning of what they call “människosyn” (view of humans), which is a part of a worldview. For a treatment of this concept, see Torbjörn Tännsjö, *Värdeut*, 1998 or Holsten Fagerberg & Erwin Bischofberger et al, 1997, *Medicinsk etik och människosyn*. See also Malin Löfstedt’s, 2005, published doctoral thesis, *Modell Människa eller Människosyn?* I will later return to the concept of worldview in the chapter on African perspective to bioethics.

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human life for utilitarians has a high value but a derivative one. This makes it subject to a trade-off when in conflict with other values. It is interesting to note this since we sometimes engage in activities that put life in serious danger. Were life an overriding value, actions such as parachuting, motor racing, mountain climbing, hunger strike, and a host of others would have longed been stopped. These clearly suggest that we value other things in life such as freedom, justice, family, kindness and so many other things.

Generally, most problems in bioethics do not concern the issue of whether life is valuable, rather than deal with the question of how this value is to be evaluated in different phases, contexts, and states of life. Kekes recognises life as one of the most important primary value of the self. He also notes that individuals and groups may value human life differently. The result of this is that it becomes difficult to formulate objective criteria in a pluralist society for the protection of life.

Each tradition may recognise life as a primary value, and yet legitimise widely different reasons for taking it. In the context of a tradition, the exposure of the old, infanticide, capital punishment, or death caused by torture or mutilation may be regarded as reasonable.

Kekes’s view of life and its conditionality are important to understanding what it could mean to apply his theory to bioethics. One might reasonably argue that the resolution of conflict of values is one of the central difficulties facing bioethics especially in reproductive ethics. The value conflicts that arise in reproductive ethics involve almost always-reproductive freedom and other values. The difficulty is often to know when reproductive freedom should be overridden by other values. In other words, it often concerns question of life. We have already seen the implication of Kekes’s theory on the tradition of the Dinkas. Kekes not only insists that Human life is conditional, but equally maintains that it has qua life, no value at all:

...What is reasonable to value is not life itself, but a life with some duration and enjoyment, one that merits self-respect and some

sense of accomplishment. It is a life that is judged to be at least acceptable by the person living it, rather than an intolerable burden.451

It is not surprising; therefore, that Kekes understands human life as possessing only an extrinsic or conditional value. It is not clear, whether conditional value must necessarily be qualified as extrinsic. In this sense, the value of human life is evaluated based on its quality, i.e., the quality of life of a given individual’s life. In medicine and health care, the term quality of life has different meanings. Quality of life as used in this context can be understood in three senses: descriptively, evaluatively and normatively. In the first sense, it refers to the attribute possessed by someone. As an evaluative notion, it means the value that is attached to the attribute of a given individual or to a kind of human life. When used in the normative sense it determines the moral value of human life. Quality of life considerations are prominent in discussing the effects of medicine and non-medical treatments of patients with chronic and highly disabling diseases. Two common notions of quality of life include quality of life as the normal functioning of the biological species Homo sapiens and quality of life as satisfaction with life. These elements are identifiable in the way Kekes evaluates human life.452 Given the foregoing, one may reasonably conclude that quality of life refers to the subjective evaluation of the experience of life. In this regard, it is important that Kekes is understood as concentrating on the content of the value of life. Much as he may be understood as basing his evaluation on the quality of the individual life, yet what is of significance for Kekes in relation to values is that they are defined more in terms of their mutual relationship than on


452 See, Carlberg, 1998, *The Moral Rubicon*, a doctoral thesis for a detailed study of the concept of quality of life as it applies to bioethics. Warren Reich characterises the quality of life as an ethic that: (1) depends on an ethical theory of consequentialism; (2) assigns relative value and unequal value to human lives on the basis of the possible consequences of variable qualities; and (3) advocates the norm that the conservation and protection of human life are not required or do not carry overriding obligation, unless the directly experienced qualities or the qualities expected to be experienced actually invest that life with sufficient value. See Reich and Singer 1978, p 833.
the ground of any moral content. In *The Moral Rubicon*, Carlberg is careful to point out what this means for moral deliberation.

/…/ By concentrating on the formal assessment of values […] and by underscoring their conditional status in moral deliberation, Kekes rightly shifts the discussion of value theory from their moral content to the act of valuation, i.e., to profoundly human activity of making sense of existence by clarifying the priorities that guide moral deliberation.453

This development is especially important for my studies since it supports generally the act of making meaning out of life. We will see later in this study how an understanding of African worldview sheds light on this perspective. The relationship in which different values stand is in this regard important to giving a reasonable and adequate understanding of human life. In bioethics, one is not only concerned with facts but also with values.

I share Engelhardt’s observation that there is an assumed matrix of values inherent in the life-world of medical practice. This matrix of values constitutes for health professionals a point of departure for ethical reflection.454 Supposedly, Kekes would agree with this observation and possibly classify them in terms of primary and secondary values, and moral and non-moral values. It seems reasonable that bioethics needs to highlight not only the values that influence bioethical decisions but also bring to the fore the particular life-view beneath a particular concrete action. The example of the Dinkas illustrates that the resolution of ethical conflicts involves value choices, not just purely technical or rational decisions. In the example of the Dinka, we see that Kekes holds the view of justification, which emphasises the controlling influence of problem solving upon inquiry. For him, theories and beliefs may be understood and evaluated only relative to the problems they would solve. In the context of the Dinkas case, the question could be whether the life burial of the spear-master gave life to the

453 Carlberg, 1998, *The Moral Rubicon*, p 55. We see here that much like Engelhardt, Kekes does not limit the scope of morality to the discussion of moral content. On the contrary, they attempt to articulate formal prerequisites of a secular ethics.

community. Since the answer is no, it could be concluded that life burial by the Dinkas is not justifiable.

By advocating quality of life as an evaluative criterion, it does seem that Kekes’s theory does not really concern itself with the protection of the value of human life. On the contrary, the focus on consequences seems to delineate the circumstances and conditions under which it might be justified to violate the deep convention protecting the value of human life.

It may at this point be asked what the implication of Kekes theory could for bioethical problems such as those encountered in reproductive technology. What could be its implications in regard to the status of human embryo, embryo research, prenatal diagnosis, genetic screening, fetal tissue research, cloning, and those at the end of life for example euthanasia, withdrawing and withholding treatment and so on? If particular bioethical questions are asked, Kekes would probably argue that the solution to such questions be pursued on a case-by-case basis by calculating benefits and harms in relation to the quality of life of the individual patient. This is similar to casuistry but differs from the latter because Kekes’s approach does not recommend the use of paradigm cases. Much like Engelhardt, Kekes’s theory would seem to justify many of these procedures by regarding them as ethically acceptable. Kekes’s own words concerning what it is in human life to value support this conclusion. We have earlier seen that human life, as human life, for Kekes, has no intrinsic value. All values are conditional and extrinsic. Consequently, the value we attach to human embryo, and fetus can easily be defeated by other values when in conflict with them.

Critique of Kekes’s Theory

There is no doubt that Kekes has provided some insight that eluded his predecessor, Engelhardt. His overall merits lie in his ability to show with his theory on rationality that it is possible to provide a rational justification of morality in a pluralistic society. There are good reasons to accept Kekes’s criteria for justification of morality: a) logical coherence, and b) practicability. Kekes is able to show that conflicts do not exist only among moral strangers but even among
those who belong to the same tradition. He reveals from this that human beings are not moral strangers. Kekes shows that it is possible to establish a secular ethics of value without succumbing to normative relativism. His distinction between primary and secondary values, which rightly recognises that all people by virtue of their common humanity share primary values as deep convention is helpful. The appeal to human nature as a context-independent criterion helps Kekes to show that plurality of values is compatible with some objectivity in moral judgement. In this way Kekes shows that the diversity of what he refers to as secondary values arises as traditions or cultures strive to give form to the content of primary values. As Carlberg points out, Kekes goes further in this aspect than Engelhardt who believed that values are exclusively social constructs.\footnote{Carlberg A, 1998, \textit{The Moral Rubicon}, p 54.} Kekes’s shifting of the discussion on the nature of values from that of supposed moral content to that of the mutual relationship existing among these values, i.e., from moral content to the act of valuation is very significant especially for my own study. Kekes successfully treats several problems in contemporary moral theory. For example, he clearly analyzes the radicality of moral conflict. In addition, he sketches a reasonable approach to the practical resolution of value conflicts in the individual and political spheres. There are good grounds to agree with Kekes in his recognition that there is objectivity in morality. It is not as Engelhardt claims just social construction. Although, it may be argued that moral pluralism seems to support the view that values are human and social constructions.\footnote{Grenholm C H, 2003, \textit{Bortom Humanismen}, p 95.}

Another merit of Kekes can be found in the clarity he brings to the understanding of moral progress. Universalists take moral progress as the realisation of whatever the overriding value is. For relativists, moral progress can make sense only within a particular context. Meanwhile, for pluralists, the fundamental idea of moral progress consists in enlarging the possibility by which individuals can make good life for themselves. In this light, he shows us that we can reasonably reconcile conflict between values and conceptions of a good life between traditions. Reason permits us to make non-arbitrary comparisons beyond the level of primary values and the
deep conventions that protect them. In this light, Kekes helps us see the difficulty in appreciating what could be the implication of cultures for bioethics. All this suggests that fundamental universality and considerable diversity can coexist in ethics whether or not all the theoretical issues have been resolved.

In spite of the strengths of Kekes’s theory, it is at the same time weak in many other points. Kekes arguably understands and describes the phenomena of pluralism much better than Engelhard. Nevertheless, it is doubtful if the conclusion he draws follows from the facts he interprets. One of the problems is that Kekes’s theory is not directly applied to bioethics. His attempt to articulate a middle position between universalism and relativism is only partially successful. Kekes’s model can be said to be a modified form of epistemological relativism. He admits that it is easier to criticise universalism and relativism than formulating an alternative to them.

Kekes grants with contemporary Aristotelian and “natural law” thinkers, the position that there are basic needs and values. These are universally recognised and even trans-cultural. That can be seen in his regard of human nature as the criterion of morality. Kekes denounces certain actions as objectively immoral for example murder. In this, one observes a model of moral intuitionism at work.457 He derives his primary values from the minimum requirements of all good lives that in turn depend on universally human, culturally unchangeable, and historically constant facts of human nature.458 Kekes believes that there are some values shared by different individuals and communities or different cultures that might constitute some common ground for resolving conflicts among values. At the same time, he adds that it in no way means that these values constitute an overarching universal ethics since these values on the secondary level must be interpreted and applied in different cultural contexts. It is tempting to assume from this that the justification of a particular action is always context-dependent. However, Kekes does not think so since primary values provide objective and context-independent criterion for moral judgement. It is doubtful whether there is a common human nature that can be the

basis for morality. Kekes’s natural law model shares something in common with ethical universalism. The reason is that it is context-independent. There is reason to question this ethical universalism embraced by his natural law model. Although Kekes does not in principle recognise any overriding values, yet there are many prima facie reasonable understanding of his version of pluralism compatible with universal theories and overriding values as his recognition of primary values especially that of human life illustrates. Kekes seems to subscribe to perhaps unconsciously, to a descriptive relativism and contextualism, both of which make universalistic demand.

Meanwhile, in some other passages Kekes seems to be espousing both descriptive and epistemological relativism. There is good reason to accept a weak descriptive relativism, which holds that different cultures and societies have different moral understanding. On the epistemological level, there is also reason to argue that there are in different cultural and social contexts different understandings of the meaning of rationality. He is, however, against all other forms of relativism.

Moral progress, for Kekes, does not mean getting closer to a pre-established pattern as there is no such thing. Good life involves selecting those values of the tradition whose acquisition suits the agents’ desires and context. Such an account of good life seems to make the justification of morality rest upon individual preference and internal coherence alone. This position suggests a form of preference utilitarianism. In taking this position, Kekes appears to have failed to give adequate account of the relationship between an individual and his or her community. In this regard, Kekes appears to have fallen prey to the western atomisation of the individual that has its roots in 1600 centuries’ social contract theories that find expression in political theories of our day. These theories give pride of place to rights of the individual and fail to account for the right of the community. Of course, many writers have rejected this type of theory. In contrast, there has been the advocacy of the social theory that sees the human person as a relational being that can only actualise himself/herself in community or in relationship with
This observation will likely become significant in any articulation of bioethics from an African perspective. Kekes’s theory when critically examined especially in its application to concrete problems becomes consequentialist. This normative consequentialist position has serious implication for bioethics. It is not clear, how one can reconcile his theory on rationality in its emphasis on context-independence criterion of objectivity and his normative consequentialist position where the stress is on the consequences of an action. For example, his justification for the abolition of the Dinkas’s tradition rested on the benefit of hindsight. The objections raised earlier in chapter two against consequentialist ethics apply equally to Kekes. In contrast to Kekes’s approach, it is possible to argue against life burial without appealing to hindsight. One can argue from the idea of the intrinsic value of human life and thereby show how life burial is inconsistent with the Dinkas’s value of life. Appealing to the intrinsic value of human life does not in this way rule out the possibility of sound argument that might warrant the taking of life in some other circumstances.

A distinction could be made between different forms of pluralism. Pluralism can be in the strong sense or in the weak sense that can in turn be subdivided into different types. Pluralism in the strong sense as espoused by writers like Bernard Williams and Martha Nussbaum embraces most features of universalism. In addition, it includes the idea that the plurality of values is itself valuable and worthy condition that warrants preservation even if it does entail the possibility of rational incomparability throughout public life.460 Pluralism in the weak sense accepts the general view of pluralistic rivalry of values, but insists that some values may be so important as to reasonably assume overriding function and therefore influence the evaluation of other values. All this goes to show that some important difficulties arise even in subscribing to a pluralistic theory of values. I suggest that Kekes’s version of pluralism does incorporate some sense of overriding and universal values especially in the recognition of others.459

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459 Taylor Charles, 1985, in Philosophy and the Human science. Philosophical papers 2, p. 189, 197 insists that theories that give rights issues first place presuppose some form of human life view, namely, atomism although their advocates deny that it is the case.

of basic human nature. As I have earlier noted, this can be said to be a weak form of ethical universalism. In fact, pluralists of almost every form can accept universal and/or overriding values. This is particularly true of weak pluralism that denies that incommensurability entails rational comparability. There is no ruling out that some value always outweighs others even if incommensurabilities sometimes arise, or that one moral theory is better than others are. Only one form of strong pluralism can be said to exclude universal or overriding claims. Nussbaum and Williams refer to this form as tragic pluralism. From the foregoing, it is not clear whether Kekes can justify his claim that the defining feature of pluralism in general is the exclusion of universality and overriding values.

Conclusion

Kekes maintains that good life must be reasonable. However, he rejects the idea that they must conform to one true pattern. He formulates and justifies a pluralistic account of good lives and values, and works out its ethical, political, and personal implications. He analyses the radicality of moral conflicts, which cannot be reasonably accounted for by universalist systems. He articulates a reasonable approach to the practical resolution of value conflicts in individual and political fields.

There are some significant insights that can be drawn from Kekes’s theory and his analysis of universalism, relativism and pluralism. Kekes regards pluralism as a middle point between the extremes of universalism and relativism. The former argues that there is only one universally valid ranking of moral goods to the reasonable agent. The common elements in all its versions include the view that there is a single truth and that the perspective of the universalist embodies that truth. Universalism helps us to appreciate that we need to make judgement (at least sometimes). Further, it makes us see that certain things are intolerable for example murder.

461 Williams identifies himself as an advocate not only of the fact of pluralism, but also of its value. For him the consciousness of the plurality of values is itself a good. Cf., Bernard Williams “Introduction,” in Isaiah Berlin, p Xviii.
and slavery. However, universalism gets some things wrong for example its tendency to claim that its truth is the only truth and its inclination to think that it cannot learn anything from others. Relativism insists that moral judgements are dependent on the social contexts in which they arise. Some useful insights of relativism include among others: (a) Helping us see the need for tolerance and understanding. (b) The recognition of moral pluralism (c) The need not to pass judgement on practices in other cultures that we do not understand. (d) Helping us see that even reasonable people may disagree on what they regard as morally acceptable. However, relativism does not help us in dealing with the commonalties of cultures. Further, it fails to give an adequate account of what part of morality is relative, what is morality relative to? In addition, how much of morality is relative? Being self-defensive, relativism does not permit us to judge others neither can others judge us. Normative relativism is neither possible among individuals sharing the same tradition nor possible between different traditions. Since we live in pluralist societies, where we necessarily must interact with others, ethical relativism is not a viable option.

Kekes differs from universalism by rejecting the argument that one value or groups of values are universally overriding other values. He distances himself from a strong form of epistemological relativism by arguing primary values that are common to a good life not minding the context or culture of their application. Ethical pluralism in this light combines the insights of universalism and relativism. The fundamental issue at stake is how to make a good life by choosing from a wide spectrum of differing and conflicting values. It recognises that we might sometimes be wrong; and sees diversity of moral visions as a possible strength.

On my reading of Kekes, there are levels on which there are reasons to agree with him and others we cannot but disagree with him. Given all this, there are good reasons to reject his consequentialist approach. Another reason is to be found in his understanding of what it is to value in human life. In spite of all, Kekes presents a good example of the need to take seriously the contributions of individual traditions in resolving ethical conflicts. This finds expression in the example of the Dinka. It is significant
that this example comes from Africa that happens to be the primary focus of this study. The example of the Dinka shows that Kekes attaches importance to the context of moral deliberation in spite of his argument for context-independent morality. I take him to mean that recognising context, as an important element in moral discussion does not make an argument relativistic. Pluralism does not necessarily imply relativism.

Engelhardt showed that it is possible to establish a secular bioethics that finds its normativity in particular traditions. Kekes went further to show that it is possible to articulate a secular framework for ethics in a pluralistic society that cuts across different traditions and cultures. However, he made all values subject to a trade-off. It is, however, possible to use Kekes axiological distinction between primary and secondary values to formulate a secular ethics. This kind of ethics is consistent with a context independent respect for the value of life. However, as we have seen from the foregoing analysis, a secular bioethical theory if it would be successful must incorporate both the insights of Engelhardt and Kekes. It needs in other words to go beyond them especially in lifting the common characteristics in our moral evaluations. Such a theory will be more consistent with the fact that morality is not just a private matter. What is clear from the dialogue with these western writers is that plurality of beliefs is not merely a matter of observable fact, but justified in intellectual and cultural life in general.
At this point of my study, an important question emerges. Why should this project continue? We have seen that Beauchamp and Childress failed to take the fact of moral pluralism seriously in their approach. That is why their method is not adequate for pluralistic society. Engelhardt took pluralism seriously but overlooked the common morality that all people share. For this reason, his account fails. Kekes took pluralism equally seriously. However, he articulates his position within the natural law tradition that is not recognised by many people. That means that the three theories are wanting at one point or the other. Furthermore, the three theories are articulated within the western context. Against this background, there is need to look for a method that takes pluralism seriously and at the same time recognises common morality that exists in all cultures. It is within this context that I move to the next section of this work addressing what could be the contribution of African culture to the formation of a common framework for bioethical analysis.

The analyses in the preceding chapters have revealed a couple of things. First, is the suggestion that the project of bioethics requires the acknowledgement of different cultural realities seen in different communities. The second point seems to be the discovery that the framework within which bioethics is done influences the result one gets. If this is correct, it is reasonable for me to start my discussion of bioethics from an African perspective by discussing some cultural realities of Africa with particular reference to the Igbo of South Eastern Nigeria. I have no hesitation calling my approach African perspective. The reasons being that Africans in spite of having remarkable diversities do share a common outlook on life, a similar worldview and similar philosophies. In this chapter, attempt is made to show that bioethics and culture have important relationship. The argument is that the theory and practice of bioethics have cultural
underpinnings. Thus, culture is significant to the understanding and articulation of justifiable bioethics in a given society.

**The concept of Culture**

The association of the concepts of culture and bioethics needs perhaps elucidation. Considerations of bioethics are often involved with culture. The reason is that people naturally view normative and evaluative questions from the perspective of their own culture and tradition. Bioethics is related to culture in the sense in which bioethicist approaches bioethical issues from the point of view of the beliefs, values, traditions, and the circumstances of his or her life as well as those of his or her people and culture.

Culture is one of the most complex and hotly debated concepts in social sciences and humanities. In the past, the concept of culture was simply used to explain the ways of life of distant cultures of particular ethnic groups. However, today, the concept is employed to explore social practices and patterns of thought in different cultural contexts. Culture has been variously defined or described by various writers. Anthropologists use the concept of culture to refer to codes that are learned and shared by members of a group.462 Yet, contemporary anthropologists continue to struggle with the concept of culture. A constant dilemma in the issue of culture concerns what distinguishes one culture from another. For example, how can Swedish culture be distinguished from Igbo culture or African culture from European or American culture? No definitive answer could be given this question. The reason is that it is difficult to claim that a particular culture is completely distinct from all other cultures in the world. However, this awareness does not deny the fact that cultures differ from one another sometimes in important respects especially in their contingent elements such as in dance, songs,

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language, dress etc. These elements are expressions of cultural self-identity.\textsuperscript{463}

Given the many uses and applications of the concept of culture, there is probably no definition of the term capable of satisfying everyone. However, a working definition for my purpose takes the concept of culture to refer to the dominant values, symbols, social practices, and interpretative categories of a community. In another words, it refers to the totality of the life of a people and how they understand reality.

One of the reasons explaining why culture has become important in bioethics seems to be the fact that there are divergent viewpoints and judgements from various cultures regarding many bioethical problems. This particular way of understanding culture implies that ethical deliberation belongs more or less to culture because the former is imbued with values and symbolic meanings. Consequently, the question of which culture is reasonable becomes important. Given this, it is difficult to understand why the ethical theories employed in health care today tend to apply simply a western philosophical framework to bioethical issues. Does the fact of diversity of cultural and religious assumptions with respect to health, illness, life, personhood, community, death, and dying not require that health care providers be sensitive and respectful of varied explanation models patients bring to the clinical encounter? How then can one engage in bioethics in the context of diverse moral convictions? The point at issue here is that cultural and religious traditions have implications for issues in bioethics.

Interestingly, there is recently a marked interest by bioethicists to the role of ethnic traditions, cultural norms, and religious practices in shaping understandings of health, medicine, person, community, agency, justice, autonomy, beneficence, nonmaleficence, illness, death, and dying. Employing relevant tools from medical and cultural anthropology, numerous researches explore cultural variations in attitudes toward truth telling, informed consent, pain relief and end-

life decisions. These qualitative studies of cultural practices contribute to distinctive understandings of decision-making in relation to family life, autonomy, and health care. This trend in bioethics has both merits and demerits.

On the one hand, bioethicists can benefit from better understanding the interpretative horizons that underpin how moral reflections and deliberations are framed. Since cultural understanding of morality, health, and illness has implications for most of the familiar topics in bioethics. Commenting on the relationship between morals and culture, Turner notes:

> Cultural explanations of health and illness, along with understandings of the appropriate social roles of family members and health care providers are interwoven with interpretations of what constitutes thoughtful moral conduct.

This passage shows that as bioethicists increasingly acknowledge the role of cultures in shaping modes of moral reasoning, the concept of culture is likely to play a greater role in bioethics. In this regard, ties between bioethics and social sciences are likely to lead to explorations that are more fruitful. This concerns the relation between cultural models and patterns of moral deliberation.

From the foregoing, it can be seen why bioethics has to appreciate the importance of explanatory models of health; sickness and moral obligations embedded within the cultural framework of patients and the cultural context particularly within the family. The concept of culture in this regard can serve as a reminder to local variations in understandings of medical care, health, illness, suffering, life and death, and dying.

On the other hand, writers such as Blacksher have raised some objections to a culturally sensitive approach to bioethics. The fear is that such might promote cultural stereotypes giving rise to a trend that will probably overemphasise the value of particular communities, and deny variations in norms within specific groups. Further, there is the danger that this approach might fail to appreciate

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adequately commonalties across cultural communities. Along with this would be the lack of appreciation of the roles of gender, status, level of education and personal experience. While these observations may be legitimate, they do not in my view, constitute strong arguments for the abandonment of a culturally sensitive bioethics. While it is important not to deny the truth of Blacksher’s observations, yet there is the need to ensure that bioethics in a global context highlights moral or ethical pluralism. That is, the existence of alternative ethical frameworks that resonate with different cultural traditions and socio-political conditions.

My analyses in the preceding chapters have uncovered the cultural underpinnings of the practice of bioethics. In the case of the US, it remains fundamentally shaped by the political and cultural pre-occupations of the US. Within this context, the ideal of democratic institution forms its bedrock. One of the questions raised by this observation concerns whether bioethics reflecting western values can be relevant in other cultural settings such as the Philippines or Nigeria or any other culture outside the West? In order to be relevant, bioethics has to be culturally sensitive. It was observed earlier in the study that non-western cultures have different, but equally encompassing ethical systems. This explains why bioethics has increasingly developed global consciousness. The difficulty with western ethical thinking lies in taking the product of particular historical, cultural, and social contexts, and endowing it with a timeless, universal validity. Commenting on the why of this global consciousness, Maura A. Ryan writes:

As bioethics has gradually developed a global consciousness, new voices from outside North America and Europe have emerged including from Africa, Asia, and Latin America, raising even more questions of adequacy and credibility.

Interestingly, Ryan observes that the issue at stake is not only the relative emphasis within bioethics on rights versus responsibilities,

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on autonomy versus beneficence. In addition, the dominance in health care of western philosophical framework developed within institutional contexts of the West especially in relation to European and North American legal and policy frameworks. A number of responses have come from non-western cultures on the debate about universal ethics and common bioethics.

In *Beyond a Western Bioethics: Voices from the Developing World*, Angeles Tan Alora, Josephine M Lumitao and their colleagues point to this global consciousness in bioethics. Having studied bioethics in the United States, they discovered the difficulty in applying the western oriented approach to the contexts of the developing world in general and the Philippines in particular. This collection of essays reflects critically on the dominant methods and languages of contemporary bioethics. It is an honest attempt to formulate a distinctively Filipino bioethics in consonant with Filipino cultural and religious values. The character of ethics in the Philippines is said to contrast with ethics in the West not just in terms of the problems and resolutions, in their contexts, but also in the language and method of moral deliberations. Western bioethics focuses on maximising individual autonomy; whereas, in most other places it concentrates on social units. In the West, the dominant approach is the principlist paradigm. The reason is that it is concerned with the application of ethical principles to concrete moral problems. On the other hand, bioethics in the Philippines is grounded on lived moral virtues. The limitations of the approach of “principlism” receive an interesting treatment by the editors Tan Alora and Lumitao in its encounter with what they refer to as “the lived phenomenology of the Filipino context”. There is a serious criticism of the pride of place given to respect for autonomy in health

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470 Tan Alora A, & Lumitao J M 2001, eds, *Beyond a Western Bioethics: Voices from the Developing World*, Georgetown Univ. Press, Washington. Alora and Lumitao after participating in a series of workshops, conducted by American bioethicists with the purpose to developing local experts in bioethics discovered the presuppositions of neutrality and universality claimed by this exercise were at odds with their own moral experiences and intuitions.
care decision-making and in policy advocacy. In this regard, Tan Alora and Lumitao observe:

Within developing countries, society, family, and church assume a moral and religious significance no longer found in the West. In traditional societies, the family takes for granted values such as authority, obligation, honor and caring.473

This suggests that the family is the greatest unit of social value. By implication, this means that in as much as the individual is important in moral deliberations, yet the good is justified by reference not only to the individual but also to the family. In this context of a family-centred and community-centred ethos, “Western ideals of individualism and self-reliance have little purchase in the Filipino culture.”474 This is further highlighted by the following observation: “Filipino bioethics as a lived ethic does not focus on individual consent to health care, individual confidentiality, or individually articulated concerns with beneficence, caring, and truth-telling.”475 These differing views on individual autonomy and the family or community have practical implications, for example in the different understanding and practice of how informed consent is obtained and provided as evidenced in end-of-life decisions for example disclosure to the terminally ill. In the Filipino culture, the family “provides emotional security, economic support, and a deep sense of belonging”.476 Health care providers are expected to communicate diagnoses and treatment options not to the patient but to the family and consent forms are normally “signed by the senior member, who often is the most prosperous family member.”477 Filipino culture in this regard illustrates how economic power is related to moral and political powers.

474 Pusung Victoria, 2001, “Care of the elderly,” Beyond a Western Bioethics, p 44.
The authors in this book move from a general discussion of the moral framework informing health care decisions in the Philippines to an exploration of a wide range of concrete issues. These matters include the following: doctor-patient relationships, informed consent, organ transplants, death and dying, medical research, care of the elderly, family planning, allocation of scarce health resources, and AIDS care. The fundamental argument in the way these issues were discussed is that cultural presuppositions of the Philippines must be normative for whatever medical interventions or policies of health care that are accepted as ethical. The authors tend to provide a sharp contrast between Filipino culture and the West. The writings suggest that the practice of bioethics is radically relative to various cultures and traditions. There is an evident stress on the things that distinguish the two cultures rather than on what they share in common. I agree with their critique of western autonomy principle and their criticism of universalism. I have difficulty with their suggestion that there may not be values that all morally serious persons accept. I argue for common values that we share as humans that can provide some basis for decisions in health care. A common morality principle model of bioethics is possible. Nevertheless, it is a model that must be contextual. In this respect, I agree with them that no paradigm of bioethics can be applicable to all contexts. It is also important to note that the authors have demonstrated the need for culture sensitive bioethics by showing that cultural ethos has influence on discussions within medicine. They have successfully challenged the model of global bioethical standards that do not adequately account for cultural and contextual differences. The contrasts they provide should be of considerable interest to health care providers in areas with significant immigrant populations.

Of interest also is another distinctive voice from Asia in the volume: *Bioethics and Asian Culture: A Quest for Moral Diversity*. This study reflects critically on difficult bioethical issues from comprehensive Asian perspectives different from the western framework. It treats such topics as the intellectual foundations of Asian bioethics, bioethics and Asian culture, life and death, euthanasia and end-of-life care in Asia. Furthermore, it shows that there is even moral diversity in Asian culture. In this regard, it sheds light on the debate about universal ethics, global ethics and moral
diversity. In his introduction to the volume, Ren-Zong Qiu made an interesting observation. He points out that there are values shared by different moral communities or different cultures that might help in resolving global problems in no way lead to the conclusion that such might constitute an overarching universal ethics or global bioethics. The reason is that shared values can and must be interpreted and applied in different cultural contexts. Against this backdrop, it may be asked whether there is a homogeneous African culture, that can form the basis for African bioethics. Kwasi Wiredu has given a list of the fundamental common elements and features of traditional African culture. African is characterised with considerable diversity. The term African culture is used exactly in the same sense as we use the term Western culture. Kwame Gyekye in *African Cultural Values: An Introduction* shares Wiredu’s view on this matter.

Apart from the voices from Asia, there have also come voices from Africa. However, there has not been Works from the African perspective as comprehensive as those from Asia. Of particular interest to me is the work of Cameroonian born philosopher and bioethicist, Godfrey B. Tangwa, who has in a number of essays attempted to articulate bioethics from the African perspective. Tangwa insists that:

> The globalisation of Western technology should not be accompanied by the globalisation of Western ways of thinking and acting, Western ways, manners and style of doing things, Western idiosyncrasies and eccentricities.

The point at stake in this passage is the argument that other cultures accepting western technology need not accept all its western

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481 Tangwa, 1999, “Globalisation or Westernisation? Ethical Concerns in the Whole Bio-business,” *Bioethics* 13:(3-4)218-226. Japan is a success story in this regard. All kinds of technology and medical practice have been taken over from the West, yet traditional ways of thinking and acting have remained. I do not mean to justify these traditional ways of thinking that still influence medical practice. What I am interested in pointing out is that cultures participating the gain of Western technology need not accept it with all of its packaging.
packaging. It is clear at the present that the globalisation of bioethics seems to be equivalent to the globalisation of western ways of thinking and acting. This way seems to view the idea of economic progress as the end for humanity. In a paper, “Bioethics, Technology and Culture: A voice from the margins,” Tangwa argues for the universality of morality. He maintains that universality is the litmus test of moral authenticity. He insists that core ethical values are the same for all human beings in spite of the remarkable pluralism of moral views and cultural diversity of the world. In the manner reminiscent of Immanuel Kant, he contends that every genuinely valid and objective particular judgement is universalisable. Nevertheless, the plurality and inevitable relativity of human cultures, leads him to advocate for the equality of cultures and the importance of different cultural perspectives in moral deliberation especially in issue of cross-cultural relevance. The reason for this is that every culture is some how limited in its perception. At issue is the contention that no single human culture can credit itself with a holistic and comprehensive view of reality. In this sense, epistemological comprehensiveness is not possible with human knowledge. Following from the foregoing, Tangwa maintains:

What all human cultures have in common is that they are all creations of human beings, reflecting, on the one hand, human capabilities, goodness, ingenuity, wisdom etc., and, on the other hand human limitations, fallibility, frailty, perversity, foolishness etc.482

The significance of this is that all cultures are equal per culture and none can credit itself with possessing the totality of knowledge. The above text suggests that all cultures have common characteristics. It also indicates, in contrast to Asian perspective, that Tangwa is universalistic, whereas Asian approach has a more relativist approach. Tangwa considers biotechnology as morally neutral. The use, to which any technology is put, is the moral issue.483 In this point, he could not have been more correct.

Worthy of interest is Tangwa’s essay, “Bioethics: An African perspective.” In this paper, he made a number of important observations. First, the project of formulating an African Bioethics is comparable to the debate concerning the existence or non-existence of African philosophy or religion.\(^{484}\) Contrasting Western cultures with African cultures, worldviews, and system of thought, diversity, religions and philosophies, he states that the latter is marked by openness.\(^{485}\) However, no sooner had he described African cultures as exhibiting a great diversity than he quickly affirmed that African cultures have similarities in many respects. Given the lack of written texts in trying to formulate bioethics from an African perspective, Tangwa points to the role of the bioethicist as that of a translator and interpreter. In the light of this view, the task of an African bioethicist is comparable to that of an African philosopher. The reason is that both of them working with the raw material of African worldview or culture have to engage in the project of hermeneutics.

Drawing from the worldview of his native land, that of the Nso’s of Bamenda Highlands of Cameroon, Tangwa formulates an African perspective to bioethics that he calls “eco-bio-communitarianism”. This view implies the possibility of transmigration, transformation, transmutation, and reincarnation, across and within species.\(^{486}\) For him, this approach is a viable alternative worldview within which some of the contemporary bioethical problems might be resolved more satisfactorily than within a Western framework. Finally, Tangwa tests his framework by applying it to bioethical issues such as abortion, suicide and euthanasia. Among the things Nso’s value would include children and community. In the case of the latter, it was so valued that they subordinate the individual to it. Euthanasia understood in its etymological sense, as gentle and painless death would probably be approved in Nso’s culture. Against the background of Nso’s worldview on the meaning of a fulfilled life, voluntary euthanasia would be unproblematic. Furthermore, since the

\(^{486}\) Eco-bio-communitarianism understood in this way differs from how the Igbo understand their world. Of all the phenomena listed as possibilities in Nso culture, only reincarnation is recognised by the Igbo. It follows possibly that in method and resolution the two cultures may differ on how they approach bioethical issues.
Nso’s fear suffering more than death, it follows that they would also welcome non-voluntary euthanasia for all categories of certified terminal patients, where all that can be expected is pain and anguish for both patient and loved ones. In the issue of abortion understood as the deliberate termination of a pregnancy before the embryo has reached term, the Nso are clearly against non-therapeutic abortion. There is a paradox in this since infanticide in certain circumstances such as incest regarded as a taboo, is permissible. Regarding suicide, for the Nso, it is a taboo and as such an abomination and an offence against the earth requiring atonement and purification. The attempt to link euthanasia, killing, and suicide in the ideas of assisted suicide and mercy killing does not make sense in Nso framework. One thing that stands out in this is that Nso ethical approach is open-ended and treats bioethical problem case by case.

Tangwa describes the Nso’s world-view as being primarily communitarian. It is interesting, however, to observe that this goes beyond anthropocentrism and even beyond biocommunitarianism. Properly understood, it is eco-bio-communitarianism. Yet “Nso’ morality is ultimately and fundamentally human centred in so far as its teleological end and limits are defined by human well-being.”

According to him:

African plural systems in all spheres always accommodate some incompatibilities, incoherence and contradictions…however, the situation does underline uncertainty, human epistemological limitations and should foster patience and tolerance.

In order to appreciate how relevant this passage is, it should be clear that the primary problem of my study is pluralism of moral and ethical visions in pluralistic society and the articulation of bioethics from an African perspective. As Tangwa points out, diversity or pluralism is not a problem for African worldview. The diversity of moral visions is seen as strength rather than a weakness. It is in fact the nature of reality itself to be plural as understood from an African viewpoint. The point is that African cultures accommodate pluralism. Within the context of this pluralism, there is an underlying similarity especially as seen in her institutions such as the family. In contrast,

Western frameworks seek to systematise, unify, harmonise, and control this diversity. Since the time of René Descartes’ *cogito ergo sum*, this has been the part western scheme of thought treads. There has been that desire for certainty in knowledge. Tangwa describes this quest for certainty as a veritable obsession in the intellectual and philosophical history of the West.\(^{489}\) This has manifested itself in the search for one correct principle by which all other things can be explained. To appreciate pluralism in this context means that we have to agree with Susan Sherwin who contends that conflicting moral theories and differing theoretical perspectives should be seen as alternative frameworks or templates through which we perceive and evaluate problems.\(^{490}\) In the same manner, we may understand culture and differing worldviews. They are both complimentary and supplementary in function.

From the foregoing analysis, it is evident that the writers from Asian perspective and those from Africa, Gbadegesin and Tangwa share some common characteristics. Obviously, both are concerned to allow the role of particular cultures in the practice of bioethics. In effect, they challenge the dominant western framework applied today in bioethics analysis. Both cultures insist that people must be viewed as members of groups rather than as atomised individuals. This means that the moral agent have to be situated within the social process that shaped his or her identity. They both support a duty-based rather than rights-based approach to ethical decision-making. These cultures also share a holistic view of the person that affirms the importance of family, culture, and the spiritual dimension of human experience. Furthermore, they generate explanatory models of illness that are similar in contrast to the West. However, there are also some differences between Tangwa, Gbadegesin, and the writers from Asia. As earlier hinted, the authors from Asia tend to provide a sharp contrast between the West and Asia. By implication, it means that bioethics is strongly relative to various cultures or traditions. Such a view of course raises questions concerning objectivity and intersubjectivity in human judgement across cultures. In contrast, for


Tangwa, all cultures share a fundamental similarity. In this sense, one may describe him as a universalist. Yet, he makes allowance for the understanding of ethical judgement from the perspective of particular cultures. Tangwa’s position perhaps rests on the recognition that there exist both community-specific morality and universal morality elements in every culture.

The question now is how I relate to these two positions. Their over-emphasises on dissimilarities in cultures to the detriment of similarities that all cultures share per culture is a basic difficulty with the authors from Asia. There is the danger of normative relativism in their positions, which makes no room for intersubjectivity. Whereas I acknowledge differences, I also recognise fundamental commonalties. There has to be the possibility for objectivity and intersubjectivity in ethical judgements. My position is closer to that of Tangwa. I share his pluralist position. Yet, in contrast, I do not share his strong universalistic feature. The reason is that ethical principles even when they are commonly accepted have to be applied and interpreted according to the perspectives of particular cultures and contexts. My position can then be understood as a middle position between Tangwa’s and the authors in *Beyond a Western Bioethics* and the authors of *Bioethics and Asian Culture*. The question of African Bioethics is related to that of African ethics. On this note, I will explore what ethics generally refers to within the African context.

**African Ethics**

Is there an African ethic? What is the source of such an ethic? Much of contemporary scholarship on ethics from an African point of view is preoccupied with the question of whether moral rules and principles arise from religion or whether these rules arise out of reason. It needs be noted also that much of this scholarship is also on descriptive ethics. Whereas ethics refers to a critical and systematic reflection on morality, descriptive ethics in this sense refers to nonnormative ethics describing what people actually do such as the works of cultural anthropologists and sociologists.
Regarding the relationship between religion and ethics in African society, there have been two opposing views. On the one side are those writers who maintain that morality derives its validity from religion. Representatives of this point of view would include Kenyan, John Mbiti and Moses Akin Makinde. On the other side are those like Segun Gbadegasin, Kwasi Wiredu, and Polycarp Ikuenobe who contend to the contrary. These normative ethicists generally argue that religion is not the basis for morality. Interestingly, it need be noted that the underlying element in both of these approaches, is the implicit assumption that ethics in African context deals with action guiding principles. These principles help individuals within a community and the communities herself regulate their conduct in relation to other human beings and of course with the natural world. It is not clear at this point to say that any of the sides to the debate is correct. However, it is doubtful whether it is possible to deny religion any role in morality and ethics in African context. Yet, African ethics cannot be said to be the same thing as African traditional religion, although they share some features. Both of them are centred on the welfare of the people.

Professor Kwasi Wiredu in *Morality and Religion in Akan Thought* 491 contends that African ethics is centred on the welfare of the people of the community. It is mostly utilitarian in outlook. He explains that the Akans would do only those things that they would expect done to them. Further, what they consider good are those things that enhance the welfare of the people. In a similar manner, Professor Sophie Oluwole argues and believes correctly, in my view, that the idea of morality among the Yoruba of Nigeria is based on the fusion of the Golden rule and on the consequences of carrying out a given act.492 Much like Wiredu, she assigned little or no role to religion in Yoruba morality. It is doubtful how one can reasonably exclude religion as one of the sources of morality in Yoruba culture.


This position flies in the face of the reality on the ground. For example, how can we explain the reverential respect shown to human being? In the work *An Ethical Study of Ethiopian Philosophy*, Summer C. argues that Ethiopian ethics is grounded in the light of reason and rationality.\textsuperscript{493} Scholars are appreciating more the extent to which African religions are founded upon a systematic anthropology and ethics. They are becoming increasingly aware that African religions are in fact anthropocentric.

Segun Gbadegesin reflecting on bioethics from African perspective points out and rightly, that the project of bioethics requires “paying attention to the cultural realities and assumptive frame of reference of different peoples.”\textsuperscript{494} This has to be acknowledged in order to understand the people’s view concerning health care and technology.

In exploring the oft-cited principles of biomedical ethics by Beaucamp and Childress, autonomy, beneficence, non-maleficence, and justice in chapter three, I argued that people do not just make their ethical decisions based on them, but also on cultural notions of personhood, health, illness, community, death, dying, and religious beliefs. In this sense, studies focusing on particular or ethnic groups find their relevance. The bioethical approach should not be abstract, but it should rather help us to bring to light the values that are ingrained in social reality.

Since a people’s worldview expressed in their culture is relevant to bioethical issues, it is then reasonable to explore the constituent of their worldview. Some of the cultural realities of Africa with particular reference to the Igbo that are relevant to bioethical questions would include their conception of the human person, family, community, life, decision making, causality, sickness, death, and health and healthcare. These concepts are relevant to understanding bioethics within an African context. I will discuss the concepts of personhood, community, and cause, as they are understood in Igbo traditional thought. The way these concepts are understood influence medical practice and health care policies within


the African setting. A fundamental value of African morality is the pursuit for consensus. This could be seen as one of Africans contribution to humanity. The pursuit of consensus is a richer and more fruitful process than any other form of deliberation where the majority approach of present democratic culture is employed. The deliberation leading to consensus is not achieved by imposing a point of view on others that may not share it. It is simply a process of carrying every vision along in reaching an agreement.

Drawing upon the foregoing, our aim in this study has been to show that there is traditional African Bioethics worthy of consideration by non-Africans. Traditional is used in the sense of the perspective being informed by the worldviews, culture, philosophy, and the concrete experience of the people of Africa. In this case, it is informed by the Igbo traditional worldview.

Igbo Worldview

The Ndigbo (Igbo) with a population estimate of about twenty-five million people495 are one of the major ethnic groups in Nigeria. They are located in the eastern, parts of the mid-western, and part of the delta areas of South Nigeria. Commenting on Igbo worldview,496 Pantaleon Iroegbu writes, “Igbo world vision is rich in symbolism, rites, celebration and music. The language, also called Igbo, rich with proverbs and rhetoric, expresses a powerful mental structure that manifests itself in a variety of art and poetry.” Interestingly, there are many views about their origin. Some writers claim that the Igbo are of Semitic origin. Some others argue that they migrated from Egypt. However, one can safely refer to all these as speculations. Of

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495 Population figures are difficult to obtain in Nigeria. The reason is that the are highly politicised since the form the basis for the federal government revenue allocation to the various States and ethnic groups. However, many writers cite this figure as being reasonable.

496 Worldview in this study refers to a complex of a people’s beliefs, attitudes concerning the origin, nature, structure and interaction of beings in the universe and the logic, which holds them together with particular reference to humankind. It seeks to answer the question concerning the place and relationship of human being within the universe. See Introduction-theoretical framework

interest in this study is their worldview and not their origin or place in the socio-cultural life of Nigeria or Africa.

In presenting Igbo worldview, a methodological question that needs to be posed and answered concerns whether what is here presented is a synthesis articulated by the Igbo people, or what I construe of the Igbo life? In what follows, I am formulating the agency, which I consider as lying behind the patterns of conduct of the Igbo people. What I am presenting stems from my experience, research, and interpretation, of the Igbo understanding of reality in the world.

One has to be aware in trying to present the worldview of the Igbo, of the variations in cultural patterns among them. Of course, this takes us back to the question raised earlier concerning African identity or in this case Igbo identity. Can one really talk about Igbo worldview? Are there not remarkable linguistic and cultural differences among the Igbo people, between Ikwere and Nsukka, between Agbor and Arochukwu to place a question mark on any descriptive claim to Igbo culture? It is not my intention to explore these variations. The point is that all Igbo writers agree and in my opinion correctly that it is reasonable to talk about Igbo worldview or culture. On the view of reality which accords with Igbo life and thought, its validity does not depend on how much it is close to or different from any other people’s view but on how much it explains what the Igbo say and interpret reality. It should be noted that even within a group, different individuals might have different worldviews. What is described here as Igbo worldview is not a worldview shared by every Igbo person but rather some characteristic features of Igbo life.

For the Igbo, the universe is multi-dimensional and comprises of three interrelated parts namely, physical, spiritual, and abstract. The first is the world of the living, while the second is the world of invisible beings. The third can be realised in any of the first two. What the abstract dimension points to is that contemporary African metaphysics which divides reality into the physical and spiritual is inadequate to explain satisfactorily the experience of the Igbo. Two examples of the third type of reality are ‘ogu’ (innocence) and ‘ofo’ abstract concepts with the status of independent existence conferred on them by the Igbo.
These three types of reality are believed to form a continuum. The Igbo give ontological status to these three types of reality. In this system, humans, invisible creatures, animals, plants and all other elements are considered to be in continuous interaction and interdependence. In contrast to Nso culture, there is no possibility for transmigration, transmutation or transformation within and across species. On the other hand, there is belief in reincarnation. The invisible universe is inhabited by four categories of spirits, namely: Chukwu (the creator), Mmuo (deities), Arusi (spirit-forces), and Ndi Mmuo (Ancestors or the living-dead). Even in this scheme of things, the place of humans is central. The reason is that they have a great moral responsibility in ensuring that proper balance is maintained in these two universes.

Whatever be the form of a worldview, it substantiates principles of different sorts, namely, ethical, religious, philosophical, scientific, cultural, sociological, and political. The Igbo use the cosmic order in classifying their worldview whereas the Yoruba who live in small urban areas draw their classification from their socio-political organisation. For the Igbo, there is the world above and the world below. Human beings occupy the space between these two worlds.

The central values of the Igbo culture are based in the social structure, particularly in the extended family. These values would include inter-dependence, solidarity, empathy, lineage continuity, dignity or sacredness of life, male offering, and community. Igbo worldview shapes the Igbo social structure, the ‘Omenala’ that is, the body of rules, social, legal, and moral, which govern Igbo society and give direction to all its institutions. On the other hand, Igbo social institutions reinforce the social structure and worldview. Among the deities in Igbo worldview, the deity, ‘Ala’ has a central place. The reason is that she is the custodian of morality. Concerning Igbo conception of morality, scholars have remarked that Igbo moral universe is thoroughly permeated with sacred symbolism and ritual in a socio-religious system. For example, ‘uli’ reflects the worldview of the Igbo. Igbo values are translated in ‘uli’ motifs on the body and on houses especially during festivals. Evidently, this illustrates a

correlation between physical beauty and moral rectitude. This interaction is captured by the Igbo aphorism: ‘Agwa bu mma’ (character is beauty), or ‘Mma di n’obi’ (Beauty resides in the heart). The reason for the socio-religious system was simply used as a means to legitimise power, wealth, and to ensure their acquisition in morally satisfactory ways. Religious ritual was used as instrument of social order. The preservation of moral order becomes the goal of social control. However, Professor Ogbu Kalu is careful to point out that the Igbo were “not so incurably religious that all modes of social control were clothed in religious garb, secular modes of control existed.” For example, the use of the ‘Age grade’ and the ‘umuada’ were among such secular controls serving as agents in the socialisation of the young into the mores of the society. In this regard, it is interesting to observe that many of the folk-tales, proverbs, idioms, dance, and music had no religious dimensions, but were educating techniques and entertainment. Commenting on this, Professor Donatus Nwoga writes:

Igbo world leaders deliberately manipulated sacrality to cover even mundane aspects of life, because there was no secular theory of obligation. Religious awe was a cudgel to control the society’s morals.

Worthy of note in this respect is that Igbo conception, indeed African conception of morality or value is humanistic in orientation. In this scheme, values are based on human interests. In this regard, what is good in general is what promotes human welfare. From the foregoing, it is evident that any serious study or research into the foundations and principles of Igbo morality and ethics must derive its inspiration and support from the Igbo philosophy and the theology of this earth goddess called ‘Ala’ the custodian of morality. Yet, it need be noted that what is good in a more narrowly ethical sense for the Igbo cannot be defined by reference to the will of God or that of any of the deities. In this context, God or the deities are logically incapable of defining the good. This suggests that there is in Igbo

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499 Kalu cited in Donatus Nwoga, 1984, “Nka na Nzere: The Focus of Igbo Worldview”, Ahiajoku lectures. Compare and contrast this with Mbiti’s claim that Africans are notoriously religious.

traditional thought a conceptual separation of morals from religion. In the hierarchy of beings, human being stands at the centre. Every other thing is appreciated to the extent they contribute to the self-realisation of human beings. God and spiritual beings exist for man not man for them. Commenting on the place of humankind, Mbiti observes, “man is at the centre of existence and African people see everything in its relation to this central position of man… it is as if God exists for the sake of man.”

Generally, the Igbo world is an ideologically open one that offers the individual the opportunity for self-actualisation in life. It is highly receptive to change, individualistic and highly competitive. In this connection, the understanding of ‘Chi’ in Igbo cosmology is of vital importance. Without this it is difficult to make sense of the Igbo worldview. The notion of ‘Chi’ in Igbo thought refers to the individual’s guardian spirit and the symbol of his or her destiny. Every adult person is expected to have a personal deity called ‘Ikenga’. This deity symbolises personal success and individual achievement, which are highly prized values in Igbo society. Individuals who become successful in the community celebrate it by taking series of titles culminating in ‘ozo’ title. It need be observed that the Igbo people did not construct a rigid system of thought that explains the world and the place of humans in it although, one of the most fundamental aspects of the Igbo cultural realities is the importance given to community or solidarity among humans. This is the case because of the great value, which the Igbo attach to communal belonging, which is a consequence of the social character of their conception of human beings.

501 In a discussion with one of my colleagues, he maintained that this couldn't be true especially with regard to the high God and the other deities that are universal among the Igbo and demand obligatory worship from the people. This objection can be met be showing that these deities are appreciated in various Igbo communities depending on how they were conceived to contribute to the general wellbeing of the people. In other words they are disposable.


Igbo concepts of health and disease

The concepts of disease and medicine are the foundation of medical treatment in Africa. Theories and practice of medicine have cultural basis. In this sense, notions of illness, disease, diagnosis, treatment, life, death, and dying must also have a cultural dimension. The articulation of Igbo ethics or bioethics in the light of contemporary realities is a task that cannot be achieved without a fruitful dialogue with Igbo cultural heritage especially in its beliefs about health, disease and treatment. It is evident that people’s belief, culture and religion play a serious role on their acceptance of a particular system of medical care. Contrasting Western and Chinese medicine Bowman and Hui point out: “In western medicine, the primary explanatory model of illness focuses on abnormalities in the structure and function of bodily organs and systems. Traditional Chinese medicine, on the other hand, views the body, soul and spirit as an integrated whole.”

This is true as well in Igbo traditional medicine. For the Igbo, good health implies that the ontological relationship between man, God, and the universe are in harmony in a particular individual. Once this harmony is disturbed, the result could be illness or some other misfortune. The focus of Igbo medicine is on maintaining and promoting this relationship. That is to say that it emphasises preventive and palliative medicine. Thus, the system of health care acceptable to the Igbo is affected by the values, goals and in their perception of the nature and meaning of illness. M. A Makinde in his analysis of ‘Ifa’ as a repository of knowledge among the Yoruba shows that African traditional medical assertions occur in an already epistemological constituted universe. Igbo traditional medicine as most of other traditional African medicine is holistic. The reason is that medicine deals not only with cures of diseases but also with their origins. Health and sickness are seen in a wide context of individual wellbeing within the social and spiritual environment.

There are various views on the origin and meaning of medicine in Africa. E. G.Parinder defines medicine within the African context as including both natural healing agencies e.g., leaves, roots and etc.,

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505 Makinde, 1988, African philosophy, Culture, and traditional medicine, p 87.
and the invocation of magical or spiritual influence that are thought to be associated with them.\textsuperscript{506} Within the Igbo context, Metuh\textsuperscript{507} defines it as anything that can be used to heal, kill, and secure power, health, fertility, personality or moral reforms. It includes drugs for curing and preventing disease as well as objects with magical powers. Medicine (ogwu) in this context has a wider application than in western concept. It can be used both for positive and negative ends.\textsuperscript{508} One observes that there is no clear line between medicine and sorcery in this sense. It is both curative and preventive. Distinction is not usually made between medicine and religion understood as a way of life. In fact, medicine is believed to originate from religion. That is why being a traditional medicine practitioner (dibia) is seen as a vocation from God. Among the Igbo, traditional healthcare givers are distinguished into three, namely, medicine man, diviner, and priest. Whereas the first heals by herbs (herbalist), the others heal by ‘afa’ divination. The divinity of medicine and divination among the Igbo is agwu.\textsuperscript{509} For the Yoruba, it is Osanyin and orunmila. Worthy of note in this connection is the Igbo conception of cause. This is important so that one may better understand the principles and practice of Igbo traditional medicine.

\textbf{Causality}

The Igbo understanding of the notion of causality are relevant to many of the issues in bioethics for example illness, suffering, death, and dying. Health care among the Igbo, implicitly or explicitly, assumes a conception of cause just as it does in those of person and community. In Igbo worldview, there are two levels of explanation for events. The first is what we may call natural explanation. The second is supernatural. In the first level, natural laws are operative, in the supernatural, it is invisible and spiritual forces that are at work.

\textsuperscript{506} Parinder, 1969, \textit{African traditional religion}, p 156.
\textsuperscript{508} Metuh I, 1985, \textit{African religions in western conceptual schemes}, p 162.
This second level has resisted a scientific notion of cause, especially as many Africans attribute causes of events to God or some spiritual powers. This is of course not true of all Africans. Yet, what is true is that African thought rejects Western reduction of mind to matter. The result is that they by implication reject philosophical or scientific materialism on which western science and technology are based. The rejection of materialism does not translate to a rejection of science but a rejection of science based solely on materialism at the expense of human values.

It was earlier noticed that the Igbo hold a tripartite conception of a human being. Besides the two primary elements of a person, ‘ahu’ (body) and ‘obi’ (soul), they believe in a third abstract element referred to as ‘chi’. We have also noted that, chi is responsible for individual destiny. Following from this, the cause of illness or any other threat to individual wellbeing may be sought in the individual’s chi. Among most Igbo people, the search for the cause of an illness or any other thing for that matter always begins from the natural level. When this level has been exhausted, the search moves to the supernatural realm. For the Igbo, nothing happens by chance.

The World Health Organisation in 1949 defines health as the state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Disease has been variously defined from a philosophical, anthropological, metaphysical, sociological and as well as from a medical perspective. Disease for my purpose would mean any thing internal or external to the human being that hinders his or her full actualisation. Within the Igbo setting, healing is more than the restoration of disturbed physical condition or sickness. It refers to the restoration of the wholeness of the individual physically and socially. This contrasts with the western view where it is seen as merely the means of restoration of the pathological state. This is explained by the difference between the Igbo concept of disease causation and that of the West.

In present day Nigeria as in most African countries, traditional medicine operates along side the modern health care system. When a Nigerian becomes sick, he or she chooses between traditional medicine and western medicine. Sometimes the two are combined. What determines which alternative one chooses is not only the person’s social condition but also his or her conception of the cause
of the illness. Traditional medicine is often believed to be more effective in curing certain illness, such as, mental illness, stroke, convulsion and bone fracture than western medicine. Many poor patients have access mainly to traditional medical health care because it is affordable and readily available. The issues of HIV/AIDS, researches involving human participants, reproductive technologies, and end of life questions have made bioethics important for Nigerians. There are the many poor and the few rich. It is this latter group that has contributed to making the issue of modern health technology an important one for the Nigerian people. It is within this health care context that the Igbo make health care decisions.

One common thing to disease, pain, sickness, medicine is that they are all universal phenomena. However, they are understood and interpreted differently in different cultures. The reason is that these interpretations are dependent upon the people’s worldview. In this connection, there is an intrinsic connection between especially culture and the practice of medicine, which is itself, a product of culture.

**Personhood in Igbo thought**

A very important feature of Igbo worldview is what the Swedes refer to as “a view of humans”. This concept refers to comprehensive view of humans.\(^{510}\) Discussion on the concept of personhood occupies an important place in Western ethics. Many authors have investigated the meaning and relevance of the concept. Anders Jeffner in his studies distinguishes between what he calls ‘knowledge about humans’ and ‘a view of humans’. The former deals with what it is about human beings that can be scientifically verified and the latter concerns those that cannot be tested in the same way. The first is of course an important knowledge for our claims concerning view of humans. However, it cannot alone constitute the meaning of view of humans. He argues that this concept includes empirically open

theories. These theories say something important that cannot be scientifically tested. Göran Hermerén argues along similar lines as Jeffner. He contends that life views consists of empirical theories like Jeffner’s open theories, speculative (i.e., epistemological theories), a view of science, metaphysical theories, evaluative and normative theories. Malin Löfstedt in her book, Modell Människa eller Människosyn? En analys av kritiska perspektiv på bilden av människan i neoklassisk ekonomisk teori, defines view of humans as: […] Consisting of a number of postulation concerning human beings, which goes beyond fully or partially, what can be empirically verified. (My translation)

It can be observed that common to the above authors is the agreement that the concept of view of humans includes elements that are not empirically provable. Igbo worldviews as I have been employing it in this study can be said to include a particular view of humans. Charles Taylor observes that human beings are living in a moral ontology through which their moral understanding is formed. This is also true of our worldviews. The reason is that they are formed within specific contexts with its values and understandings-geographical, historical and cultural. In this sense, views of humans could be holistic or reductionistic as in B.F Skinner’s psychological theory that claims that human beings can be reduced to his or her behaviour. The latter could be methodological and ontological. What follows now is an analysis of some elements of Igbo worldview or view of life that could be significant to understanding bioethics in their context.

In Igbo worldview, and indeed, among most African worldviews, the human person occupies an important place in the society. The concept of personhood is all encompassing within an African context. It has significant implications on virtually all events of life.

The realities of sickness and healthcare are examples where the concept of personhood plays a significant role.

The Igbo thought on the place of human being strikes a balance between his or her personal identity as a unique individual person and his or her collective identity as a member of a community. The Igbo word for human being is ‘mmadu’. Etymologically, ‘mma’ means goodness while ‘du’ refers to exist, ‘Mmadu’ therefore, means ‘let goodness exist’. Evidently, this word refers to a human being without qualification. Primarily, Igbo thought believes that the human being is a creature of God. This explains the reverential respect shown to him or her. However, Igbo mythology does not emphasise the human person as a creature of God. The reason as earlier observed is that Igbo world is humanistic in orientation.

Engelhardt’s book *The Foundations of Bioethics* defines persons as “entities who are self-conscious, rational, free to choose, and in possession of moral concern”. This definition leads Engelhardt to the conclusion that “fetuses, infants, the profoundly mentally retarded, and the hopelessly comatose” are non-persons, having no “standing in the secular moral community” and falling “outside of the inner sanctum of secular morality.” Engelhardt’s position may be said to be radical and perhaps not representative of western positions or only a form of reductionistic positions within the West. Nevertheless, it may not be denied that western liberal cultures have individualistic tenets, which serve as basis for the various notions of personhood held by different individual writers. Contrasting this Western view of the human person and the African view, Tangwa writes:

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African concept of a person is not in fact and cannot be different from Western concept, unless there is some linguistic problem of translation or interpretation. Both understand the person to be fully self-conscious, rational, free, and self-determining being.

It should be clear from the passage that Tangwa is no cultural relativist. He maintains that African concept of a person is not different from Western concept. It could be said that for him, what defines the human species is the universals of culture not their particularities. Where then does Tangwa locates the apparent difference between the two cultures since each recognises the various developmental stages of human being and the qualitative differences rooted on the degree of attainment of positive human attributes or capacities? Tangwa points out that the difference lies in the fact that the African concept does not draw the same conclusions as are drawn in Western ethical theory. Developing further this observation, he writes that the difference between a mentally retarded individual or an infant and a fully self-conscious, mature, rational, and free individual do not entail, in the African perception, that such an individual is outside the inner sanctum of secular morality. Moreover, such a condition does not imply that they can or should be treated with less moral consideration. Unfortunately, Western notion of personhood is preoccupied with drawing out such a consequence. It is in this regard, that one can argue that African concept of personhood is totally different from the West. The African notion does not make a distinction. It applies to the human being in all its developmental stages and to all its possible conditions. This is the case because Igbo thought rejects the purely materialistic conception of the person that characterises Western conception. In order words, it rejects scientific materialism especially the aspect that denies objectivity to anything that cannot be proved in a laboratory experiment. One should note that the concept of personhood in this sense is not solely determined by its descriptive content, but also by its normative value as understood in African philosophy.

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520 Professor Kwasi Wiredu, who locates the basis of cultural universals in the fundamental biological similarity of all human beings, also supports this view. See Wiredu, Kwasi W, 1980. “A philosophical perspective on the concept of human communication”, *International Social Science Journal*, vol. xxxii, no 2.


522 Distinction is sometimes made between descriptive personhood and normative personhood. I refer to the former as social personhood; by this I mean how a particular culture understands the question of who is a person in that culture. Meanwhile, normative personhood is the ontological fact of being of the human specie without any further description attached.
Nevertheless, Tangwa is careful to point out that qualifying Western thought in this way by no means implies that all Westerners accept or are even aware of this conception. The impression can be that there is only one Western culture. There is diversity even in Western thought as illustrated for example by personalist or communitarian thoughts. However, the point to be noted is that the conception referred to as Western here has had significant influence on legislation in Western countries. To this effect, it should not be difficult to see why referring to it as Western conception can be justified. It is the dominant orientation in the West.

The classification of a person could be along the lines of metaphysical and actual (social) elements of personhood. The former is a formal act of recognising an individual as a person, i.e., conceptual personhood. This is based on the identification of the individual as a member of the human species. The latter is an outline of descriptive characteristics that are required of an individual to merit personhood. It is descriptive of what is required of an individual for personhood. The status of personhood is socially constructed and it varies. This refers to status earned by an individual through personal achievements in the society. This differs from society to society. This is where the humanistic element of African personhood can be located. While all human beings may be recognised as persons in the normative sense, yet normatively, an individual who is socially accorded the status of personhood is expected to actually demonstrate this through his/her achievements in the community. There is an inter-mutual relationship between these two components of personhood and between the individual person and the communal person. Neither of the two can alone be adequate for the attribution of personhood. Personhood within the African culture is not simply defined by the possession of the capacity for autonomous choices through the exercise of rights in isolation from the community. African concept of personhood has both normative and descriptive elements. It has two levels of normative significance.
The ability to act based on rational reflection is therefore a major requirement of the individuals in order to be considered a person.\textsuperscript{523} This characteristic is not only employed to judge the morality of an action, but also to determine the status of the actor’s personhood. However, personhood is not simply derived from outstanding traits such as rationality. Within the Igbo setting, the personhood of an individual is not merely determined by mere existence or psychological state, but also and primarily, by his/her connectedness to the social and cultural network in which one is situated. The individual is defined much in terms of the community to which he or she belongs. Metuh informs us and correctly too, that a person is thought of first as a member of a particular family, kindred, or community.\textsuperscript{524} Africa concept of personhood does not exclude from personhood human beings who have lost permanently or never attained consciousness.

**Personhood in medical decision making**

One of the important principles of western bioethics is autonomy expressed through free and informed consent. This means that decision-making process is an important feature of all bioethical decisions and generally of modern health care. The autonomy of the patient is always at the centre of various models of patient-physician relationship in the clinical encounter. In western societies this model of autonomy is legalistic and stresses disclosure and the patient’s level of understanding. It seems to focus solely on the individual patient and his/her choices. This model apparently gives inadequate account of one of the component features of African concept of personhood. How does the African concept of personhood operate in medical decision making process? In order to address this issue, it is reasonable to explore how decision process operates within an African setting and particularly within African traditional medicine (ATM). The question to be investigated concerns what could be

\textsuperscript{523} Harley, Fluck, Pellegrino, 1992, eds., *African- American Perspectives on Biomedical Ethics*, p 108.

considered as a justified and reasonable ethical decision in the care of patients within the African context.

There is a lot of emphasis placed on self-guarding the rights and wishes of patients. Mason J.K explains that the reason why this is the case is in order to avoid or limit the therapeutic zeal, abuses and unwarranted invasions of human personality. The patient’s rights should always be respected. However, healthcare givers are sometimes confronted with situations such as in the treatment of mentally ill and others that are incompetent. In such cases, it is difficult to know how best to respect the rights of the patient. In African traditional medicine, mentally ill is treated with or without his or her consent. This is understandable because the community plays a significant role in the treatment of the mentally ill and healthcare in general. In this context, the implementation of the respect for personal autonomy is much more deficient. The reason could be the nature of African ethics where decisions concerning healthcare and indeed other important issues of life transcend the individual. These are matters of communal interest.

The western views of autonomy emphasise the primacy of the individual in decision making. Most African cultural context places the individual in a network of relationships with the family and the community. These networks are included in the decision making process. Seen in this way, a competent individual does not abrogate his or her autonomy by letting another family member act as the primary decision-maker in his or her case. In this connection, what is usually practised in most African traditional setting is shared decision-making. It might be argued in addition to other reasons given for the emphasis in most western societies on atomised individual autonomy is the consequence of a culture where human beings no longer want to be their sisters or brothers keeper. It re-echoes the biblical Cain’s question: ‘Am I my brother’s keeper?’ The risk is that truth is imposed and not offered in the dominant model of autonomy in the West. Decision-making should not be imposed on the patient who has a different understanding of decision-making.

process. It is important to let the patient decide whether to make the decision alone or share it with a family member.

In formulating a model that could both respect individual autonomy and at the same time considered ethical within the African setting, the communal person has to be integrated. In his work *African concept of personhood in medical decision-making*, Benedict Faneye has argued and correctly too, that medical decision making in an African context and or for an African requires that all characteristics of personhood be acknowledged. When this is not done, disservice is done to the person of the patient. As Faneye argues, the concept of personhood in Africa already provides a concept of the patient with its own inherent guidelines concerning what would be deemed ethical in the care of patients. The reason as he points out is that this view of the person is not merely an ideal but essentially a notion of which does inform the ethical standards for human interaction. In this regard, what is ethical is what is in conformity with the values and interests at the core of the notion of personhood. Since an ethical treatment of patients is about respecting their person, then treatments or research within the African setting have to respect the communal person.

Within the Igbo worldview, the greatest development of human beings is tied to the service of community, a concept, to which I now explore.

**Person in community**

What and how we use the concept of community is significant to understanding what makes Igbo culture different from Western culture. How are we then to understand the notion of community? Is it to be understood as a cultural, ethnic, geographical or a political group? In its conceptual sense, community is a spirit of communing. “It underlies the ideas of sociality, exchange, intersubjectivity and reciprocity among the members of a given society”. It is a conceptual way of describing corporate relationship. In this sense of community, there is an important element of relatedness, which the

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members share with one another. The concrete expression of the concept of community is found in the family, socio-cultural associations, religious, the state, etc. In Nigeria, the ‘umunna’ is the basic political community. Umunna can mean children of the same parents. In other sense, it could refer to half brothers or sisters in a polygamous family. It can also mean extended families of a putative ancestor. By extension, people of the same town, area, circumscription, or state can also be referred to as ‘umunna’. The community or Igbo ‘umunna’ is foremost a cultural or ethnic community. It could also refer to individuals who are, per force of culture, birth, and place of origin constituted as a community. Africans belong to more than one community; yet all of them belong to a large community called the African community yet, together with other people, to a larger one referred to as the human community.

Perhaps one of the most debated concepts in African literature and possibly in the West is the relationship of the individual to his or her community. Generally, there is the belief by many western and African writers that Africans do not think of themselves as discrete individuals, but rather as understanding themselves as part of a community. This is sometimes referred to as African communalism. John Mbiti is often cited in support of this view: “I am because we are: and since we are, therefore I am.”529 This is partly true and partly false. The reason is that personhood cannot be completely constituted by the community as my arguments will show. Since Mbiti, a number of works have been devoted to either showing on the one hand the nature of African community or on the other maintaining that there is a distinctive African notion of the person or individual.

Concerning the status of person in community in African traditional thought, there are two major views. The first maintains that one is not born a full person at birth. According to this line of thought, full personhood is achieved or earned, not given at birth. The process through which one arrives to full personhood comes through family, clan and community.530 Commenting on this, Ifeanyi

A. Menkiti, a Nigerian philosopher observes, “the African view of man denies that persons can be defined by focusing on this or that physical or psychological characteristic of the lone individual. Rather, man is defined by reference to the environing community.” In defining a person, the emphasis is not on the psychological traits of the individual person, but rather on the community. This is referred to as the processual nature of being in African thought. Menkiti explains further:

The various societies found in traditional African accept this fact that personhood is the sort of thing which has to be attained, and is attained in direct proportion as one participates in communal life through the discharge of the various obligations defined by one’s stations.

There are a few salient points in this text worthy of note. What Menkiti seeks to point out is that a person is one who discharges satisfactorily according to traditions the obligations his or her state in life demands relative to the community. Evidently, the community establishes most of the roles and obligations and all one needs to earn personhood is simply to follow them. This can be said to be a radical form of communitarianism. Accepting this view of individual’s relationship to his or her community in Africa has severe implications on how embryos, fetuses, children, morally handicapped are treated in bioethics. An important question in this regard concerns whether African culture or worldview supports such implications. Unfortunately, the answer would be a resounding no. Why is this the case? One argument that undermines such a view of personhood is the value African culture places on life and its affirmation. The Western distinction between human being and human person is only relevant for the ascription of moral culpability, responsibility rather than for the ascription of moral worth. Human life in all its stages has dignity and therefore worthy of respect.

Menkiti’s model of characterising a person’s moral life has been objected to by a number of African philosophers such as Kwasi


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Wiredu and Kwame Gyekye. Gyekye’s examination and interpretation of African proverbs, folktales, rituals, etc., has led him to advocate equal value for both the person and the community. His studies demonstrate the existence of proverbs and folktales that give support to both. Gyekye refers to this position as ‘moderate or restricted communitarianism.’

Moderate communitarianism as defended by contemporary African philosophers such as Gyekye, Wiredu and Gbadegesin regards society not as an aggregate but rather as community of individuals. For them, personhood carries with it specific moral and ethical qualities even if the accomplishment of this is located within a community. The underlying point in their argument, “is that personhood can only be partly never fully, defined by one’s membership in the cultural community. The most that can be said, then, is that a person is only partly constituted by the community.”

The emphasis is on sensitivity and wellbeing of the community. Rights and responsibilities of the individual within this framework have equal status.

One other interesting point of this view is that persons are capable of individual judgement despite the fact of belonging to a particular community. Gyekye’s reflection challenges our way of thinking on the concept of community particularly in African context. Gyekye is interested in bridging the dichotomy between individual and community and in finding a balance between individuality and communality. Nevertheless, Gyekye’s work in this regard fails to make a distinction between the relationship of individual and community on the level of value and on the level of self-actualisation. These two levels have been collapsed into each other. How does the Igbo Worldview relate to this discussion?

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535 Gyekye, 1995, *An Essay on African philosophical thought: The Akan Conceptual Scheme*. Revised edition, Temple University Press, Philadelphia, Pa, p. 161. The point Gyekye makes here is that rightly understood communitarianism does not devalue or destroy the individual. Although, it maintains that person can be all they can be only in community. We also see this double emphasis on the individual and community in literature dealing with personalism. However, I do not intend to explore this similarity further. It suffices for my purpose just to mention this.
For the Igbo people, ‘Mma’ (good) and ‘Mmadu’ (let goodness exist) can only be realised within the tenets of the community. The reason for this is that “morality in Igbo and indeed African traditional thought is essentially interpersonal and social, with a basis in human well being.”\(^{536}\) In other words, Igbo ethics is based on communal living. Morality and ethics are primarily concerned with human conduct within human communities. Given this, human beings morally constitute themselves not solely through free and rational choice but also through family, kindred, and community. On this note, Igbo like most African peoples tend to define a person in relation to the community he or she belongs. It is in this sense we say that life for the Igbo is a communion of the living, the living-dead, spiritual forces and the rest of the created universe.

In contrast to Western thought that focuses on the individual, Igbo thought does not ignore the web of relationship such as the family and the community that are intimately connected to the individual. By saying that Western thought focuses on the individual, it is not implied that community has no relevance. It is on this note that one should view with suspicion the use of clichés such as ‘Western values are driven by individualism while African values are driven by communalism.’ The fact that one culture emphasises community does not imply that it necessarily deny an individual his or her personal judgement and unique characteristics in community. Obviously, the individual has a moral responsibility towards his or her community. In the same manner, to place priority on unbridled individualism does not entail that the individual is not living in a sort of community no matter how loosely such a community is conceived.

The Igbo person is a member of a particular ‘umunna’ (kindred). It is the individual who is central, but in community. Despite being individualist, Igbo people hold strongly to their community. Perhaps the most abiding principle of value in Igbo thought and system of morality is solidarity, what South Africans call ‘ubuntu’.\(^{537}\) A point


\(^{537}\) ‘Ubuntu’ has been viewed as the basis for a morality of human solidarity, co-operation, compassion, communalism, community, and respect for the dignity of personhood. It is in other words the organising principle of African morality. Ubuntu or humanness refers to a fundamental respect to human nature as a whole. It is a social ethic, a unifying vision captured in the Zulu maxim ‘umuntu ngumuntu ngabanye’ (‘one is a person through others’).
which demonstrates this is the fact that wherever the Igbo people are found, they always form Igbo community be it in Nigeria, in other African countries, or any other part of the globe. Here in Sweden, the Igbo people refer to their community as ‘umunna’. There are ‘umunna’ groups both in Stockholm and in Gothenburg.

From the foregoing, it is clear that the individual is not submerged in his or her community. I think the point of contention here is the undue emphasis placed by Western culture on rights of the individual to the detriment of his or her obligations and responsibility towards the community.

The liberal individualist may be sceptical to this ideal and contend that it threatens individual autonomy. This objection can be met by pointing out that far from endangering it, it presupposes it. The difficulty with the liberal view is that it takes as its starting point the view that people must be viewed as individuals rather than as members of communities. Given this backdrop, only individuals count. Evidently, this is based on a false ontology as it ignores the fact that community membership and shared cultural values are important to individuals and are instrumental in shaping individual values and personalities. It fails to reflect the fact that individual identities are in a fundamental sense socially constructed. Contemporary liberal theories emphasise neutrality that is the view that the function of the State is to provide a neutral framework within which different and potentially conflicting conceptions of the good can be pursued. Will Kymlicka argues and correctly that “liberal neutrality is incapable of guaranteeing the existence of pluralistic culture which provides people with the range of options necessary for meaningful individual choice.” It is difficult to see how individual’s capacity choice can be meaningful and self-sufficient outside the context of community. As Joseph Raz points out neutrality of the State is likely to undermine the chances of survival of many of our cherished cultural values. The reason is that self-

fulfilment and the working out of personal identity are likely to fail without them being at the same time a communal affair.

For the Igbo, all moral principles must be evaluated based on how well they serve the wellbeing of the individual, the family and the community. We may, therefore, characterise Igbo ethics as humanistic. Obviously, this demonstrates its communitarian orientation. One may argue that this is not unique to the Igbo or Africans. Of course, that is correct. However, it may rightly be argued that the dominant bent of western ethics is technology-centred rather than humanistic. Science, technology, and commerce primarily detect moral and ethical thinking and rethinking in most western societies. The Igbo way of conceiving of a human being and community seem to resonate better with our ordinary moral intuitions and sensibilities. Thus, it is a more satisfactory framework for the protection of the dignity of human life. An objection that might be raised about this picture of African ethics concerns how one reconcile this ideal of African sense for community, compassion, kindness, openness, solidarity, respect, hospitality and sensibility with the waves of horrible forms of brutality, human rights abuse, and corruption.541

It is important to note that the tension between individual and community arises because of inadequate clarification concerning different levels of conceptualisation in discussing individual and his relationship to community. Most of the writers set or accepts a distinct opposition between individual and community that is not only Western but also foreign to African culture. The point is that distinction is not made between the level of value and that of individual actualisation.542 In the former, there should be no doubt that the individual in relation to community has a unique and personal value that must at all time be respected. On the other hand, individuals cannot actualise or realise self without the community. The community is the centre of all his or her activities. In the light of

541 I do not intend to delve into this problem. See Innocent I. Asouzu’s The Method and Principles of Complementary Reflection in and Beyond African Philosophy, 2004, Calabar University Press, Calabar. In this book, he identifies the problem as arising from the phenomenon of ambivalence of human existential situation. I am inclined to subscribe to his explanatory paradigm to this problem.

this, the understanding of individual full humanhood is only possible within community. On the level of self-actualisation, that is to say on the question of how individual constitutes himself or herself, the community can be said to be primary since we achieve no actualisation as individuals, whereas on the level of value, individual enjoys primacy.

However, there is a sense in which liberals should be taken seriously. For example, if it is correct that Igbo ethics is solely community focused, there is then the difficulty as to how such an ethics can give adequate response to the challenge to growth in personal unity, integrity, and dignity. Further, liberal positions indicate an effective motivational source for good action and it is remarkable for its emphasis on respect.

Having investigated these elements of Igbo or as the case may be African worldview; the question that remains concern how one can engage culture in the practice of medicine. In this respect there is need for healthcare professional to recognise the importance of understanding patients’ cultural frames when for example taking histories and deciding about patient care. They can improve their skills in this area by improving their skill of listening, opening to other cultures and by acknowledging the basis of their own beliefs and assumptions. These will help them in seeing both the commonalities of shared human experiences as well as the differences.

Conclusion

I have sought to demonstrate with examples drawn from the West and Asia that the theory and practice of bioethics is related to culture in an important way. What is clear from this discussion is that culture has an important role in the project of bioethics and pluralism describes better the nature of things as they are in the world. The idea has been to show cultural realities of the Igbo and by extension African peoples that must be considered for a fruitful practice of bioethics among them. Igbo or African ethics in general is foremost anthropocentric, dynamic and open to changes. It is also clear in Igbo traditional thought that the community is involved in the process of
the individual’s journey toward full humanity. I have argued for an ethic of person in community rather than an ethic of community or an ethic of individual. The individual and the community are equally important and their rights and obligations go hand in hand in any moral deliberation. In relation to Western culture, it has shown that there are values in other cultures, which do not support the applicability of Western individualist autonomy or right dominated approach to ethical issues in health care. The values of family, personal relationship, solidarity, compassion, respect and care for elders, hospitality give birth to significant differences in the ways the principles of bioethics are understood and interpreted. Furthermore, it has been shown that the Igbo conceptions of disease, health, personhood, decision making process and cause are crucial for any resolution of bioethical or medical problems. This framework appreciates reasonably the full contribution of group membership to the development of individuality. Generally, the view has been that Igbo thought and in deed African thought presents us with a conception of persons and human community that could enrich and offer a holistic view of what it means to be a human being in a pluralist world. Having discussed some of the conceptual schemes significant for bioethics in the context of the Igbo and in deed most African cultures, we are now in a position to explore how we can articulate a bioethical framework from an African perspective.
7. Framework for a Possible African Bioethics

One of the conclusions that might be drawn from the preceding chapter is the point that the formulation of bioethical principles should start within a specific context. It should also account for the differences in ethical values that obtain across cultures. Current approaches in bioethics tend to overlook the multicultural social context within which contemporary ethical issues emerge. Within bioethics, the particularities of culture, ethnicity, and language are what make illness a unique experience for each person. True healing takes place only when all these elements are taken into account in health care. The view in this connection is that bioethics should be, contextual, pluralistic and respect cultural diversity.

The idea is that the concept of culture embraces facts and values and makes the identification of common elements across diverse communities and people possible. Furthermore, it implies that reasonable beliefs about the good and the true possibly take a plurality of forms. I should add in this respect that we require more than one scheme of framework to truly see the world. In the light of this, bioethics in African context should have its own ethnological, cultural, and philosophical basis. Against this background, African bioethics may differ from Western bioethics. This chapter will try to articulate what could be an appropriate framework for bioethics in an African context.

543 An objection that could be raised against the recent UNESCO Universal Draft Declaration on Bioethics and Human Rights 2005, is its apparent view that various cultures or people can reach trans-cultural judgements having moral authority about health, science and technology.
545 Pellegrino and Thomasma, 1997, Helping and Healing, Georgetown University Press, Washington D.C.

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This chapter consists of two parts. The first part explores the project of bioethics within an African context using the basic elements of Igbo worldview and philosophy discovered in the last chapter. What could constitute a framework for African bioethics may differ from country to country and even from individual to individual. However, what I attempt to articulate here, largely are characteristics that could be considered basic for most Sub-Sahara African countries. In the second part, I will critically examine what could be common characteristics between my framework and Western bioethics and in particular the frameworks of the three major works that have been analysed in this study.

**Why an ethical framework?**

What do we mean when we speak of bioethical framework? In this study, framework is to be understood as a system that informs all bioethical practices and choices. It is intended to guide us in the ethical evaluations of the actions, decisions and policies of individuals, groups and organisations. Framework, as I construe the term, is used to characterise a way of reflecting about bioethical questions, not primarily to formulate action guide principles for dealing with them. This is something my framework shares with non-principle approaches to bioethics such as: virtue ethics, communitarian ethics, and casuistic ethics. I should add, however, that the framework I have arrived at also incorporates three principles that could be important in deliberating on bioethical conflicts within the African context. It is to form the ground for the articulation of the duties, obligations, and expectations of those involved in making bioethical decisions. These principles are understood as basic considerations in the African context that could give rise to a more specified set of principles when dealing with different issues such as reproductive technology, research involving human participants, genetic manipulation and germline enhancement, ethics at the beginning and end of life. Given this description, it should be then a consistent and comprehensive theoretical foundation for ethics. An ethical framework that pays attention to the African reality becomes all the more important because conflicts in bioethics is less conflicts
among beneficence, nonmaleficence, autonomy, and justice as it is about the meaning of life for the community and the individual patient. It also deals with phenomenological account of how people conceptualise value, the good life, moral virtues and obligations.546

In Europe and North America, principle-based ethics has moulded bioethics largely.547 In the same manner, Beauchamp’s and Childress’s four principles of bioethics are primarily individual oriented.548 Principlism is proving to be the most influential approach in contemporary bioethics, and despite its weaknesses, it is being adopted by one country after another549 even by African countries.550 Yet these bioethical rules and principles that claim universal validity do not resonate with the holistic view held by African cultures and most other non-western cultures. However, some writers have suggested we dispense entirely with principles.551 The reason is their tendency to oversimplify moral problems, and their excessive claim to universality. As much as I agree that bioethical frameworks need not necessarily be principle based, yet, an adequate bioethical theory should embrace universalisable moral principles as long as such principles are articulated in such a way as to reflect the relational context of individual lives. Moral principles have virtues that we should not simply dismiss. They provide a sound and useful framework for analysing moral conflicts. They help physicians and other health professionals to make decisions when reflecting on moral issues they encounter in their work. They offer a common

546 This is one of the features this framework shares with Beyond a Western bioethics: voices from the developing world edited by Angeles Tan Alora & Josephine M Lumitao.
548 Ren-Zong Qiu, 1993, What has bioethics to offer the developing countries, in Bioethics 7 (2-3) 108-125.
550 Ugandan within the context of End of Life Care has chosen the framework of the Four Principles approach to health care for global ethical analysis. Cf., International Observatory on End of Life Care 2005 report on Ugandan.
551 Followers of Nel Nodding have advocated this approach. For them, bioethics should be approached through narrative case-specific framework. Other such as Nelson is sceptical to this approach, but are convinced that the narrative approach has useful bioethical implications. See Nelson H. L., Damaged Identities, Narrative Repair, Ithaca N.Y., Cornell University Press.
basic moral language, clarity, simplicity and universalisable framework for moral thinking. The reason why I suggest universalisable moral principles is that I am convinced that it is possible to identify a set of non-relative elements, which relate to universal human experience no matter how ‘thin’ they may be such as birth, illness, love, and death. They are thin because they are expressed differently in different cultures and history. Martha Nussbaum refers to these as non-optional events.\footnote{Nussbaum M, 1988, “Non-relative virtues: an Aristotelian approach”, in French P, Uehling TE Jr, Wettstein HK, eds. Ethical theory, character, and virtue.}

The basic question here would concern whether it is possible to articulate a structure of ethical framework that could be employed to support discourse within which positions could be justified. To embark on this task would require an identification of values that are congruent with African context. This presupposes of course that it is possible to identify framework within which competing perspectives might be argued with shared understanding. Ethical framework in the context of bioethics provides guidance for resolving bioethical conflicts. There are many reasons why formulating a bioethical framework from an African perspective is necessary. For my purpose, three of these seem most important.

- We have difficulty dealing with the new set of questions arising from science and technology, particularly biosciences.

- Mainstream bioethical frameworks are not sufficiently sensitive to cultural realities in issues of health and health care outside the West.

- Africans have different concerns and problems in the area of bioethics that require a framework that is congruent with their cultural realities.

In the light of the foregoing, an acceptable framework for African bioethics should consider the following.\footnote{These concerns have been addressed in chapter 6.}
1. The significance of cultural views on health, health care, illness, suffering, decision-making process, personhood, community, death, and dying.
2. Address the problem of the universality and relativity of ethical principles.
3. The relationship between the individual and community in ethical decision-making in health care.

Relationship to Western bioethics

There is today a common trend to contrast Western bioethics with non-western bioethics such as that of Asia. While it is reasonable to do such a comparison, it should be borne in mind that ‘Western bioethics’ is itself not a unified whole. Within Western bioethics, contrast is also made between American autonomy-based approaches and European bioethics. Furthermore, different approaches can also be identified within European bioethics. Donald L. Dickson has identified three major voices within European bioethics.\footnote{Dickson D, 1999, “cross-cultural issues in European bioethics,” Bioethics 13: 3(4): 250-55.} They include: the deontological codes of Southern Europe; the liberal, rights based models of Western Europe; and the social welfarist model in Scandinavian countries. This of course raises obvious questions concerning the possibility of a common bioethics. Does a common bioethics in this sense mean searching for, or promoting lowest common denominator, homogenised bioethics? If there are many voices within Western bioethics, how reasonable or desirable is the contrast between it and other non-western bioethics such as African or Asian bioethics? Definitive answers cannot be given these difficult questions now. However, it suffices to show why such a project is necessary and even desirable.

Many Asian and Latin American bioethicists have used the concepts of identity and authenticity to show why it is important to make contrast in this field.\footnote{The idea of identity and authenticity imply a responsibility to live our lives in agreement with the values that constitute our unique cultural perspective. If authenticity is a real value,} They argue that there is need to assert
their respective identities in the light of the dominance of Western concepts in mainstream bioethics as is evident in bioethics literature. The crucial question concerns whether non-western bioethics ought to employ the same assumption, theories, methods, concepts, principles or approaches as Western bioethics, or ought non-western bioethics reflect their own peculiar features to the subject?556

The starting point for such a work surely is the criticism of the emphasis on abstract autonomy universal norms and framework of allegedly universal moral norms that have dominated bioethical theory. This means that our framework should critically examine the analytic methods of Anglo-American Philosophy that have been employed to answer bioethical questions. Such an ethic should move away from the “Western understanding of autonomy as self-defining, self-interested, and self-protecting, as if the self were simply some kind of property to be preserved”.557 It should draw from an ethics of care, communitarian ethics, and virtue ethics. These approaches integrate autonomy-based approach key concerns within a more comprehensive moral framework that is sensitive to solidarity and justice questions that are significant to African situation given the scarcity of medical resources and economic handicaps of most African countries. Ruth Groenhout has shown that an ethic of care and virtue theory perspective provides a fruitful theoretical perspective for bioethical issues.558

Is there an African bioethics?

This question might interest both Africans and non-Africans especially the West. However, my purpose is not to give an answer

556 Sakamoto H, 1995, “New initiatives in East Asian Bioethics”, Eubios Journal of Asian and International Bioethics, 5, p 30 gives a response to this question in connection with the brain death debate in Japan. He observes that the discourses touch on aspects that may be peculiar to Japanese.


as to explore what could distinguish or qualify bioethics as African. This aim presupposes two things. First, African bioethics must be peculiar. Second, African bioethics must be common to Africans. These two issues raise further questions. Does being peculiar entail that these distinguishing features are not shared with non-African bioethics? Is there really a bioethics that is common to Africans?

How much peculiarity and commonality can be expected, given the earlier observation that there is no one single African culture but cultures? There is the existence of variations, different orientations and divergent visions across African countries. The implication is that if there are no peculiar features distinguishing African bioethics from others, and no shared commonality in African experience, it is, then, not worth speaking of African bioethics. Where then lies the distinguishing feature of Western and African bioethics?

The central concept in western political philosophy is the notion of individual freedom. It is upon this that the principle of right is grounded. This is understood as the starting point both for the understanding of human relations and society, and for defining and justifying other concepts, such as justice, obligation, and rights. Western society is based on the values of liberal tradition and the essential ethical principles are derived from values such as autonomy and respect for democratic traditions. This tradition gives primacy to rights over the good. Given this, it can be said that many of the assumptions implicit in Western autonomy-based approach could be foreign to many non-western cultures such as Africa. A major characteristic of bioethics in the West is that it is dominated by a rights approach. Most of the ethical problems are couched in the language of rights such as human rights, individual rights, woman right, patient’s right, embryo’s right, foetus’s right, children’s’ right, animal right, right of the dead and so forth. Because of this, little or no attention is paid to the meaning of life and common good. The outcome of this is an ethic that is severed from a sense of ultimate

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559 See introduction.
orientation, that is, an ethic without a telos. Human life in this sense is no longer seen from a holistic perspective. This right language seems to be congruent with an individualistic orientation. In contrast, Igbo culture and most African cultures emphasise the interdependence of individuals, family and community.

Another feature of Western bioethics is the tendency to look at technology as a ‘saviour’ a sort of ‘messiah’ that can solve all problems. Generally, whatever is technologically possible, it is often believed ought to also be done. There is in this sense a technological imperative. In many quarters, many do no see the gap between the promises of technology and the limits of the same. Biomedical technology has made serious improvements in diagnosis, therapy, and prevention of diseases. At the same time, it has raised many questions and problems that it cannot resolve. It is unreasonable to think that biotechnology can solve all human health care needs. The finitude of human life has to be acknowledged.\footnote{Callahan, D, 1990, \textit{What Kind of Life: The Limits of Medical Progress}. See also Engelhardt, T. 1991, “Medical ethics for the 21\textsuperscript{st} century”, \textit{JACC} 18, 303-307.}

The fact that Africa has in addition to the common issues in bioethics peculiar African problems makes crucial the search for a framework congruent with her cultural perspective. Of vital importance is the discovery of comparative bioethics that the core assumptions and values of mainstream bioethics are not shared by other non American- European cultures. If this is correct, it might be argued that the project of a global bioethics is not only impossible but also undesirable. In commenting on the need for African bioethics Temidayo Ogundiran, a physician and bioethicist notes:

\begin{quote}
[---] it is imperative that African bioethics must involve which should take cognisance of its unique needs and circumstances and which, though amenable to improvement as a result of continuing interactions with other cultures and values, yet is not overshadowed by those influences.\footnote{Ogundiran T, 2004, “Enhancing the African bioethics initiative”, \textit{BMC Medical Education}, 4: 21.}
\end{quote}

This passage highlights the need for an African perspective. However, whatever differences there might be, between African bioethics and non African bioethics, there is no doubt that the fundamental issue in all these frameworks is the value and dignity of human life. In each framework, there is an implicit if not explicit
commitment to protecting human dignity. This is what is common to all approaches. Yet, what is different is how this concern for dignity is formulated and applied in particular cultures. What follows is how this could be engaged within an African context. It is now time to turn to this question by first exploring what could constitute the theoretical basis for such a framework.

**African Perspective on bioethical theory**

It is important to recognise that individuals live within particular societies, whose cultural assumptions and practices shape their understanding of themselves and other. This is as much as true of African as it is of Europe and North America. It has been shown that the values and beliefs present in American or Western bioethics represent a particular cultural view of a section of the world. The conceptual framework has given priority to individualism, thereby underscoring the principles of individual rights, autonomy, and self-determination. Unfortunately, these cultural attributes have been taken for granted and have been regarded as being trans-cultural. For example, the emphasis that is given to the principle of autonomy in Western bioethics is not found in the same manner and degree in non-western cultures in the context of healthcare. This raises a serious question concerning the validity or legitimacy of the principle of autonomy as it is understood in the West being the basis of health care relationship between caregivers and patients and the public.

There is the tendency among bioethicists and physicians to reduce autonomy to informed consent within a given set of alternatives that are presented to patients. It is not clear what the relationship is between the acceptance of autonomy as an ethical principle and the question of what is to be done in a given concrete case. How do we explain the primacy given to the four bioethical principles advocated for by Beauchamp and Childress? Why can we not place more emphasis on the values of community, solidarity,

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565 See Nuffield Council of Bioethics, 2002, “The Ethics of research related to healthcare in developing countries”.

566 Even within the North American context, it cannot be said to represent all groups and subcultures that characterise the American life.
respect for life, and common good rather than on the principles often favoured in western bioethics? Writers like Raanan Gillon would like us to accept the purported claim that the four principles given scope, can account for all our moral worries and apply straightforwardly to all situations and contexts. Gillon contends that any other moral principle or value can be explained by one or some combination of the four principles.

Within the U.S., for instance, bioethics has adapted to the commodification of health care, which is alien to African culture and value system. This issue is illustrated by the HIV/AIDS crisis in Africa. How can we explain the death of millions of people dying from this epidemic because other human beings have made retrovirus drugs that could help prolong their lives unaffordable? As we saw in chapter six, traditional Igbo culture placed high value on human health. Within such a context, health care was within the reach of everyone, poor or rich. The only condition for access to health care was that one was ill. In the light of this, how do we understand the number of people who die from communicable diseases that could easily be checked? This shows that issues relating to social justice between developed and developing worlds are largely overlooked in formulating universal principles and policy formulations in bioethics. The danger is that abstract principles are often not sensitive to the fact that universal value commitments emerge out of particular historical and geographical locations. It tends to forget that the practical conflicts of bioethics often presuppose common questions of the meaning about human nature, suffering, dying and human destiny. These issues have different significances in different religions and cultures.

In this context, there is need to search for compatible moral grounding for bioethics that resonates with African lived experience. Obviously, such a search could lead to different directions. Yet, there are common elements drawn from African experience that should constitute the bedrock of such a project. In the light of these, it is important, then, to explore what an appropriate framework for an African bioethics could be and how such could contribute to the

debate on common bioethical framework. Though there is variety in African culture, yet they share significant commonalities, both in their worldview and in what the dominant structures of their life are as we earlier observed. These values provide an interpretative framework helpful in deliberating on most of the issues in bioethics. This explains the reason d’être for involving African experience in all its diversity, plurality and complexity in the bioethical project.

*The Principles of Biomedical Ethics* by Tom L Beauchamp and James F Childress as we have seen has had tremendous impact on the development of bioethics through their American common morality theory which advocates four principles: respect for autonomy; non-maleficence; beneficence, and justice. These four principles are not adequate for bioethics in general and cross-cultural bioethics in particular. The difficulty I have with the four principles is that they have an individualistic basis that is not congruent with African life. In this respect, they are not suitable to answer the questions about appropriate needs of communities. Autonomy is given a place of honour among the four principles. In examining concrete cases, one observes that conflict exists mainly between autonomy and the other three principles. The reason is that these other principles are interpreted and applied in such a way that minimum damage is done to a person’s autonomy. The four principles make claims that they are not able to justify. They suggest that we can resolve bioethical problems effectively by calculating the benefit and harm ratio of a chosen action, yet they do not provide us with adequate method for making this complex judgement. They are focused more on the socio-legal dimension than on how people actually deliberate on moral issues. Based on the foregoing, I suggest that a different framework or set of ethical principles could be suitable in some other cultural contexts in dealing with some bioethical conflicts in areas like genetics. Therefore, the different normative methods are seen as complimentary to one another. Complementarity in this sense is a holistic methodology and it concerns the epistemological character of perception. In this connection, what would an African bioethics entail?
Principles of African bioethics

In this section, an attempt will be made to explore some dominant philosophical ideas derivable from Igbo worldview discussed in the last chapter. The exploration of this is obviously important for this study. This is because the daily life, values and attitudes of the Igbo are direct offshoot of their dominant philosophical ideas. In addition, ethical principles, which are congruent with this worldview, are derivable from these ideas. Question may be raised concerning what constitute a distinctive African bioethics. African bioethics is distinctive insofar as treatments of bioethical issues are grounded in African worldview and conceptual framework. By this is meant an approach that draws on African culture and value system. In order to proceed with this task, it is important to delineate the criteria for such a framework. Drawing from preceding discussions, the following criteria adequately serve my purpose for the articulation of an African bioethics: (i) It should be internally consistent. (ii) African bioethics should be based on African worldview. (iii) It should cohere with basic moral sense after reflection. (iv) It should be African values that generate principles as practical guidelines for action in concrete cases (vi) It should be pluralistic. It is a consensus building approach in terms of method. These values can be said to express the main features of African life:

- Humanity
- Community
- Morality

The reason for these three values is that they in a special way capture the organisation of the worldview of the Igbo or indeed most African peoples. Humanity in this framework is the first object of respect. All other values are enjoyed because one is human. In this sense, humanity means that all humans have dignity. Lennart Nordenfelt gives an interesting analysis of four notions of dignity\footnote{Nordenfelt L, 2004, “The varieties of Dignity,” in Health Care Analysis 12(2): 69-81.} namely: 1) dignity of \textit{Menschenwürde} that pertains to all human beings to the same extent and cannot be lost as long as the persons exist. 2)
Dignity of merit, which depends on the social status and formal positions of the individual in life. This kind of dignity can come and go. 3) Moral dignity, which depends on the moral standing of the persons. One loses moral authority when one behaves in a way unbecoming of the positions or status in life. 4) Dignity of identity depends on the integrity of the subject’s mind and body. It is sometimes tied to the subject’s self image and can come and go because of the actions of others. These notions of dignity help us to understand both the complexities of the term, and the moral intuitions that underpin their use. In another study, Nordenfelt points out that these four notions of dignity are all important in health care. However, the first two of them are of special relevance.

The term dignity features often in ethics and international documents such as the Universal Declaration of Human Rights, approved by the General assembly of the United Nations on 10th December 1948, UNESCO’s Universal Declaration on the Genome and Human Rights and Council of Europe’s Bioethics Convention 1997. The first article of UN states: “All human beings are born free, equal in dignity and human rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.” The UNESCO document says that research on human genome must respect human dignity, freedom and human rights. The term dignity is also seen in the latest version of the Swedish Law Hälso- och sjukvårdslagen 2000. In the second paragraph, it says that health care must be given with respect to human equality and dignity. Without sharing in humanity, a generic term, there can be no talk about human dignity. The sense of dignity that captures Igbo notion of humanity is Menchenwürde.

Community is the consequence of the social and communal nature of human life. Community is also the spirit of communing and highlights the interdependence nature of being human. No one is an island. We are born into a family and into a concrete community. It is within the community that the last three kinds of dignity in Nordenfelt’s analysis are experienced.

571 UN, 1948, Universal Declaration of Human Rights, article 1.
572 SOU 2000, Hälso- och sjukvårdslagen, para 2.
Morality arises within the community when we encounter one another in relation to the different interests and values that we may have reason to desire or defend. In a fundamental sense, it pertains to how the dignity of human life both as experienced in humanity and in individual lives is protected in the web of human interactions. These three are the fundamental values or first level principles from which mid-level principles could be derived within the Igbo context.\(^{573}\)

I have arrived at these fundamental values of Igbo worldview from the analysis in the preceding chapter. My position is that a framework that emphasises these elements would be a coherent approach that resonates with African worldviews, cultures and value systems. Furthermore, human life within the African context can best be protected within such a framework. These values in combination can justify substantive and universalisable moral principles and norms of health care ethics within the African context. The discovery of ‘self’ and the presence of the ‘other’ create a relationship which brings with it the awareness that both the self and the other are moral agents and subjects, that is a being that is responsible and accountable for his or her conduct. The high value placed on morality by the Igbo people confers on ‘Ala’ the highest place among the deities as the custodian of morality.

I should now turn my attention to this project using African perspective on bioethical theory to provide further insight on how bioethical discourse can be engaged in a pluralistic society. This project calls for a broad understanding of ethics, which understands morality not only as studies of action motivating and guiding principles and theories but also as embracing the formation of human life. This is why a reasonable holistic approach is inevitable. Three elements are needed in a full normative medical ethical theory. They include a theory of values, a theory of virtue and a theory of principles. It is difficult to ground the first two in a universal

\(^{573}\) First level principles anchor the philosophical suppositions that support middle-level principles or moral rules. Middle level principles are situated between first level principles and moral rules. According to Edward Keyserlingk W, their function is “to establish parameters and priorities for debates and decision-making involving human life and to judge and test moral rules”. Keyserlingk, 1979. Sanctity of Life or Quality of Life in the context of Ethics, Medicine and Law. Protection of Life Series. A study written for the Law Reform of Canada, Ottawa, Ministry of Supply and Services.
foundation. As for the third one, it is not only desirable but also essential to do so.\textsuperscript{574} This is the challenge that confronts bioethics today. Most ethicists are concerned about the future of bioethics, and argue the first item on the agenda of bioethical discussion for the next century is:

To decide whether bioethics will be authentically an enterprise of ethics, or instead, it will become an amorphous expanding universe of preferences, opinions, feelings, or value choices filled with exquisite existential detail but enfeebled by lack of normative content.\textsuperscript{575}

I suppose by calling for a bioethics that is genuine ethics, it presupposes that bioethics cannot be a project without value orientation. In order to realise this vision, there is need for an ethical framework in given contexts that not only is accessible to others but could also be acceptable to most people given similar context. This obviously suggests that there could be many frameworks arising from different cultural realities provided they are compatible with the basic commitment to human dignity and respect due to her.

Ethics is fundamentally grounded on the views of human life. This means that views of humans that take seriously the human subject-in-relationship, especially in relationship to the ‘other’ offer the possibility for a shared framework in bioethics. For example, the African notion of personhood is not merely an ideal but essentially a view of person that informs the ethical standards of human interactions within the African setting. If the purpose of bioethics is to provide for the best way to protect human life, it must then take account of the needs and rights of the people involved in moral decision, their cultural and social milieu. This means that it has to be reflexive of the community or context where it is employed. It is just to the extent it reflects the values and beliefs of those making the

\textsuperscript{574}There is no universal account of the good that everyone should be expected to accept. For some the good is whatever someone prefers or whatever satisfies desires (preference and satisfaction theories) For some helpful readings see DeGrazia, David, 1995, “Value theory and the best interests Standard”, *Bioethics* 9: 50-61; Gert, Bernard, 1990, “Rationality, Human nature, and Lists”. *Ethics* 100:279-300; Parfit, Derek, 1984, “What makes someone’s life Go Best”, Reasons and Persons, pp 493-503.

decision and those affected by the decision. Without relating to the background values of the general society, and the particular communities or contexts, where it is to be deployed, then its ethicality is in question. This is why it is important that the values outlined in the framework resonate with the context it serves. This would suggest that the quality of human wellbeing is determined in large degree by our success or failure in the pursuit of our goals and that our goals are formed within existing social forms.576

The major problems confronting Africa according to C. Olweny are ethics of scarcity577 and poor leadership. He contends that contemporary issues such as euthanasia, surrogate motherhood, organ transplantation and gene therapy that occupy bioethicists in the West are, for the moment irrelevant in most developing countries. While different bioethical problems confront different countries or cultures, it is incorrect to say that these issues are irrelevant now.578 The reason is that every human problem has also a global perspective in such a way that makes the problem of one country indirectly the problem of others. The challenge is not so much how one uses technology and its implications and consequences to human conduct, as it is how to have access to scarce medical resources, that is, the question of how society fairly delivers health care to different classes of people. Yet, the dignity due to human beings seems to be a common feature of most bioethical analysis. In any bioethical decision, this moral value is fundamental. In this context and in the light of the analysis of Igbo worldview, it would seem that a bioethics of scarcity is called for to address these inequalities in health care delivery. In line with the foregoing, principles of bioethics within an African context would tend to lay emphasis on the following principles,

578 The assumption that biotechnology is irrelevant to the health needs of the world’s poor or developing countries has been challenged by the results of some studies on the applicabilities of biotechnologies in developing countries. The survey was carried out by Abdallah S. Daar, Halla Thorsteinsdottir, Douglas K. Martin, Alyna C. Smith, Shauna Nast & Peter Singer which identified ten top biotechnologies for improving health in developing countries, *Nature genetics*, 2002, vol. 32.
1. Respect for life
2. Solidarity
3. Justice in health care

It is interesting to inquire into the relationship between the earlier three values argued for as the fundamental elements of Igbo worldview and the present three principles. Let me say that I cannot discuss in detail the relationship between them in this study. It would require a great deal of conceptual reconstruction and line drawing. For example, it would entail demonstrating why humanity, community, and morality are values and what kind of values they are. The later would mean drawing an axiology of values. Likewise, we would have to consider how these values are related to bioethical conflicts. There is, however, one distinction that I particularly find crucial. This is the one between the first three values as first principles and the last three as midlevel principles. There is always a starting point or ultimate premise in moral deliberation. It entails some leap in order to get off the ground. No reason can judge these starting points without begging the question. The first three values serve as our ultimate premise within the African setting. Whereas we can argue for or against the midlevel principle of respect for life, solidarity and justice in relation to their appropriateness in bioethics and health care, we may not do the same with our fundamental premise, the first principles of our discussion.

I will proceed by exploring what each of these midlevel principle means in the concrete and how they relate to one another. I then compare them with the three main frameworks presented in chapters 3, 4, and 5. Then the question of what this framework could contribute to common bioethics will be examined. It is significant to note from the onset that these principles are formulated as prima facie principles. That means that they are not absolute and stand in no lexical order to each other. They are not universal principles in the sense of applying in equal degree to non-African cultures. They are primarily principles that would seem to resonate with the moral experience of the African people in their current stage of development in health care services. At the same time, they are universalisable principles because their importance could be
recognised in most cultures and contexts. The difference is that within the African context they gain special importance because of the unique African experience of reality and the communal nature of political organisation. The formulation of these principles in this way helps us avoid ethical relativism on the one hand and moral imperialism on the other, the latter being the view that its view is the one and only correct way to doing bioethics. In what follows, attempt will be made to outline the nature of these principles in bioethical decision making context within an African context.

Respect for life

We saw from the preceding chapter that this is a fundamental feature of Igbo worldview. The Igbo say ‘Ndu bu isi’ (life first). In Igbo philosophy, much emphasis is placed on the value of human life. It is the heart of values. Because of this, the Igbo go to great length in order to preserve or protect life. It might be said that the traditional Igbo attitude to religion is primarily manipulative, as the worship of divinities was a pragmatic way to ensuring material satisfaction bordering on life, offering and health. It is in this connection that we can understand why the Igbo view childlessness as a threat to life. The reason is that it hits at the very root of the traditional primary value, life.

At the heart of bioethical issues is the question, what is life? What is the meaning of life? So many literatures have tried to answer such questions. Yet, no one has offered any answer that is satisfying to all or at least for most people. It is crucial that a meaningful answer has to be sensitive to how a particular society understands itself both as individuals and as a community. Respect for life is borne out of the fact that each of us is a unique source of value. This respect pertains to the dignity of human life that is the inalienable source of human values. Therefore, it justifies the requirement that we regard each other as worthy of respect. It is significant to observe in this connection that it is human life that is first and foremost the object of respect not some other characteristics defining her such as respect for
persons or the autonomy of persons.\textsuperscript{579} It would mean in this regard that respect for life is not determined by culturally distinct moral views, although various cultures understand this respect based on its context.

What is it in humans as a species that confers on them this high dignity? The traditional Igbo answer would probably be that God gives dignity to humans. Western Philosophy would refer instead to capacities crucial to humans such as the ability to think, self-consciousness, and freedom to decide their own way of life. According to Kant “autonomy is [...] the basis of the dignity of human nature and of every rational nature”.\textsuperscript{580} As I argued earlier in chapters three and four, the arguments of \textit{PBE} and Engelhardt have their bases in attributing to autonomy and rationality the sources of human dignity. The individualism underlying the frameworks of \textit{PBE} and Engelhardt is best observed in the central place they accord to autonomy. Their principles reflect the liberal, individualist culture from which they emerged. If the ground for human dignity is rationality, autonomy and freedom then those humans who do not have them or possess them in diminished degree or have lost them through sickness or old age such as fetuses, babies and the senile can have no dignity. Conversely, non-humans who possess these capacities would have dignity. Within health care context, such a position would be problematic. The reason is that it could legitimate inhuman treatments on those lacking these abilities.

By contrast, the framework I propose does not make the dignity of humans rest on any other factor other than on being human and its transcendence. Human capacities of autonomy or rationality are subject to changes and degrees, but transcendence is not determined in terms of quality of life. However, it is an abstract term much like autonomy and rationality. Unlike them, it does not discriminate between autonomous and non-autonomous persons. It belongs to the third category of Igbo conceptualisation of reality called the abstract.

\textsuperscript{579} Belmont Report advocates a principle of respect for persons. This principle of respect for persons was transformed by Beauchamp and Childress into the principle of respect for autonomy.

Transcendence in this framework has an ontological status and is conferred with independence existence. This also implies that respect is intrinsic to our nature as human beings. The implication of this position is that every human being has a dignity that is intrinsic and that must be protected in spite of her psychological, physical or mental conditions.

In regarding each human being as worthy of respect, we are committing ourselves to be just to them and to treat them respectfully as we would want them to treat us. Among other things, within health care it means that we have to grant equal opportunities of access to the basic health needs of everyone. It equally means that we have to help create conditions that would help them to live worthy and meaningful life. Respect for life entails a duty not to harm the other or his or her interests, which is a duty of nonmaleficence. In this regard, it encompasses not simply physical harm or interference with autonomy, but threats posed to people’s values, social relationships. The principle of respect for life equally implies a duty to positively benefit the other in one’s conduct, which is an obligation to beneficence. This should include an effort to determine what really constitute the good of individuals. Of course, any such project requires community reflection and support. In addition, it enjoins also a duty to respect and be sensitive to the other’s culture.

Among the Igbo human life is sacred. The sacredness of life comes from the fact that it is a gift from God. This means that no one has right to violate it with impunity. It equally implies that human life is inviolable. Interestingly, this respect for human life finds its expression in the ritual of kolanut breaking among the Igbo. This act remains for them the celebration of life aptly captured in the saying ‘onye wetere Oji wetere ndu’ (He who brings kola brings life). It was not by chance perhaps that the first indigenous University, the University of Nigeria, Nsukka has its motto as “To Restore the Dignity of Man”.

The requirement to respect life when overstretched could imply that life is to be preserved at all cost. This makes respect for life all embracing in such a way as to have primacy over other important

581 That motto truly represents the finest articulation of the finest Igbo minds, Dr Ojike, Dr Mbadiwe, Dr Okpara, Dr Akanu Ibiam, and etc the general affirmation of Igbo view on the worth and dignity of man. This remains for the Igbo a vision; a mission and a commitment.
values. There is also the risk that it could be understood as being contrary to the principle of autonomy as it is often times employed by anti-abortionists in the U.S. However, it does respect first and foremost autonomy exercised within a communal framework. The sacrificing of human life for religious purposes and capital punishment to serious offenders against the laws of the land show that life has no absolute value. It could be offered for the greater good of the people. That means that it is subject to trade-offs. In spite of these apparent dangers, the principle of respect for life serves a useful purpose in most cultures in preserving and protecting life. It is the first of all moral convictions that inspire the highest confidence in moral thinking. In order to ensure that the dignity of life is respected we explore another value that makes this possible.

**Solidarity**

Sometimes the principle of solidarity is considered as a principle of justice. Within the African setting, it is much more related to the concept of community or common good. African cultures are normative for any justifiable bioethical resolution within the African context. African culture shapes the character and conduct of Africans and enables communal discernment. The principle of solidarity is a direct implication of the institutional life of the Igbo and indeed most African people, which is communitarian in orientation. I should also add, it is the result of the social and communal nature of human life. The interdependence of Igbo people calls for solidarity, which reflects the awareness of the interdependence of the community and, even of the human family. This realisation of interdependence should give rise to new and broader expression of solidarity, which respects the dignity of all peoples. Solidarity requires equally an awareness and acceptance of co-responsibility for the just development of the community in finding solutions to the problems that beset her. As earlier noted, one of the values that could be said to specifically characterise Africa as far as morality is concerned, is the pursuit for consensus. This is a consensus that builds on the plurality of moral visions of every of her member. For the concept of interdependence to be raised to the moral level, solidarity is a necessity. One way this
could be effected is by recognising that the very reality of interdependence entails that the goods of creation are meant for all. The validity of this principle in African bioethics is one of the fundamental implications of African view of social and political organisation epitomised in the Igbo notion of ‘umunna’. This concept aptly captures the saying: ‘Because we are, I am’. The principle of solidarity enables individuals and communities to take account of the interest of others in their conduct. The principle functions as a moral category that leads to choices that promote and protect the common good. The common good is understood as those social and cultural conditions that empower people to reach their full human potential and to realise their human dignity. Surely, a fundamental common good is the protection of human life and the vital goods of human sustenance, food, water, and shelter. It moves us beyond blind self-interest and private advantage. It also reminds us that we are social beings. For example, it encourages the terminally ill to see the community as participating in their sufferings and pains. In addition, it helps the community to empathise with those who are in need among her members.

The principle of solidarity and the concepts of common good and community are both interrelated. The awareness of interdependence or communal living gives rise to a concern for common good which is achieved in solidarity. It includes the need for greater solidarity with the elderly and sick. This solidarity embraces providing adequate medical attention and palliative care. However, it goes beyond the technical, because our attitude towards others is also a measure of our level of humanity. The erosion of a sense of community results in a decline for common well being. This is also related to the principle of respect for life, which is founded on the worth and value of human life by virtue of her existence. Every human being has an inherent dignity and right to life consistent with that dignity. Equality of all people is the consequence of this essential dignity. It does not depend on ‘quality of life’.

Solidarity understood in this sense goes hand in hand with an equal and important demand for individual responsibility and accountability. This seems to be most congruent with Igbo culture and philosophy with its emphasis on communal living and individual achievement. As we saw earlier, the Igbo are both communitarian
and egalitarian in the pursuit of the goods of life. Applied to health care, the principle of solidarity would require an enforceable right to basic health needs for everyone and for individual contribution in ensuring a healthier society for self and others. Solidarity can serve as a necessary corrective to the abuse of freedom that holds up utility as the supreme moral criterion for humankind. If a community framework is to endure, it must always recognise the solidarity of its members as a fundamental principle and ensure that both advantages and burdens are shared equally and justly among her members.

Now, of course, my account is open to debate. Some may contend that this principle can threaten individual determination. While this may sometimes happen, it does not necessarily follow. We have to recognise that there are legitimate motives for patients to aspire to autonomy such as discouraging paternalism. There is little doubt that respect for individual autonomy expressed by informed consent is an effective way to discourage the danger of paternalism in health care. Nevertheless, it is false to assume that it will lead to a better and more humane health care and solidarity with especially the most vulnerable for example the unborn, children, the sick and the aged. Critics may argue that the principle of solidarity would be weak in answering questions about individual cases. While this point could be legitimate, yet in policy issues, that is in answering questions about the appropriate needs of communities such as germline modification, sale of human organs the principle of solidarity has great merits than individualist based principles such as autonomy. Such a view requires us to focus more on values enshrined in and promoted by our society, and less about individualism and non-interference with scientific innovations and market mechanisms.

**Justice in health care**

Bioethics in African and indeed most developing countries is confronted with the problem of scarcity of medical resources. While this is the problem of most countries, in African it assumes a proportion unimaginable because of the overwhelming poverty of the people. This poverty has in turn generated an atmosphere of corruption and discrimination affecting all sectors of life including
health care provision. The gap between the few rich and the many poor widens every day as the rich become richer and the poor become poorer. This situation challenges the values of solidarity, equal dignity, and freedom of human beings. The perennial problem of poverty not only deprives people of the advantages of technology but even of basic preventive health care. What makes this situation grave is that not only are resources scarce, they are also inequitably distributed as they are usually available only to the rich, thus the problem of resource allocation and distribution.

Many international bodies recognise the right of the individual to the best standard of health attainable, and that there should be no discrimination which would preclude access to the best standard. This challenge suggests that there have to be a guaranteed right to a standard of living for everyone adequate for his or her health and well being. This provision is contained in the *Universal Declaration of Human Rights* (1948) of the United Nations. The *European Social Charter* makes detailed provision for the right of the individual to good health.\textsuperscript{582} Sadly, most African nations are yet to apply this to their people. For example in Nigeria, although there is in principle the policy for the provision of essential health to everyone, but in practice, this is far from the case. Like most other African countries, it is still characterised by gross inequalities in access to health care. This goes back to the question of social justice in Africa. It is important that this inequality is seen as a serious moral problem. The principle of justice in health care within this context calls for a just and fair distribution of basic health services to everyone. This implies that those services should be allocated justly across society, with special provision for the most disadvantaged or most vulnerable to neglect, example, the aged and handicapped.

Theories of justice differ with respect to the material criteria with which they justify their position. Earlier, we observed that these could be utilitarian, communitarian, libertarian or egalitarian. Within the context of our study of Igbo value system, it would seem that communitarian and egalitarian theories of justice would have special appeal. The *PBE* and Engelhardt would seem to understand the reason for treating people justly, or allocating resources to them in an equitable manner is to selfguard their autonomy, ensuring that they

\textsuperscript{582} UN, 1948,*Universal Declaration of Human Rights*. See especially articles 3, 11, & 13.
are not harmed by unjust treatments. Communitarian theories of justice would encourage moral thinking that sees individual people not as lone individuals but as fulfilling themselves only within the life of the community. It is in this sense that it would tend to promote values that are community centred rather than based on individualism. This could be seen as an argument against utilitarianism and liberalism where unity and respect for individual self-determination respectively form the bedrock of moral judgements. In being egalitarian, the Igbo culture respects the right to private ownership and thus extols hardwork. Such a view calls also for equal access to the basic health needs that every human being values. Although egalitarian theory calls for equal distribution of social benefits, yet it does not make this a requirement for justice. This is because inequalities can be permitted when it is to the advantage of the most vulnerable. It is significant to note that the kind of communitarian ethic that is advocated for is a moderate one. Within this context, both the needs of the community and that of the individual are given equal considerations. Interestingly, there is also recognition given to some liberal theories in this scheme. Therefore, an acceptable health care ethics or bioethics should have these features as its foundation.

Like Beauchamp and Childress, I advocate a conception of justice that recognises an enforceable right to a decent minimum of health care for everyone. It is important that distributive justice be given adequate attention because the “problems of distributive justice arise under conditions of scarcity and competition.” However, my principle of justice goes beyond the question of autonomy and utility as to include protecting the vulnerable and to the furtherance of human dignity not based on purported quality of life calculations. It is also a conception of justice rooted in virtues that are extolled in a community. This means in effect that the justice of health care should address inequality of access arising from social, political and economic structures. It entails that imbalances of wealth must be seriously confronted. Corruption and poor leadership must be tackled at their roots. It is ironical that many people are denied access to health care, because of poverty in spite of the dominance of a

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communal ethos of life in Africa. Health care system that guarantees basic health needs of everyone should be a right not a privilege that only a few enjoys. In this connection, the justice of health care within the African context has to be evaluated by its ability to bridge the gap caused by poverty between people by ensuring equal access to basic health services. Distributive justice in the allocation of health care resources can achieve this process. It will not only be concerned with fair distribution of scarce medical resources but also with what constitutes appropriate resources to distribute. In order that such an effort could be realised, one requires a substantive notion of the human good to make justice concrete. In demanding for a right to basic health care, one is underscoring the value and dignity of human life. The view of justice that has been addressed in the foregoing has its basis evidently in the Igbo concepts of human being, human community, common good, and the phenomenon of scarcity of medical resources. It recognises one of the fundamental values of Igbo morality, which is the pursuit of consensus.

Within the global context, inequalities of power and advantage between rich and poor countries, as a moral demand call for the powerful to refrain from exploiting the vulnerability of the weaker especially in the area of research. Fundamental to the concept of justice among the Igbo is the concept of “Egbe bere, Ugo bere” (Let the Eagle perch and the Kite perch or live and let live).

A major question concerns the nature of these principles and how the relate to one another. These three principles satisfy the criteria for justifiable ethical framework listed earlier in this chapter. The principle of respect for human life is consistent and coheres with the core of Igbo worldview on the primacy of life, which gives rise to the dignity of the human person. In turn, it is related to both the principles of solidarity and justice. Fundamental to ethics and bioethics in particular is the problem of justifying or generating reasonable decision process. How then can the three principles of African bioethics inform a justifiable decision-making within the African setting? How are conflicts within these principles reconciled? When in conflict, none of the principles takes precedence over the others. Each one of them is subject to a trade off depending on the context.
However, the principle that is directly related to decision-making process is solidarity. The reason is that it underscores the interdependence of life within the African context and the consensus model of African morality. It entails both the acknowledgements of both the communal person and the individual person. This means that for any decision to be ethical within the African context, it must incorporate these two features. The web of interpersonal relationship particularly that of the family must form part of the decision-making body, otherwise, the person of the patient, is not respected. I will now explore how the bioethical framework I have formulated relates to the frameworks that were identified in the Western theories that have been analysed in this study.

Relationships to the three theories presented

The framework I have formulated shares some common features and dissimilarities with the positions of the authors I have presented in my study.

A basic similarity between Kekes’s position and mine is that both of us hold the view that pluralism of moral vision is a fact of human experience and that in itself it is good. While Kekes tends to regard pluralism as evidence of objectively valid moralities, I think this could only be true at the level of specific practices. A further point on which we agree is that there are shared commonalties among people, values that still look different in various cultures. This is the evidence that fundamental universality and considerable pluralism can coexist in bioethics, whether or not all the theoretical problems have been settled. In the Morality of Pluralism, Kekes is committed to protecting what he calls the “deep conventions” in “morally acceptable traditions”. By this, he means those that set appropriate limits on the making of good lives. Kekes argues for a genuine pluralism while at the same time affirming a common conception of human nature. In this sense, he makes a universal claim. He posits a set of objective primary values that are founded on human nature. While I do not locate my framework on natural law founded on human nature, I do agree with Kekes that we can and rightly so make universal claims in given contexts. In contrast to Kekes, human
nature thus does not emerge as the criterion of African bioethics. Common morality theory that constitutes my theoretical framework does not depend on human nature but on considered judgements of a people. Much like him, I hold the view that good lives necessarily take many forms and are lived in different contexts. This means that there is in deed reasonable beliefs about the good and true, but they take a plurality of forms. In a sense he is right to believe that no specific way of life is the only meaningful way to life.

Engelhardt and I both recognise the serious challenge of pluralism to ethical deliberation. Both of us are also interested in bioethical problems arising from biosciences and biotechnologies. Nevertheless, Engelhardt presents a bioethical framework that recognises the principle of permission as the one and only basis for moral authority. Engelhardt argues that patient autonomy expressed in informed consent is the only philosophically justifiable basis for that can be shared in a pluralist society. This is a contractual theory in as much as the only requirement for those that participate in moral deliberation is their permission. The reason for this is that he regards these participants as moral strangers who do not share anything that could help them reach agreement in moral matters. Engelhardt maintains that our inability to resolve moral conflict is caused by the different moral languages we speak. While it is correct to say that we give different reasons for our moral values from culture to culture, traditions or contexts, it is false to assume that it is impossible for us to agree on at least some criteria for ethical reasoning. For example on the requirement that our reasoning should be congruent with moral experience and that ethical principles should be consistent and cohere with the full range of our moral commitments. Although we belong to different traditions, yet we are not complete moral strangers to one another. For example, we have the capacity to listen and understand one another. That means that cross-cultural or trans-tradition communication is not only possible but it is also desirable. Engelhardt’s framework is concerned with a method for resolving moral conflict and not about the good. For him bioethics becomes equal to negotiating standard that is acceptable to all. He is in this sense pragmatic and gives priority to the right in moral deliberation. It is doubtful whether he succeeds in this venture. Autonomy, which is the basis of the principle of permission or agreement, is not a
neutral concept. It is value loaded. More importantly, bioethics depends upon an understanding of human nature and destiny. In short, it rests upon a worldview. Basil Mitchell has contended and rightly too that

What is needed is an understanding of morality which is capable of being defended at each of the three levels at which moral disputes take place and which can explain how it is that moral considerations have an integrity of their own while yet being open, as they plainly are, to the influence of divergent world-views.  

This observation makes an important point. It means that any worldview, which carries with it important implications for the understanding of humans and their place in the universe, would yield its distinctive insights into the scope, character, and content of morality. The Igbo worldview or indeed African worldview cannot be said to have the same worldview as the West. It means then that different worldviews have different implications for bioethics. This model of thinking assumes that our standpoints and decisions about what is right or wrong are anchored in our worldview, a point that Engelhardt missed. It is based on our worldview we choose or create our moral principles.

Another important question concerns how my methodology relates to the four-principle approach advocated for by Beauchamp and Childress. There is disagreement not only on the foundational source of these principles but also on their content in various cultures. For example, the conception of Western autonomy does not share the same content with African conception of autonomy. Beaucamp and Childress arrived at their conclusions based on the view that the principles they proposed have an ‘abstract content’ that remains unchanged and therefore provides the basis for objective moral judgement across cultures and traditions. However, this is not the case. The reason is that there is no shared content for instance between the principle of Western autonomy and the African understanding of autonomy. The Western model of autonomy promotes individual independence, demands self-determination, and

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assumes an individualist subjective conception of the good. By contrast, the African notion of autonomy presupposes an objective conception of the good, requires interdependence, and family-determination. Ruiping Fan has showed this observation true of East Asian cultures.\textsuperscript{585} It means, therefore, that the Western model of autonomy should not been seen as the model for all conceptions of autonomy. There continues to be controversy regarding the list of principles. I have argued that worldviews give rise to principles that are normative in particular cultures and contexts. The view that the four principles of Beauchamp and Childress can in substantive way represent all our moral concerns is not defendable. From the preceding analysis it has become hopefully clear that the principles of bioethics need not be limited to the four principles dominant in mainstream Western approach. African countries have a different way of appraising reality that is not exactly the same as the West.

The three principles I have formulated are compatible, however, with their framework on a number of points. Firstly, our principles are based on common morality theory. Methodologically, these principles function for both of us much as considered judgements function for John Rawls in his discussion on the method of ‘reflective equilibrium’. This means that moral conceptions serve as first principles for more specific moral conceptions. Secondly, we both agree that principles need to be specified to make them function as action guides in concrete cases. Thirdly, we both believe that all moral persons share general moral principles, but that specified moral framework as such are subject to variations from culture to culture and context to context. Yet our frameworks differ in important respects. The reason is that the four principles articulated by Beauchamp and Childress are construed as the sole principles of bioethics that justify and override all other principles. These four principles are based on individualism that does not resonate with African value system. In addition, they are utilitarian basing their application on benefits and harms calculations. More important, they are universalistic thereby neglecting the important element of context in moral evaluations. My position is that different set of principles than their four principles could be justified or even better suited

within different contexts. In this connection, the four principles of
*PBE* alone or in combination do not justify all universalisable claims
of bioethics. The framework I have presented in this sense takes
seriously the fact of moral pluralism and arrives at judgements in
decision-making by the process of consensus having its roots in
African worldview. In this regard, it is contextual.

There are obviously some common elements to be observed
between the *Principles of Biomedical Ethics* and the positions of
Tristram Engelhardt and John Kekes and my position. A common
feature running through these texts is the attempt by each of us to
secure some common morality capable of binding people, despite the
diversity and plurality of moral visions. It may also be argued that in
spite of the differences in our theories each of us acknowledge a
moral diversity without embracing metaphysical scepticism
regarding the existence of moral truth.

Nevertheless, Engelhardt, Beauchamp and Childress with their
emphasis on individual autonomy tend to paint a picture of isolated
persons living in a society with isolated autonomy. Within African
thought, individuals are regarded as part of a network. This explains
the acceptance of the concept of ‘relational self’ within African
culture, the ‘interdependence of persons’ and ‘relational autonomy’.
The kind of framework formulated by Engelhardt, Beauchamp could
be called a bioethics of right. On the contrary, my framework could
be referred to as a bioethics of solidarity. Could there be a danger of
neglecting the rights of individuals within such a framework,
especially those of the marginalised? The possibility of this danger in
no way implies a framework that is inhumane and congruent in
health care within the African context.

With Kekes, we all share the recognition of the plurality of moral
vision. While I agree with Kekes that this pluralism is itself moral,
Engelhardt holds it to be a weakness. Beauchamp and Childress see
it and I would think correctly that pluralism is more of a challenge,
although they did not take serious account of this fact in their
framework. This conclusion is confirmed by their contention that
those four principles can alone or in combination justify all
bioethical judgements. They obviously did not take account of the
fact that their principles are a reflection of the North American
liberal individualist worldview. Kekes’s theoretical framework for the source of moral values is natural law informed by human nature. Natural law does not constitute the basis neither in my theoretical framework nor in that of Beauchamp and Childress or Engelhardt. However, Kekes’s framework underscores the importance of taking pluralism seriously, and that there could be some common elements in human life.

It may be of interest to note the relationship between African bioethics and non-principle based approaches to bioethics such as communitarian ethics, virtue ethics, and casuistic ethics. The central feature in these approaches is the critique of the abstract individualistic conception of personal autonomy within mainstream bioethics. These concerns can be expanded to include the formulation of bioethical theory to integrate concerns of non-western cultures, class; the re-examination of the principles of bioethics; and the articulation of methodologies that incorporate the concerns of the marginalized.586 Both approaches emphasise the holistic nature of humans, their particular social contexts, and the narrative that give their lives meaning. African perspective shares with feminist approaches the view that moral agents are not fundamentally single-minded, rational, self-interested beings but social beings whose selfhood is constituted and maintained in a matrix of interrelationship with others in community.

The notion of communitarian ethics as employed in this research differs from the western concept. In the western ethical theories, communitarian often refers to the view that it is not possible to find a common ethics for humanity, but different moralities for different local communities. Within the African setting the notion of communitarian ethics is expressed by Mbiti’s statement “Because we are, I am” or South African notion of ‘Ubuntu as a holistic concept that does not discriminate. Community in the sense used here may mean a specific community ‘umunna’. However, in a fundamental sense, it embraces all of humanity. This community has a normative significance in the life of every individual member. A community,

586 In this connection, it is to be noted that African bioethics shares a lot in common with alternative approaches to bioethics. It could be observed that the concerns noted above are also shared by feminist approaches to bioethics. However, the commonalities are not to be understood as if this study has the same agenda as feminist bioethics.
once it comes into existence, is apriori to the individual members who constitute it.

The framework I have argued for shares some common features with Western communitarian ethics, especially its objections to central characteristics of liberalism and individualism, the emphasis on the values of compassion, fidelity, love and sympathy. Another important feature of our framework is its contextual approach to bioethical problems. It seeks to look for solutions in particular contextualised communities and cases not just in the application of ethical principles to cases. It is not a choice to choose between principles and reflecting the true nature of humans.

In this light, that African perspective to bioethics supports a relational model of autonomy that emphasises an ethic that understands human beings as social beings. Within Western tradition, autonomy has been often understood as self-determination in the way that denies the relational character of human beings. Liberal individualism in this sense prizes highly individual autonomy and devalues interdependence that forms the bedrock of the communal living among Africans. The individualism of Western autonomy differs from African recognition of individual autonomy in that the former regards autonomy as an absolute right. Whilst in the latter, the autonomy of the individual is recognised within the context of the individual’s obligations to the communal person. The former gives primacy to the right before the good. In the latter, how individual right is recognised and defined is tied to the overall vision of the good of the community and the human person. This implies a real autonomy of human person, but relative, i.e. a freedom in community and responsibility.

It is important to note that the recognition of the existence of diverse cultures and communities with different moral frameworks does not lead to normative moral relativism. The normative relativists falsely assume because a particular set of values is embedded in the culture, it must be accepted uncritically. This view confuses two distinct issues: (i) what does the local culture allow? (ii) What is the right action aware of the prescription of the local culture? The framework I have articulated enjoins sensitivity both to
local cultural traditions and to general ethical requirement implied by
the concept of common morality.

This bioethical framework consists of the respect for life, 
solidarity, and justice. It embraces both the bioethics of common 
morality and contexts as well as moral principles. It is formulated 
primarily for the practice of bioethics within the African context. It is 
pluralistic and contextual.

One objection that could be made of this framework is that it 
tends to accept some kind of relativism. It is true that it accepts a 
descriptive relativism, and it might also be possible to defend a weak 
epistemological relativism, the view that reasons advanced to justify 
a particular moral action varies and they depend on social and 
cultural contexts. How may a bioethics that is both common and 
pluralistic be possible in a pluralist society? First, one needs to 
understand that the idea of a common bioethical framework is 
grounded on the notion of common morality. This common morality 
is in turn based on the idea of considered judgement derived from 
worldviews within particular communities. This framework is 
pluralistic because it proposes a number of principles that are 
primary for resolving bioethical problems within the African context 
instead of advocating for a single principle as in utilitarianism or 
permission. When culture is understood as also describing contexts, 
then it is not difficult to see that contexts are relevant for bioethical 
judgement. By implication, different frameworks could be justified 
within different contexts. This issue may be highlighted by 
recognising that the problem is both a question of different emphasis 
on different values such as community and individualism as it is also 
of different outstanding problems that are to be resolved such as 
those of scarcity and poverty endemic within the African setting.

How could the culture and philosophy of the Igbo be generalised 
for all of Africa? This problem can be met by realising that what has 
been done is to highlight some basic features of Igbo life that can 
also be said to be common to most Sub-Saharan Africa. These 
elements are employed as the bedrock for the articulation of the 
principles that I find most relevant for bioethics today in Africa. It 
also has a common morality perspective. Nevertheless, it is 
compatible with the authenticity and integrity of individual cultures. 
It does not trump all other views. It is a pluralist view. Why this is
important is that one can easily fall into the danger of universalising one’s own perspective in an attempt to characterise a particular perspective to bioethics.

Notwithstanding this word of caution, there is equally need for a universalisable framework, but one that is grounded on shared experiences. By so doing, we would be showing “how the richness of human cultures blends together in a common understanding of the obligations and opportunities of human inventiveness and moral agency in health care.” We need an account of character, not just of the right and wrong decisions, in order to give a holistic account of the moral agent within health care provision.

This will hopefully promote what John Paul II called a ‘culture of life’. In this respect, we gain practical insight on how cross-cultural norm conflicts should be addressed. This is an area salient normative theories in bioethics provide little practical help.

Conclusion

What is the appropriate framework for bioethics within the African context? I have tried to show that the principles of respect for human life, solidarity, and justice resonate with the moral sensibilities of the African peoples. These three principles have their basis in the Igbo worldview. They have been formulated as prima facie principles forming the basic considerations in the question of what could be considered ethical in bioethical decision making from an African perspective. I have argued for these principles as a framework for ethical thinking not primarily as decision-making procedures. This is an element my framework shares in common with non-principle based approaches such as communitarian ethics, virtue ethics, and casuistry. My framework and the PBE agree on a common morality that could form the basis for the articulation of a common bioethics. Of the four principles of bioethics by Beauchamp and Childress, only justice is included in my framework. Even so, it is understood in

relationship to African worldview where it is based on a particular conception of the good. While the framework of *PBE* is based on the calculation of benefits and harms, and autonomy for competent adults, mine has its basis on human transcendence, which is a permanent feature of human life. Both *PBE* and Engelhardt frameworks have their roots in the liberal individualist Western framework. Consequently, they are incapable of answering the question of what our values, as communities living together ought to be.

By contrast, my framework emphasises both the individual person and the communal person in moral judgement. It offers a holistic answer to the question of what is the nature of human life and its destiny not only for the present generation but also for future ones. Engelhardt helps us to see the need to recognise and take moral pluralism seriously in our moral deliberations. However, he fails by exaggerating the differences that exist in human culture by failing to recognise basic similarities. His concept of person, the project of bioethics as seeking for solutions that are acceptable to all participants in the concrete moral deliberation, his notion of rationality all fail to reflect the nature of humans who are moral agents.

Kekes tries to capture the point missed by Engelhardt by trying to show that it is possible to formulate a secular framework for ethics in a pluralist society. However, he based his argument on natural law ethics. This is problematic. The reason is that it is difficult to derive normative ethical judgement based on human nature as a context independent criterion. Kekes claims that what it is to value in human life is what has meaning. Human life has no value of itself. In this regard, he could be said to base his conception on quality of life considerations much like *PBE*. Kekes shows that it could be possible and desirable to defend a weak epistemological relativism. With Kekes, I share the view that common morality and diversity can coexist in bioethics.

I have shown that the three principles I have formulated are reflexive of the worldview of Africans. They are basic principles upon which concrete actions could be undertaken in Africa precisely to address bioethical issues. A bioethics of solidarity is regarded as being congruent with the communal way of life of most Africans.
This framework could be used to address concrete questions such as the spread of HIV/AIDS, just distribution of scarce medical resources, genetic manipulations, reproductive issues, emerging palliative care questions, and a host of other issues. The idea has been reconciling respect for cultural diversity with concerns for societal cohesion and the promotion of universalizable values and common morality principles. How then could this project be engaged?
8. Towards a Common Morality Bioethics

As earlier observed Engelhardt’s *Foundations of Bioethics* was a reaction to the claim of common or universal morality or bioethics. In chapter one of this study, where different bioethical issues were raised questions concerning the universality of ethics in particular bioethics were also discussed. The point of the present analysis is to respond to the three fundamental questions that were raised in chapter one concerning the possibility or the impossibility of a common bioethics, namely,

a) Is it possible to formulate a common bioethical framework that could be shared by individuals and groups in a pluralistic society and how?

b) What is the basis for such a common bioethics?

c) What could be the contribution of African culture and value system to the issues of bioethics?

These questions relate to the discussion concerning relativity and universality of bioethics. It pertains also to the relationship between morality and pluralism. A fundamental question in this regard concerns how a common bioethics could be achieved in culturally or ethically pluralist societies. I now discuss two questions dealing with relativity and universality. The other is what is common morality in order to establish the context within which the above three questions would be explored.

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589 Cf. Chapter four, pp 138ff.
Relativity and Universality

The Ghanaian philosopher Kwasi Wiredu in his book *Cultural Universal and Particulars: An Africa perspective* confronts the problem of universalism and particularism in human culture. Wiredu argues that previously colonised peoples seeking to redefine their identities insist on cultural particularities. He holds that universals that are grounded on common biological identity are compatible with cultural particularities and it is in fact what makes intercultural communication possible.\(^590\) My interest in this is not about the reason why people generally defend relativity in human cultures. Rather I am concerned with the issue of whether there are cultural universals and particulars in human culture. If there are, where are they located? This question is relevant as it responds to the challenge about the possibility of a common grounding for bioethical judgement. The diversity of moral judgements, coupled with the challenge of moral conflict and disagreement can lead to two distinct antithetical positions, namely, universalism or relativism. The first one insists on the existence of objective moral standards that are universal to all people while the latter rejects all talks about universalism in moral thinking. For example, Godfrey B. claims that every valid moral judgement is universal. In his words

> The litmus test of authentic moral judgements, for me, is universality. I believe that every genuinely valid and uncontaminated particular moral judgement is universalisable, although not every such judgement is necessarily absolutely exceptionless.\(^591\)

This means that ethical rules or norms are cultural universals because moral rule can be described as ethical only if it has cross-cultural validity, in the sense of being understood as applying in all similar circumstances, irrespective of place and time. Why does Tangwa reason this way? The reason is that he conceives ethical principles and norms much like scientific laws that are by their nature general rather than particular, abstract rather than concrete. Tangwa’s position assumes that morality is in a state of equilibrium in all

cultures and that the reason for moral and ethical diversity is not within morality but in human beings. It assumes that moral rules are timeless. These disagreements concern whether inter or intra societies and cultures are the result of human epistemological limitations and intellectual weaknesses, human egoism and self-centredness. While it is true that human epistemological capacities are limited, it is not clear whether it can be given as the sole reason for pluralism of moral and ethical views. It seems simplistic to do that. There is reason to question such a universalism.

Many writers in bioethics are agreed that there are valid moral standards between good and bad, right and wrong actions. This position could presuppose that the either hold universally or the hold relative to particular cultures or traditions. The assumption is that if they hold relative to a particular culture, then they cannot be universally valid.

My position is that there are both commonality and particularity in human culture. Moreover, these positions are compatible to each other. In every culture then is to be found justified moral norms that are universalisable and those that are relative to the framework of that particular culture. A central problem in this regard concerns the possibility and desirability of a common morality. A number of reasons could be given for the desirability of common morality. I here present four I consider most important. 1) Immigration is the first of the reason. In the past peoples did not travel as much as they do today. The situation is that wars and natural disasters have led to great numbers of people moving from their native lands to resettle in other lands. There is need for a common moral language to enable communication and understanding among people from different cultures who now have to live within the same society. 2) Globalisation or internationalisation has created conditions that make it possible for different nations and peoples of the world to be in closer contact and interaction with one another. The result is that we have a globalised world that calls for a greater understanding of one another. The globalisation of economy, of communication, and of medical sciences raises many issues of ethics at a global level that could only be effectively treated by a common vision on those

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specific issues. 3) Effective health care provision is another reason why a common morality is desirable in a pluralist society. This is related to the first two reasons. The situation today is that health care providers from different traditions now provide health services to those belonging to other traditions. It is a situation where immigrant health professionals provide health services to their host society or native health care givers providing health services to immigrants with different moral visions. There is need to have a common moral understanding in order that the best possible health care may be given. 4) The fourth reason why a common bioethics is desirable is that bioethics concerns the common problems of humans: respect for life, scientific innovations and relief of human suffering. What then do we mean by common morality? In recent times, the concept of common morality has provided the basis or starting point for many bioethicists including Bernard Gert, Charles Culver, and Danner Clouser’s Bioethics.\(^{593}\) What this shows is that there is more than one theory of common morality although there is only one universal common morality. This concept is one of the most important developments in recent ethical theory, especially bioethical theory.

In their 2001 edition of *PBE*, Beauchamp and Childress discuss the subject of common morality. They make a distinction between common morality and particular morality. The two are not synonymous. Beauchamp locates universality in the common morality and relativity in particular moralities. “Common morality”, in this connection refers to “the set of norms shared by all persons committed to the objectives of morality”.\(^{594}\) These objectives “are those of promoting human flourishing by counteracting conditions that cause the quality of people’s lives to worsen”.\(^{595}\) This morality is applicable to all persons in all places and all human conducts are judged by its standards. Beauchamp goes on to maintain that common morality contains only general moral standards that are universal, thin in content and abstract. This pretheoretic moral point

\(^{593}\) Gert B, Culver CM, Clouser KD, 1997, Bioethics: A Return to Fundamentals; Others include Alan Donagan, 1977; W.D. Ross, 1939.


of view transcends local customs and attitudes. Analogous to beliefs in the universality of basic human rights, the principles of common morality are universal standards. To underscore the last point, it is stated that an important function of the standard in common morality that are advocated by them is to provide a basis for the evaluation and criticism of actions in countries and communities whose particular moral viewpoints fail to acknowledge basic principles.\textsuperscript{596}

The primary idea of the concept of common morality is the view that all morally serious humans have a pretheoretic awareness of certain moral norms. This implies that most humans in all places and cultures ‘recognise’ certain moral requiredness such as the view that there is something wrong in lying, killing people, breaking promises, stealing, harming others, punishing the innocent, causing pain and suffering to others and the like. Similarly, most people recognise in all cultures moral virtues such as nonmalevolence, honesty, truthfulness, trustworthiness, honesty, kindness, fidelity integrity, lovingness and so forth. In every society there are norms prohibiting the former and promoting the latter. These norms achieve the objective of morality, which is the harmonious co-existence of members of the society. They ensure human flourishing. In addition, this accounts for their moral authority.

Particular moralities on the other hand are moral norms that spring from the many responsibilities, aspirations, ideals, attitudes, religious traditions, professional practice, institutional rules, and the like.\textsuperscript{597} These norms are particular to groups, traditions, and even individuals. Moreover, they are concrete, non-universal and rich in content. It means that the data of common morality are quite limited embracing only a small set of norms in comparison to particular moralities that are unique to particular cultures, groups and individuals.

Kwasi Wiredu acknowledges the distinction between common morality and particular morality when he comments

\begin{quote}
Two assumptions that may safely be made about human species are, one, that the entire race shares some fundamental categories and criteria of thought in common and, two, that, nevertheless, there are
\end{quote}

\textsuperscript{596} Beauchamp & Childress, 1994, \textit{PBE}, p 100.

some very deep disparities among the different tribes of humankind in regard to their modes of conceptualisation in some sensitive areas of thought. The first accounts for the possibility of communication among different peoples, the second for difficulties and complications that infrequently beset that interaction.\textsuperscript{598}

I suppose that some of the sensitive areas of thought Wiredu is referring to no doubt would include morality and perhaps religion. If we are correct in distinguishing moralities that are universalisable and those that are particular to different cultures, traditions, and even individuals, we are then correct in arguing for a bioethical framework that is congruent with African life and thought. We noted earlier that the specifics of African morality is to be found in her worldviews with respect to cosmology, causality, conceptions of community, personhood, individuality, health, illness, suffering, death, and dying. In short, it is found in the way African people understand and interpret reality. These distinctions and clarifications between common morality and particular moralities are highly useful for my purposes.

\textbf{Perspectives on Common Morality}

Bernard Gert, Charles Culver and Kenneth Clouser have presented a different version of common morality in their book \textit{Bioethics: a return to fundamentals}. Common morality, according to them refers to a system that people use, usually unconsciously when they make their moral judgements following reflections on the facts involved in a specific situation.\textsuperscript{599} It is not a theory. An account of common morality is compared to the account of grammar provided by grammarians whose function is to describe the grammatical system that speakers of the language usually unconsciously use when the speak or interpret the speech of others. Common morality in this regard functions to explain why, although there is agreements on a vast majority of moral decisions and judgements, there are some

irresolvable moral conflicts. The content of common morality are to be seen in its rules, ideals and methods. These rules are based on the universal desire to avoid harm and proscribe behaviours such as killing, deceiving, and causing pain that are harmful. Two major sources of genuine irresolvable moral disagreements are identified. The first is a difference in the rankings of various benefits and harms. For example, two people suffering from the same painful terminal illness may make different choices that are both rational. One may ask for withdrawal of treatment to avoid continuing pain, whereas the other may decide to continue treatment despite the pain. The second source of irresolvable conflict deals with the different views about who is included in the moral community. Some include the unborn and infants, whereas some others refuse to include the unborn. Some like to include non-human animals such as dolphins and chimpanzees, others disagree.

In his book Common morality: Deciding what to do, Gert continues to defend the idea of common morality. Gert describes common morality as the moral system that most thoughtful people implicitly use when making everyday, common sense moral decisions and judgements. It is useful because although not resolving all moral conflicts, it is, however, able to distinguish between acceptable and unacceptable answers to moral controversies. Gert argues that there is only one morality, common morality. According to him, it is possible to provide an explicit description of this common morality that is coherent and comprehensive. Again, Gert identified moral rules and moral ideals as the fundamental features of common morality. The underlying concepts that justify common morality are notions such as rationality, fallibility, vulnerability and impartiality. For Gert, common morality should shape moral theories and not the reverse. Moral rules and justifiable violations of them largely determine what is or is not morally acceptable. However, this is in turn dependent on the moral value of avoidance of harm. This has been a common feature of their version of common morality. Beauchamp and Childress point out in this respect and correctly: “Clouser and Gert rely almost exclusively on nonmaleficence in their ethical theory.”

601 Beauchamp and Childress, 1994, PBE, p 318.
From the foregoing, common to PBE’s and Gert’s discussion of common morality is the view that all people share it and that they rely on ordinary shared beliefs for their content, rather than on pure reason. In this sense, it forms the basis for the articulation of moral theory or moral principles. However, the difference between them is that PBE’s version of common morality advocates more than one principle. Beauchamp and Childress argue that common morality is captured by the four principles of biomedical ethics they formulated. Gert’s common morality is built primarily on a single principle of nonmaleficence. PBE justifies its moral judgements by adopting coherence model of justification, whereas Gert’s justifies his by appeal to moral rules and their justifiable violations with basis in the avoidance of harm.

Much like PBE and Gert, my framework is principle-based common morality. Question might be raised why I think this type of theory could be the consequence of the preceding analyses. The reason is that for most Africans, moral norms, principles and rules have their sources in the values and beliefs shared in common by a given community. Most times, they are inseparable from religion and other social institutions. However, my version of common morality is closer to PBE’s than to Gert’s. There are advantages to advocating this type of theory. First, they find their bases in the beliefs shared by all those concerned about the project of morality. Second, they are pluralistic. Third, they employ prima facie principles in adjudicating moral issues. Fourth, they provide specific action guidelines for addressing concrete ethical cases. Fifth, Common morality theory fits best with our moral convictions and intuitions.

Common morality may be described as the basis of justification people consciously or unconsciously appeal to ordinarily when making morally acceptable choices from a host of other alternatives or when making judgements on theirs and other peoples’ actions. Though this common framework exists it does not imply that everyone agrees in particular moral decisions and judgements. This position presupposes that morality is universal and that we can give an adequate account of it in a way that is rational and acceptable to most people. One major problem with this position is the difficulty in explaining the reasons why many even informed impartial observers
have disagreements among themselves concerning what are morally right or morally wrong in particular concrete cases. In this respect, I agree with Gert that some of the important reasons for the disagreements include the different views on the rankings of benefits and harms among humans and the different views concerning those to be covered by morality. While there are irresolvable disagreements, it is important to observe that there is in fact substantial agreement on moral matters among humans. A look at any society would reveal that there are far more agreements on the laws, policies, rules and principles that hold that particular society together than disagreements in most aspects of the life of that society. In fact, they cannot be compared. The view that there is no such thing rests on the concentration on mostly controversial matters that form only a small part of moral discourse among people. Once this fact is acknowledged it becomes easy to see that “most moral matters are so uncontroversial that people do not even make conscious decision concerning them.”

In recent times, our world has experienced tragic natural catastrophes of unbelievable magnitude in South East Asia, Sudan, U.S. and in Latin America. There is evidently universal moral praise given to those who help victims of such disasters. No one disagrees concerning the moral worth of helping the needy. In the same manner, no one hesitates to condemn murder, slavery, cheating, child abuse, rape, dishonesty, breaking promises and irresponsibility in carrying out one’s duties. This shows that the form of morality is universal even if the content may vary in different cultures.

By common morality, I mean not only the set of norms shared by all persons committed to the objectives of morality but in a special sense also the capacity of humans to reason morally. In this sense, I do not just refer to norms but the inherent inclination to seek and articulate those norms. This feature of humans can form the starting point for the articulation of a common bioethics that transcends particular cultural values. This predisposition simply put is the desire to will and act only as it is morally acceptable. It also embraces the frame of reference that constitutes the system of values a particular

society, culture, tradition or community employ in making sense of the meaning of their lives and universe. It is common both in a primary and secondary sense. The former refers to those beliefs or experiences that are trans-culture such as the experience of finitude, vulnerability, illness, suffering, medicine and death. These phenomena are universal and primary in the sense that they are experienced by every human being irrespective of culture and tradition. Yet, it is not universal in the sense of being understood or interpreted in the same way in all cultures. In this connection, it is culture and context dependent. This is why it is said to be common in a secondary sense. Morality is also common in the sense that moral judgements are made about all rational persons and there is agreement on the overwhelming majority of cases.

Let us take an example of a moral norm that is particular. Among the Igbo, it is morally wrong for a man to take a woman as a wife without first going to the family of the woman and settling the bride price. When a man marries in Igbo land the wife is expected to follow and live with him in his own father’s compound. In some other tribes in Nigeria, the man follows the woman home to her own father’s compound. Among the Igbo before Christianity, twins were regarded as abomination to the community. Consequently, the last to be born was thrown away into the ‘evil forest’ to die. Kings were also sometimes buried with some of their slaves. These norms were not universal or even universalisable. They did not even apply to some tribes in Nigeria. However, consider the moral norm of not telling lies and not harming the innocent, they are found among all groups in Nigeria. Moreover, these are universalisable moral norms. These moralities both universalisable and particular develop in time.

Bioethics much like biomedicine claims to be a common enterprise constructed upon the belief in the universality of scientific truths. Western bioethics, in the form of principlism, claims neutrality. Presupposed in this view is the assumption for instance that the four principles of bioethics proposed by Beauchamp and Childress can explain or justify, alone or in combination, the entire substantive and universalisable claims of bioethics and probably ethics in general. However, I have contended that bioethics much as biomedicine reveals a concept of personhood, autonomy,
Biomedicine and bioethics do not appear to acknowledge the limitations of their own worldview and hence lack an understanding of their applicability and appropriateness in diverse social and cultural contexts; a situation which adds credence to the claims as to the hegemonic and imperialistic nature of such global enterprise.

This passage suggests that western biomedicine and bioethics are reductionistic. The reason is their conceptual foundations within the western philosophical tradition with its roots in Cartesian dualism of body and mind (soul) or in the Kantian emphasis on respect for autonomy, within the framework of western liberal democratic tradition. Against this backdrop, it is crucial that western medicine and moral theories recognise the limitations of their worldview and allow for intercultural dialogue. Consequently, for a common bioethics to be true to its name there is need for a holistic perspective, the acceptance of pluralism. However, how is this possible in a liberal society where personal autonomy, the right of each person to choose his/her own set of ethical values, is the paramount value?

Possibility for a common bioethical framework

It is reasonable to doubt the possibility of finding a single framework for grounding bioethical judgements. This, however, does not necessarily mean the impossibility or undesirability of such a project. It is clear that bioethical practices differ from one culture to the other. Yet, the issue is whether it is possible to find a common ground for resolving bioethical conflicts. Many people hold that there must be a way to knowing the moral content of the source of morality. If the analysis presented earlier is correct, then, there has to

be a way too to reconciling differences in methods, approaches or frameworks.

The challenge of bioethics is to discover what it can say generally as a common enterprise. Different methodologies have been used in bioethics. These methodologies are often presented as if they were at war with one another. The approaches range from utilitarian and consequence approaches to right based and obligation theories. Further, it stretches from common morality to virtue ethics to casuistry and communitarian ethics. Each of these methods claims precedence over the others. This shows that none of the theories can independently provide all that is required to resolve many of our ethical problems. The arguments advanced by each of these theories cannot be shrugged off with a general yes or no. These methodologies can help us deepen our understanding of the moral life. The question is, can the apparent conflict in these methodologies be reconciled in such a way that they complement and supplement one another? Contrary to Engelhardt and MacIntyre, it is my view that they are compatible and commensurable in fundamental ways. Despite their apparently conflicting perspectives, each of them can contribute effectively in ethical praxis. Edmund D. Pellegrino talks about this as the challenge that bioethics must now confront:

Contemporary methodologies applied to moral life, its experience and decisions can enhance our understanding by giving us a firmer grasp of the particularities of that life. Each methodology reveals insights into the real world of moral experience not grasped by the others. All have some methodological utility. All, in one way or another, enhance the public and personal pursuit of ethics. ⁶⁰⁵

Given the pluralist nature of our society, it seems that bioethics must operate within a framework like John Rawls concept of an ‘overlapping consensus’. This is where people with different comprehensive worldviews agree to work within a framework of shared criteria of what Rawls refers to as ‘public reason’.

Beauchamp and Childress recognise the deep disagreements in the theory of moral justification of ethical principles between utilitarian

and deontological theories but contend that this is less profound when it comes to practical moral deliberation. It is interesting to observe that in the first three editions of *Principles of Biomedical Ethics*, they emphasised ethical theories that could support the mid-level principles of bioethics they advocated. While Beauchamp maintained that rule-utilitarianism was preferable to any form of deontology, Childress held that rule-deontology was preferable to any form of utilitarianism. A closer reading shows that neither of them completely endorses any of these theories. One can in this connection argue that they were from the start pluralistic at the level of ethical theory. Nevertheless, emphasis on theoretical pluralism became more prominent in the subsequent editions. They observed that despite the difference in starting assumptions, they and others nevertheless seemed able in many cases to agree on a solution to a bioethical case. They believe that it is possible to come to substantive moral agreement despite methodological disagreement. It is this discovery that leads them to the formulation of the four principles of bioethics that, they argue, speak across moral commitments. This is an attempt to harmonise the differences between utilitarian and deontological bioethics and provide a common framework for bioethics in a pluralistic society. It is then apparent that the practicability of reconciling the theories can be seen in the consequentialist Beauchamp, and his deontological colleague, Childress as they opine:

Differences between types of theory are exaggerated if they are presented as warring armies locked in combat. Many different theories lead to similar action-guides and to similar estimates of the role of character in ethics.

On matters of justification, rationality and method, theories are often in rivalry but they often converge on mid-level principles. By middle level principles are meant those fundamental principles for ethical analysis that in themselves need further specification in concrete matters for them to serve as action guides in decision making. Of course, I do not imply that the convergence is perfect. The reason is

608 Cf. Chapter seven, pp 242ff.
that there is divergence when it comes to the specification of principles in concrete cases and in the derivation of moral rules from the principles.

In like manner, Sven Danielsson has pointed out that the description of any theory as teleological or deontological is misleading. He contends that any moral theory can be employed both consequentially and deontologically. He rightly observes that neither of these approaches by themselves implies a substantive moral position. It may at this point be asked what kind of relationship exists between these theories. Danielsson’s insight has shown that there is certainly a relationship of complimentarity between these theories. Donald Davidson makes this idea more persuasive as he argues similarly. If you and I disagree about some proposition, moral or non-moral, we will at least have enough in common to make sense of that proposition. Our disagreement would not be possible if we cannot make sense of it. When disagreement is pushed too far, it tends to become merely verbal.

In the beginning of this study, MacIntyre was noted in his book, *After Virtue* to claim, “there seems,” he says, “to be no rational way of securing moral agreement in our culture.” He went on to suggest that the reason is because people argue from various premises that are conceptually incommensurable. If MacIntyre is right, it means that we are doomed to failure in our project. Interestingly, the insights of Danielsson and Davidson can show that this account of moral discussion in our society does not entirely ring true. It needs be observed that moral discourse in a pluralistic society is not threatened by lack of agreement among moral theories about the good but by how best to understand this good. It is equally threatened by the attempt to deny a plurality of moral visions that is not equated to normative relativism, scepticism or nihilism. The success of ethics committees and ethics commissions in arriving at common decision in difficult cases show that there is evidently common morality that members of such committees employ to justify their positions. The argument that is sometimes made that their success is because the

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members of such groups do not fully reflect contemporary moral diversity is not persuasive enough.\footnote{Engelhardt argues along this line. He believes that a group composed of socialists, libertarians, and communists, capitalists examining the issue of public allocation of resources may not reach at any conclusions or recommendation.} Common predispositions to moral judgement, characterising humans can actually give access to common ethical values through shared reflections, despite differences in moral visions across cultures.

From the foregoing, we can give an affirmative answer to the question whether it is possible to articulate a common bioethical framework for a pluralistic society. In spite of the differences, theories converge most times in similar moral principles that can be employed as guidelines for action in a given ethical problem. I do not regard theories as the source or justification for praxis. They are to be seen as lens for the understanding of praxis. In responding to the question of whether the formulation of a common bioethical framework is possible, we have also touched on the second question concerning what could be the ground for such a common framework.

**Basis for a common framework in a pluralistic society**

The question of a common framework for bioethical judgements is intertwined with the issue of the existence of common morality? How is this notion used in the three theories analysed in this work? How do I understand and employ this notion in my study? Furthermore, what is common morality theory or in another words principle-based common morality theories? In the materials studied, only Beauchamp and Childress made explicit appeal to common morality in the formulation of their theory.

Morality includes rules as well as ideals. Wide spread agreement on what constitutes a moral rule is one of the evidences for the existence of common morality. Most conflicts about morality concerns the scope of morality; differences in ranking of harms and the significance attached to relevant moral facts rather than the existence or non-existence of common morality. In a significant way, it concerns when a particular violation of a moral rule or principle is justified. In spite of diversity in moral visions, most people accept
the view that what counts as an adequate justification for one person in a given situation must also qualify as an adequate justification for another person in the same situation granting that all the morally relevant facts are the same.

I maintain that there is a common morality. The reason is that people from different communities; traditions and cultures are able to communicate with one another. If there were no common morality, trans-cultural or cross-tradition communication would be highly impossible. “The notion of cross culture evaluation of thought,” as Wiredu points out, implies the universality, at some levels, of some canon of thought.” Human beings are characterised among other things with imagination, compassion, intelligence and inventiveness. One may argue that we could still agree on a set of criteria for moral deliberation even if we are not able to communicate transculturally. The question in this regard concerns how such an agreement could be achieved if there is no possibility to communicate? My position in this regard can also be defended on the ground that morality has objectives and that it is possible to give account of the principles and norms that achieve this objective. Furthermore, it is equally possible to offer a normative justification of these objectives and norms.

It could be objected that pluralism of moral or ethical vision illustrates the absence of any common morality. Added to this is the view that it is impossible to provide a comprehensive account of morality. Some writers have also objected to the idea of common morality by claiming that there is little or no anthropological or historical evidence to support the thesis of a universal common morality. This latter challenge can be met by observing that no known empirical studies have shown that the standards of obligation enumerated above are accepted in some cultures while others reject them. We see variations in ‘particular moralities’ and not in ‘common morality’. One cannot reasonably argue from the latter that common morality does not exist.

614 Beauchamp defends also the existence of a common morality along this line.
Beauchamp and Childress have pointed out that one of the objections against their method which is aptly captured by Hume runs thus, “the principles upon which men reason in morals are always the same; though the conclusions which they draw are often very different.”616 Practically, this cannot be denied. Nevertheless, it is worth noting response to this observation. “True, a relativity of judgement is inevitable, but a relativity of the principles embedded in the common morality is not.”617 While it is desirable to aspire to such framework for moral deliberations across countries and cultures, yet, we have observed that the principles proposed by Beauchamp and Childress and their interpretation are those that support the liberal individualistic American society or western liberal democratic culture. It is difficult to see how such could make claim to universal validity in the way they do. By exploring the redefinition of death debate within the context of the human organ transplant, Jones S.F and Kessel A.S attempt to "demonstrate the Western concepts implicit within both biomedicine and bioethics."618 This is achieved by analysing the concept of personhood implicit in the discourse. It is argued and rightly too, that this concept is in agreement with that held by most western cultures and within biomedicine as can be seen through an exploration of western historical and philosophical foundations.619 Their analysis led them to the conclusion: "Biomedicine and bioethics, in the form of principlism, share a common conceptualisation of personhood and one that is not universal."620 Jones and Kessel point out that moral theory and principlism in particular has their foundations in western concepts and philosophy, as does biomedicine itself.621 The implication of the worldview implicit in this framework is often not accounted for in current approaches to bioethics.

It may be argued and rightly too that contrary to the position of Beauchamp and Childress, there could be both relativity in

617 PBE, 1994, 105. This seems to suggest that there could be no other principle or principles other than the four they have proposed. This is a difficult and an impossible position to defend.
619 Jones S.F, & Kessel A.S, 2001, 7:64.
judgement and relativity in the moral principles employed by different cultures and traditions. This position is defended in chapter seven where I presented the set of principles that are relevant and justified within the context of African life today. Particular moralities change over time seen from this perspective. In principle norms in the common morality could change but such changes are almost unlikely. The reason is that any change would also require that the objective of morality remains stable. No new change can be justified that does not cohere with the entire moral system. However, it needs be observed that the scope of common morality does and have changed in the course of history. We have the changes in the way women, slaves, people of ethnicities have been treated. Even at that, it is better to describe them as changes in particular moralities than in common morality.622

The foregoing analysis implies then that it is possible to have a common bioethical framework. The fact that worldviews and conceptual schemes can overlap permits for mutual understanding and evaluation.623 It needs be quickly added that agreeing to a common moral system does not imply agreeing to a single unique solution to every controversial bioethical problem and to a single method in Bioethics. Hopefully, I have adequately shown that common bioethics can be formulated on common morality that all people share by the fact of their common humanity and being committed to the objectives of morality. I have equally suggested that the path of bioethics consist in encouraging diversity and rejecting all attempts at a single, monistic, and overarching framework. We should be open to the possibility of justified norms in particular moralities and stop assuming all the time that they are unreasonable and unjustified. This implies that we need to allow for greater diversity in method of approach to these bioethical questions that create dilemma in our moral life. The reason is that in order to give appropriate response to these challenges in bioethics, there is need to pool together the intellectual and moral resources of the different cultures that constitute humanity, taking into account its

622 The practices of throwing away of the last of twins to be born among the Igbo and the burial of kings with some of their slaves have long been abandoned.
diversity and plurality. How then do the three approaches presented in this study relate to the concept of common morality?

Beauchamp and Childress ground common morality in considered judgement of the people. They do not make appeal to natural law tradition as Kekes evidently does. However, I do not think that Beauchamp and Childress would have any problem accepting Kekes assertion that all values are conditional. Although Kekes does not accept the view of prima facie values, yet the way it is explained by PBE is compatible with the manner he understands his primary values. In terms of conflict resolution, both Kekes and PBE seem to hold similar views. According to Kekes, conflict occurs against the background of the whole system of value that constitutes the tradition. Resolution of conflict in this sense needs to proceed by cohering with the whole system of values. This model of conflict resolution can be said to agree with PBE model of justification, which accepts a coherence model of justification. Beauchamp & Childress, Kekes, and Engelhardt are both examples of the principle-based paradigm in bioethics although at different levels.

The Foundations of Bioethics by Engelhardt evidently developed as a critique of the view expressed both by Kekes, Beauchamp and Childress. That is, the contemporary understanding that bioethics can uncontroversially be established on a common morality ethic, which can be applied to medicine and biomedical sciences. According to Engelhardt, there is a plurality of moralities in the very strong sense of incompatible sets of considered settled judgements. Engelhardt does not recognise any common morality that human beings share in common. For him as we earlier noted, secular bioethics is only practicable on the condition that there exists agreements among moral participants. Even as he rejects the idea of common morality, it might still be argued that he in some sense accepts that there is still something that can be common to all moral

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625 See Chapter four. In a recent volume edited by Engelhardt, 2006, Global Bioethics: The Collapse of Consensus, the authors explore what Engelhardt describes as the persistent failure to produce a universal set of standards for bioethics and much less a global health policy.
strangers. That thing is the ability to give permission.\textsuperscript{626} As my analysis have shown Engelhardt may be correct in his account of moral pluralism, yet it is possible to rationally justify our moral convictions contextually.

Although Kekes does not use the term common morality, yet it is easy to see that in an implicit way the concept features in his articulation of an axiology of human values. Kekes identified two types of values, namely, primary and secondary values.\textsuperscript{627} Every individual by virtue of sharing in the human nature shares the former. The latter although it might be present in all cultures is nevertheless understood differently in different cultures and traditions. Where Kekes, Beauchamp and Childress recognise shared common morality,\textsuperscript{628} Engelhardt observed controversy when participants in moral discourse meet as moral strangers. The reasons could be in the sense of sharing neither: (1) sufficient basic premises and rules of moral inference, so as to resolve moral conflicts by sound rational argument, nor (2) a common understanding of who is in authority to resolve such conflicts.\textsuperscript{629} For Engelhardt, bioethics is confronted with substantive disagreement at the level of both theory and practice. He views the principles as a further proof of this claim. Engelhardt dismisses the argument for the existence of common morality. Whereas Kekes, Beauchamp and Childress are of the view that reasoning from common morality can and do justify particular moral actions. Engelhardt holds the contrary. He makes a distinction between common morality and common elements among different moralities. According to him, common morality, were it to exist would be a shared understanding regarding appropriate conduct. Engelhardt explains the common moral concerns shared by all humans that may be identified when different moralities are analysed.

\textsuperscript{626}Engelhardt’s interest seems to be in moral justification and not in the source or motivation for morality.
\textsuperscript{627} See Chapter five, pp 172ff.
\textsuperscript{628} See Chapter Five, where Kekes distinguishes between primary and secondary values. These values identified by Kekes can be regarded as being grounded in the common morality shared by all humans. In the same way, this distinction captures the distinction made by \textit{PBE} about common morality in the broad sense and in the narrow sense. Whereas Kekes recognises hierarchy among primary values, \textit{PBE} is not prepared to give any kind of lexical order to the principles and the accompanying derivative rules.
as resulting from common human contexts and the character of embodiment for example, pain, pleasure, property, death and such others.

Given this view, ‘common norms of moral concern’ do not constitute a common morality. Therefore, in Engelhardt’s view, to speak of humankind sharing a common morality is not only unfounded but also strategically deceptive. Contrary to this view, Beauchamp & Childress make a distinction between morality that is general and morality that is community specific. There is no talk of morality in the plural sense as Engelhardt does. In my view, our common moral intuition tends to support the position of Beauchamp & Childress. The reason is that there seems to be far greater agreement in moral matters than disagreement. However, the few disagreements are sensational and attractive.

He argues that Beauchamp and Childress began from similar ideological and moral visions such as could bridge certain theoretical differences. He holds that if they were to begin from disparate moral visions, including radically different theoretical understanding, their principles will promote divisions rather than bridge them. The reason for this is the mistaken assumption by Engelhardt that it is only in particular communities that content-full morality can be found. Interestingly, one observes that he overstates the degree of shared agreement within the ‘communities of friends’. By overemphasising diversity among his moral strangers, he overlooks fundamental similarities. Similarly, by overstating similarities among communities of friends, he was blind to obvious differences occasioned by changing times and circumstances. I doubt if Engelhardt would disagree with this observation: parents have the obligation to love and care for their children. If he grants this as an obligation that applies to all people and cultures, it is then doubtful how he can sustain his argument that common morality does not exist. Our ordinary moral sense refutes that. Common norms of moral concern are surely part of our common morality.

Question may then be asked concerning what it is that distinguishes morality. To this, Engelhardt holds that moralities are distinguished by settled judgements they support regarding the general conditions under which common norms of moral concern

630 Contrary to this view, Beauchamp & Childress make a distinction between morality that is general and morality that is community specific. There is no talk of morality in the plural sense as Engelhardt does. In my view, our common moral intuition tends to support the position of Beauchamp & Childress. The reason is that there seems to be far greater agreement in moral matters than disagreement. However, the few disagreements are sensational and attractive.

631 The basis of this is the sceptical position that there are no substantive grounds of any kind of bioethics other than historical roots in communities. See Engelhardt, 1996, pp 105-124. Engelhardt & Wildes, 1994, pp 135-147. See also Wildes, 2000, pp 7, 133, 137-140.
may be permitted or prohibited. In contrast to the four principles identified by Beauchamp and Childress, Engelhardt places the ‘will’ as grounding morality of moral strangers. This ‘will’ is reduced to the principle of permission. This is the sense we can argue that Engelhardt proposes a moral framework, which has a single supreme principle in the name of permission or autonomy. This purely procedural morality alone provides an adequate account of the common morality that can establish moral authority among moral strangers. For Engelhardt, although, there is ground for the existence of truth, yet he maintains that there are grounds for moral epistemological scepticism about the capacities of secular moral rationality to justify a particular moral action. This scepticism is located in the characteristics of contemporary moral conditions: the limits of secular moral epistemology.

Whereas Kekes and Engelhardt are prepared to hold that many conflicts can be resolved by appealing to a reasonable ranking of the values in conflict, PBE does not admit of any ranking among values or principles when they conflict. Kekes makes the distinction between primary and secondary values by appealing to human nature. There is no explicit discussion of the place of human nature in the frameworks advanced by Engelhardt and PBE.

More importantly, a common framework running through these approaches is the philosophical basis on which they are formulated. They all regard the individual as the sole source of moral authority. In line with this foundation, western medicine and clinical practice justifies its legitimacy, authority, and efficacy from a scientific tradition that makes claims to universal validity. Kekes may be said to situate his theory within anthropology while Engelhardt, Beauchamp and Childress locate theirs within social justice in a democratic culture. For a true common bioethics, all these elements are necessary. Each of these approaches captures a particular aspect of reality that is important if the complete picture is to be seen. That is why I have argued for a pluralistic approach in method in

634 See Chapter five, A Secular Ethics of Value, pp 172ff.
addressing these highly contentious ethical matters in reproductive technology, genetics, and research involving human participants, the use of embryonic stem cells, palliative or end-of-life care.

Within the context of healthcare, it is important for healthcare professionals to realise that the framework that is employed in medicine is the same framework as are used in general moral life. This assertion does not deny that healthcare givers do have specific duties that cannot be explicitly deduced from common morality. All the same, these duties are compatible with them. Morality is an informal public system. This refers to a system that has no established procedures or authorities for resolving moral disagreements. Formal public systems such as the game of sport have procedures for resolving difficulties. Given the fact of morality being an informal public system, it is not possible that all conflicts within it can be resolved. The continued debates concerning abortion, contraceptives, and euthanasia, withholding and withdrawing treatments illustrate this point.

What can an African framework contribute?

In this final section, I hope to highlight some of the contributions of an African framework to bioethics and to show that my position differs from the three authors analysed in this study. As my analysis reveals, problems that emerge at the level of articulation of bioethical frameworks and principles are mainly conceptual and theoretical. Those that arise at the level of application of such frameworks are mainly practical and procedural. At the first level, it is important to capture clearly in concepts and in language ethical imperative that are embedded in worldviews. At the second level, it is vital to translate the framework and principles into concrete action within a given culture and context. These must be accounted for in every bioethical framework. The frameworks articulated by PBE, Engelhardt, and Kekes have each given insights into different aspects of the elements of moral life especially in decision making regarding method and theory. PBE establishes a common bioethics on the common morality that all those committed to the objective of morality share. It formulates four prima facie principles that can be
said to be the content of the whole of moral life. However, it fails to take into serious account the fact of pluralism. Engelhardt emphasises the need for individual consent in moral deliberation. He formulates the principle of permission. Engelhardt overlooks elements common to human life. Kekes establishes what is common on the view of natural law presupposing human nature. Since human nature needs to be interpreted and translated into action guides, an area his theory could not account for, his approach much like the two others is not adequate. Although they have provided us many interesting and useful insights, it is highly unlikely that their frameworks give a proper account of bioethical decision-making within the African context.

Within the framework of respect for life, solidarity, and justice in healthcare consistent with African world is argued for. The African view of humans is vital in this connection. Human beings are either moral agents or patients. Within the African framework some human beings such as fetuses, infants, the comatose and the mentally handicapped, lack the capacity to be moral agents and are only moral patients. In this respect, the concepts of rationality, autonomy and competence only describe moral agents, not human beings. This is because all humans no matter at whatever stage of development possess moral worth. Personhood within this understanding does not confer moral privileges; on the contrary, it imposes moral responsibilities.

From this framework, a number of implications could be derived for example in research ethics and reproductive technology. Respect for life would require equal treatment to all human beings in the context of medical research involving human participants, ‘persons’ and ‘non-persons’. This is a fundamental way to respecting the dignity of the human person. Each human being is a unique source of value. This justifies the requirement to respect human life. It may then be argued that the value or dignity of the human person is not determined by material, economic, cultural and political context of that person. Rather, human life has equal dignity irrespective of great disparities between levels of health across the world such as levels of morbidity and mortality and the degree of socio-economic development of different countries. The WHO report 2000 shows
that average life expectancy for most of the children born in developed nations could be more than 70 years. Whereas in the majority of African countries it is less than 55 years, in some others it is less than 40 years for example in Zambia 38.5; Malawi 37.8 and Sierra Leone 34.3. The temptation may be to evaluate the life of individuals and populations in poor nations by the amount of resources available for health care in these countries. This would be mistaken, as the value of individual lives cannot be measured in terms of the resources devoted to healthcare in their various nations.

The acknowledgement of the intrinsic value of each person challenges us to respect his or her legitimate interests. In this connection, humans should not be used as a means either to our own ends or to the welfare of others. It implies a duty not to exploit the vulnerable. Sponsors of medical research have a duty to refrain from exploiting to their own advantage the vulnerability of the weaker.

The principle of solidarity requires a duty to identify with those who are bearing the burden of HIV/AIDS and other chronic and terminal diseases. We should positively do things to alleviate their suffering. It may be argued in this connection that the act of conducting those trials was an expression of the challenge of this principle. The principle of solidarity within the African context would imply a duty to discourage all forms of violations of the dignity and integrity of the human person both in its individual and communal dimensions. Given the shared heritage of life, there is therefore obligation on every human being to stand in solidarity with human life and protect it against every form of exploitation and manipulation. This study has argued for a pluralistic approach to ethical problems. In keeping with this conviction, there are situations where it might be justified to employ different standards or alternative standard of care in research ethics. I think the situation of African countries qualifies for such a situation. It is a situation of nothingness. While this may be the case, it is difficult to explain why those who happen to fall into the control arms of trials in wealthy

nations receive standard care while those who fall in the same group in Africa receive no treatment at all. It is not justified to leave them with placebo even when the local situation is such that they could not have received anything if they were not participating in the trials.

While respect for human life challenges us to respect persons and to be sensitive to their cultural values, solidarity enjoins us to realise that we form one human family with them, to help shoulder each other’s burden, a collective obligation to take care of one another. This realisation should make pharmaceutical companies to set service to humanity above profits. ACTG 076 could become affordable if those companies have the willingness to make them so. It may be argued in this connection that solidarity should challenge WHO and the United Nations to invest more on programs and researches to prevent MTCT. This carries a note of urgency in sub-Saharan Africa where there is a greater need and thus a greater claim to ACTG 076. HIV/AIDS is a huge burden for sub-Saharan Africa. In 2003, an estimated 23-27 million people were thought to be living with the disease which also caused up to 2.5 million deaths. This is a great loss and affects significantly on health systems, social and family life. Nigeria statistically, is one of the worst HIV/AIDS hit countries in the sub-region. It is estimated that in Nigeria, between 2.4 and 5.4 million people were living with the disease at the end of 2003. Furthermore, in the same year, up to 490,000 adults and children were estimated to have died from the disease.638 In fact, access to this drug should be easier in sub-Saharan Africa than in developed countries because their need is greater in this regard.

What would the principle of justice in health care demand in this particular case? These three *prima facie* principles as I earlier presented are interrelated. It recognises a communalistic ethic, an ethic, which emphasises corporate, and communitarian rather than atomistic existence. A duty to be just is a consequence of the communal nature of the African society. The three principles defended in this study can both be said to be principles of social morality. They are the direct consequence of the social nature of humans. The principle of justice in the Igbo context implies an idea of social co-operation. African humanistic/social ethics of solidarity

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emphasises social justice and discourages the for-profit global marketing of research and biotechnology. African culture in this regard can humanise Western culture. In Igbo philosophy, the principle of justice is well captured by the saying, ‘may the kite and the eagle perch whichever says the other should not, may its wings break’ (Egbe bere Ugo bere, nke si ibe ya ebena ka nku kwaa ya). The Igbo have an equalitarian and egalitarian philosophy. This explains why the pursuit of consensus is a fundamental element of their moral life. This requires, equal, fair and just share of the goods of life, deriving from the ideas of common good and the value of community. A basic question in this regard concerns how the benefits and risks of research are to be distributed. There may be more than one way to distribute benefits and risks.\textsuperscript{639} The account of justice I have presented in this study is that which is pluralistic. This would support a pluralistic standard of care for those participating in medical research trials. The particular situation of African countries gives rise to problems of distributive justice. The reason is the scarcity of medical resources. Justice in this situation is dependent on the context in which the researches are carried. The idea of overarching ethical principles is a mistaken one. Now what implications could this framework have in the field of reproductive technology within the Igbo setting?

Within an Igbo context, the morality of ART will most likely not be in doubt. This technique would be seen as simply assisting the natural moral act, the marital act that has already taken place. Its strong point is that conception takes place ‘in vivo, that is in the body. I earlier pointed out that generally conception without marital act would be accepted by most Igbo people. The reason is that the child who is the result of such procedures is valued above marital act per se.\textsuperscript{640}

\textsuperscript{639} The distribution of benefits and risks has been based on for example: to each person an equal share, to each person according to individual effort, to each person according to merit, to each person according to societal contribution, and to each person according to individual need. Each of these formulations has its problems. I would suggest a combination of these criteria after careful study of the particular context. This is a complex issue. Questions about allocation of scarce medical resources involve not only philosophical dimensions concerning the prioritisation of values, but also economic, legal, and sociological and public policy dimensions.

\textsuperscript{640}Nnene Emenawo, a woman aged 95 from Umuariam Obowo collaborates this conclusion in a personal interview with her in 2002 at her residence in Umuariam.
Nevertheless, a basic difficulty that surrogate motherhood may confront among the Igbo is the idea of it being reduced to commercial terms. For the Igbo, children are not sold in the market. This idea is found in such expressions as ‘nwa agbagi n’ahia’ (children are not sold in the market).\textsuperscript{641} It is important then to make a distinction between surrogate motherhood based on altruism and surrogate on the ground of commercial contract, i.e. giving the child to the contracting couple for a fee. The former would be considered moral while the latter would be impermissible. Such a commercialisation of childbearing would not be in line with the value of children and motherhood within the Igbo culture and it is fraught with difficulties including the risk of the gestation mother refusing to relinquish the baby to the contracting couple.\textsuperscript{642} Generally, surrogate motherhood is a highly complicated process.

Infertile couples face one of the worse kinds of infirmity in traditional Igbo society. Within the context of traditional Igbo worldview, where ethics is based on communal living emphasising respect for life means support given for the creation of new life and solidarity implies support shown to those in need. Justice in health care within this framework requires policy-makers in health care to make these techniques available and affordable to those couples who need them. Marriage for the Igbo is not an end in itself. The primary end is procreation for the continuity of the family lineage and the desire to reach ancestorhood. Any failure to have children is

\textsuperscript{641} Tangwa AFFIRMS this view by contending that “part of the packaging of ART/…/ that would not sit well with African ideas and attitudes, is its almost overt connection with business and commercialisation, patenting and marketing, talk about quality control, shopping and advertising, and all the media publicity that goes with these.” See Tangwa, 2002, p 59.

\textsuperscript{642} In Sweden and Norway, a fertilised egg may only be placed back into the woman from whom the egg is removed. Cf. Swedish Law on Fertilisation outside the Human Body, 1988, No. 117, at 2 and Norwegian Law on Artificial Fertilisation, 1987, No 68, Chapter III. In Spain, surrogacy with or without money is unlawful, even when there is a contract for gestation, it is still the mother who gives birth to the baby is the rightful mother. Cf. Spanish Law on Assisted Reproduction Procedures, 1988, No. 35, Chapter 10. In Germany, both surrogate motherhood and embryo transfer are banned. See Reproductive Rights Reporter, Oct 26, 1990, II, 19 at 8. For the Council of Europe, “maternity should be determined by the fact of giving birth, rather than genetics (origin of the ova), firstly because of the necessity of giving the child clear legal situation at birth.” See Council of Europe, 1989, Human Artificial Procreation Strasbourg, Principle 14 arts 28-29.
considered a tragic end. Africa communalistic way of life makes marriage and procreation the first prerequisites of achieving personhood.\textsuperscript{643} Thus, marital act is for having children. Where by natural marital act is not able to give children to a couple, any interventions aimed at overcoming infertility will be considered prima facie moral by most Igbo people.\textsuperscript{644} The basic criterion in this connection for judging the morality of ART procedures would be those technologies that promote human good and flourishing. In the context, it implies those goods that define a fulfilled and realised life for the Igbo people, providing for the continuity of the lineage.\textsuperscript{645} The wish of couples to have children in this connection can be said to override the view that children have right to a life that begins in the natural way. Given this, the morality of these techniques are not in doubt for most Igbo people. However, it needs be observed that some of these positions supported by Igbo culture are in conflict with mainstream Christian positions particularly that of the Catholic Church\textsuperscript{646} on the problems discussed. This may be a challenge for Christian bioethics to address as over 95% of the Igbo are Christians.

The question that could arise at this stage concerns what distinguishes my approach from the western methods discussed. It could be seen that the approaches of the three works studied as well as mine are committed to the objective of morality. More importantly, PBE and Engelhardt share with me an interest in bioethical matters in a pluralistic setting. In contrast to them, my approach may be said to differ from them on four basic grounds, namely, (1) A different set of principles; (2) A different decision-making process; (3) An ethic of solidarity; and (4) A contextual and holistic bioethics.

In contrast to the four principles of Beauchamp and Childress, I propose a different set of principles that I argue to be congruent with African life. These principles do not by themselves constitute morality neither do they alone or in combination resolve all

\textsuperscript{643}Harley E. Flack & Edmund D. Pellegrino, 1992 eds., \textit{African-American Perspectives on Biomedical Ethics}, p 87.
\textsuperscript{644} Personal communication with a group of women suffering from infertility problems in Alike, Obowo, July, 2005.
\textsuperscript{645} This conclusion is shared by a group of elders interviewed in Alike in July 2005
bioethical problems. They are, however, fundamental to the ethicality of any decision made within the field of bioethics. The reason is that they capture in an important way the current value system of most African people. They have serious implications for the consent process and autonomy process that are considered highly necessary in health care delivery.

Decision making process in order to be ethical must respect the person(s) involved in the decision making. While western-styled decision process emphasises individualism, African perspective stresses the web of family and community relationship that should be involved in the decision process. It is in this way that the person of the patient is respected within an African setting. A particular contribution African bioethics could make to common Bioethics is balancing an ethic of rights or autonomy that is dominant in mainstream bioethics today with an ethic of solidarity. While it is important that individual patient’s right should be protected against paternalism and all the like, it is equally necessary that solidarity with the ill and vulnerable is not neglected. In view of the HIV/AIDS pandemic and other health problems, I share Walther’s view that we should add a principle of mutuality, solidarity or community to the four principles of bioethics by Beauchamp and Childress. Interestingly, we have seen that it is preferable to see different theoretical perspectives as providing alternative frameworks for engaging issues in different contexts. Each framework provides important insights that can be applied in our quest to address thorny issues.

Solidarity is the direct consequence of the communal life of most Africans. Since common morality relies heavily on ordinary shared beliefs, considered judgement and values; it finds its expression in a special way in a community. As was earlier noted, within African culture unique relationship exists among members of the same

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647 Commenting on the need for solidarity, John Paul II writes in *Evangelium Vitae* No 19: “Life is not protected by the notion of freedom which exalts the isolated individual in an absolute way, and gives no place to solidarity, to openness to others and service of them”. He continued in No 20: “When the promotion of self is understood in terms of absolute autonomy, people inevitably reach the point of rejecting one another. Thus society becomes a mass of individuals placed side by side but without mutual bonds”.

extended family and members of the same community. This relationship is essentially that of care and solidarity within the family or community. An ethic of solidarity acknowledges the limit of medical technology, which though it can alleviate suffering, yet cannot obliterate the phenomenon of death. Solidarity with the sick and dying humanises these conditions. Patients, the sick and dying do not merely seek for cure and healing. They seek for solidarity, consolation, compassion, empathy, and hope. This solidarity assures the person that he or she is not alone in the journey of life. This gives meaning and value to ones life rather than just an ethic of rights with autonomy as its principal element. This ethics of solidarity suggests that bioethics in a pluralistic society needs to be open to those phenomena of life that are important in peoples’ life. Within the context of healthcare, it gives rise to care in solidarity, compassion, sensitivity, respect for the dignity of the sick and elderly. Instead of an ethic of individualism as in most western societies, African perspective defends an ethic of solidarity where the weak and powerless are catered for by the community.

The framework I have formulated is a holistic one. This means that it is not reductionistic. It rather acknowledges all aspect of reality that is relevant to understanding and making moral judgements, namely, the physical and the transcendental. Within African moral life, transcendental values have as much an important place as material values. In seeking a resolution to bioethical conflict, an African perspective accepts the insights of all dimensions of experience. The practice of modern medicine in spite of focusing on evidence based solutions remains a normative activity. The notions of disease, pathology, abnormalities embrace evaluating elements concerning good health. All these contain value judgements. The practice of medicine therefore is not an area where facts and values are clearly separated. What counts as justified medical care are very much dependent upon the understandings of health, illness, morality, death, healthcare, and appropriate modes of conduct. Bioethics in pluralistic setting must embrace and respect the whole diversity of worldviews both religious and secular. In contrast to PBE, my framework takes moral pluralism seriously. Objections may be raised that PBE is pluralistic. They write
…We reject the assumption that one must defend a single type of theory that is solely principle-based, virtue-based, rights-based, case-based, and so forth. In moral reason we often blend appeals to principles, rules, rights, virtues, passions, analogies, paradigms, parables, and interpretations. To assign priority to one of these factors as key ingredient is a dubious project.649

It could be said that the formulation of their four principles is inspired by different and even diverging theories. How then could we accuse them of not taking moral pluralism seriously enough? While it is true that PBE incorporates relevant elements in other theories into their framework, yet it is questionable whether they could be said to be pluralistic in the sense of embracing other cultural frameworks and ethically relevant contexts outside of the North American context. The difference lies in the fact that their four principles function in bioethical decision-making within a culture where individualism with its roots in the concept of autonomous self is given primacy among all other values. Individualism as I have argued indicates a value system. By contrast, my framework has a communitarian base.

Thoughts for the future

This thesis has given a critical analysis of different theoretical perspectives within western biomedical ethics, and an analysis of how worldview and view of humans in African culture can have implications for the formulation of theory in bioethics. In this project, I have discussed and analysed the works of some moral philosophers and bioethicists, namely: John Kekes, H. Tristram Engelhardt, Tom L. Beauchamp and his co-author James F. Childress. In the analyses, an investigation of how they relate themselves respectively to the question of common morality in a pluralistic society is conducted. First, I discussed whether in a multicultural and secularised society it is possible and desirable to articulate a common morality that could serve as basis for bioethics. The response is in the affirmative.

649 Beauchamp and Childress, 1994, PBE, p. 111.
This thesis has demonstrated that it is possible to address the problem of moral or ethical pluralism in a pluralistic society without falling into a normative relativism. It has been shown that rational and justifiable reasons can be given in bioethics for carrying out a particular action within a specific context. This has been achieved by employing the theoretical tool of common morality.

One of the conclusions is that Africa has a bioethical context that is though similar to that of the West is yet different in many ways. A strong correlation is discovered between worldviews, cultures and bioethical problems. The bioethical issues that are prevalent in Africa are as wide-ranging as those felt elsewhere in the world, from overpopulation to assisted reproductive technology, from medical intervention to euthanasia, from artificial contraception to abortion, and research in HIV/AIDS vaccines. One inescapable conclusion from this study is the need for Africa countries to address the bioethical issues that directly affect the daily lives of millions of her people. It has highlighted the limitations of western bioethical framework in addressing bioethical issues that emerge in the African situation.

I have only developed a general African bioethical framework using the three-prima facie principles of respect for human life, solidarity, and justice in health care upon which concrete action could be undertaken within the African context to address these issues. These principles have been argued to be congruent with the worldviews of most African people. By arguing for these three principles, I do not wish to suggest that they are the only principles that could guide concrete bioethical deliberation within the African context. Bioethical issues prevalent in Africa are varied and pose various challenges. In the west, the challenges concern the issue of the use of technology and its implications and consequences to human behaviour. Within this context, bioethics and health care are characterised by technological imperative. In Africa, however, the challenge though similar to that of the West is not so much the human use of technology because they are scarcely available in most of the continent. The major challenge seems to be the perennial problem of poverty, which not only deprives people of the advantages of technology but even the basic and preventive health care. Worse still is the fact that the scarce resources are unequally
distributed as they are only accessible to the very rich, in this connection raising the problem of resource allocation and distribution. These challenges depend on where one finds himself/herself in the continent.

African as throughout the world joins others in hoping for developments and medicine that will improve the health and wellbeing of all people including the poor. This study has shown that it is mistaken to assume that biotechnology is irrelevant to the health needs of the world’s poor particularly Africa. It is equally false to believe that biotechnology cannot contribute to the prevention of diseases and the promotion of health. Biotechnology, which aims to alleviate human suffering and promote progress of society, must be accountable and responsible in its praxis. It can deviate from its true purpose, and this is where the problem begins. This is why there is need for guidelines to regulate its development and thus ensure that it keeps to its true purpose. Yet, we know that this is no easy task. I believe there are ways of achieving such results without compromising research ethics, ways that promote health and human wellbeing.

In Africa, there is need to identify priority biotechnologies that can help improve health in the continent. These should be affordable, robust and adjustable to the health care context of Africa, which is at the same time socially, culturally and politically acceptable, i.e., to the lived phenomenology of the African context. Future studies could concentrate on this area. There is need to strive to reach an appropriate balancing between the biotechnologies discussed in this study and conventional ones. Such a task we are aware is not an easy challenge, yet its relevance and application to the life of the people of the African continent should not be ignored. The diversity of cultural, social, religious and philosophical assumptions demonstrated in this thesis regarding human beings, health and illness, life, death and dying, the status of the individual vis a vis his or her community have shown the relevance of cross-cultural studies in pluralist society.

Bioethics is an ever-increasing field. In Africa, there is need to study clinical ethics, i.e., health professionals and patient relationship. In most cases, this is still characterised by paternalism
promoted by illiteracy on the side of care receivers and the authoritative position of many health givers. There is need for hospital ethics committees to protect the rights of patients and ensure the dignity of the human person is respected. This concerns the whole area of bioethics and health care management. Other important areas of comprehensive research would include the ethical bases of the concepts of autonomy, informed consent, health, suffering, personhood, death, and dying within health care delivery in Nigeria, and research ethics especially those involving human participants especially with the issue of HIV/AIDS pandemic. Furthermore, ethical issues in the emerging palliative care services constitute an interesting area of study and also the relationship between bioethics and law e.g., the role of civil, penal and administrative law in the protection of human life and health, bioethics and human sexuality. My intention has not been to develop a framework that could address all the bioethical issues that emerge in Africa. My humble ambition is to present a way of thinking thereby providing framework for analysing and debating policy and bioethical questions relevant to the Africa context.

Conclusion

In this study I have discussed the question concerning the possibility and desirability of a common bioethical framework for a pluralist society. I have also explored what could be the contribution of African culture and value system to such a project. In the course of this study a number of problems that have emerged from developments in biotechnology, biosciences, medical technology and bioethics have been presented and analysed. The response to the question of the possibility of a common bioethical framework is in the affirmative provided such a framework takes into serious account diversity and plurality in human cultures and is contextual. I also discuss the question of what should characterise an acceptable African bioethics. Among other elements, it is concluded that African worldview expressing itself in conceptions of personhood and community must be normative for any bioethics that would be African. In addition, it should have relevance for the understanding
and interpretation of reality among Africans and at the same time holistic in its approach.

The analyses of the central concepts and principles in the three Western ethical theories discussed in this study demonstrate the role of cultural values and worldviews in bioethics. The conclusions reached here can be utilised in transcultural bioethics including bioethics education and in clinical health care ethics not only in Africa, but internationally. The very idea of common morality or notion of ‘human right culture’ shows that some social goods are basic humans flourishing. It is observed that the experience of finitude, illness, suffering, death, and dying are common human phenomena. Different cultures have developed different ways of responding to them. The goal and objective of both traditional and modern medicine are those of restoring health and wholeness. Thus, it can be said that health is a common value to all people. This forms the basis for the possibility of bioethics in a pluralistic society. What this study emphasises is that particular cultural and religious traditions shape experiences of birth, suffering, illness, health, death, and dying. Bioethical deliberations will do better by paying attention to them.

In the last chapter, I have argued that morality is both universal and particular. The conclusion is that we can in general secular terms come to some substantive or normative conclusions regarding bioethical questions and health care problems through sound rational deliberation. Although there may be some irresolvable bioethical problems, yet most problems are resolvable. A universal morality can be formed on the motivations of those committed to the objectives of morality. In line with this, I have argued that a common bioethics is possible and desirable. It is justified by the existence of common morality. Equally, this provides a warrant for political authority and governance. This finds ample expression in human right language accepted by most people in the world. Nevertheless, common bioethics must be one that accepts and sees diversity as some thing positive rather than an obstacle to human flourishing. This entails that common bioethics must respect pluralism, both religious and secular.
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Glossary of Abbreviations

ART Assisted Reproductive Technology
AZT Zidovudine
EG Embryonic Germ cells
ES Embryonic Stem cells
ET Embryo Transfer
GFBFR Global Forum on Bioethics in Research
GIFT Gamete Intrafallopian Transfer
ICSI Intracytoplasmic Sperm Injection
IUI Intra Uterine Insemination
IVF In vitro Fertilisation
JMP Journal of Medicinal Philosophy
MRC Medical Research Council (UK)
MTCT Mother To Child Transmission of HIV
NBIN Nigerian Bioethics Initiative
NCB Nuffield Council on Biomedical Ethics
NDHS Nigerian Directorate Health Services
NIS National Institute of Health
PABIN Pan African Bioethics Initiative
PBE Principle of Biomedical Ethics
SCNT Somatic Cell Nuclear Transfer
SMER Swedish National council of Medical Ethics
STIS Sexually transmitted Infections
NIH National Institute of Health (US)
CIOMS Council for International Organisations of Medical Sciences
WHO World Health Organisation
AIDS Acquired Immune Deficiency Syndrome
US United States
WAB West African Bioethics Training Program
HIV Human Immunodeficiency Virus
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