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these principles continue as implicit, if not explicit, premises underlying analysis of ethical issues and decision making in clinical settings. Indeed, a cursory review of recent scholarship immediately illustrates the enduring reliance on Beauchamp and Childress for an ethical framework for theory and practice.[4] O'Neill, for example, opens a discussion on "Practical Principles, Practical Judgment" by stating that the most well-known approach to bioethical reasoning that

that leave considerable room for judgment in many cases.” More surrounding health and disease. Empiricism is requisite for a just and informed bioethics—a descriptive bioethics that grounds each case in its cultural, historical, and political-economic contexts. There are two main critiques we make: that the individual is so prioritized and central as to become an unquestioned presumption of care; and that the notion of a common morality is a false, if not a culturally imperialist, idea that justifies the devaluation of locally meaningful moralities. Were one to explore it at a sufficiently high level of abstraction, one might be able to identify areas of widely shared values. However, when one gets to the specifics of when certain moral values can be imposed, then what seems in the abstract to be morally universal quickly becomes culturally specific. For example, when is it acceptable to kill? Is it ever acceptable to rape? What constitutes child abuse? Analysis of local moralities a.wtoalysis universaes 0 0 100 160.5 160 610.2198 Tm /TT6 43

That is, to propose as a theoretical principle a concept (i.e., autonomy) that is disregarded must call into question the validity of the theory. If patient autonomy is viewed in the vast majority of settings as not just a right but an obligation of patients, then this problem demands both theoretical and pragmatic remedies. The Four Principles approach offers neither.

As we have noted, Beauchamp and Childress behavior and motivation. This distinction is far too general to guide clinical practice.

So to employ the Four Principles approach, we must accept that humans share innate (i.e., universal) processes or characteristics that eventuate in a common morality. Anthropologists, trained to be sensitive to the diversity of human thoughts and values, typically eschew such assumptions about innateness or universality. Virtually all schools of anthropology entail an acceptance of at least a weak form of descriptive relativism. Normative relativism, favored by some anthropologists, goes a step further in asserting that, because cultures judge each other according to their own internal standards, there are no universal standards to judge between cultures.[20]

for bioethicists to choose from. For example, casuistry, relationship-based approaches, utilitarianism, character or virtue ethics, and communitarianism. But few of these provide for the type and depth of descriptive context we propose, and none address authoritative knowledge and the power structures within which decisions about health and health care are made. So if none of these options provide the solution, what exactly can anthropologists add? Why would could enhance the understanding of how decision-making competence is determined, and the limits of individual autonomy. That is, anthropologists can add ethnographic detail, informing ethicists and clinicians of the personal narratives, cultural meanings, and local moralities that shape decision making. We should note that the concept of "personal narrative" might suggest an idiosyncratic, subjective account. However, as Kaufman cogently argues, narratives are constructed from shared understandings of the cultural world, and as such, identify important cultural and structural features that shape to the patient and/or family the preferred decision of the clinician, based presumably on medical expertise or institutional concerns about liability.

Should we consider these “flexible negotiations” a form of benevolent paternalism? We suggest the importance of acknowledging the authoritative knowledge of the physician, and other biomedical practitioners. Physicians, whose moral weight and perceived scientific expertise are linked to formidable medical technologies, are in a position of power, and rarely in an egalitarian, collaborative interaction.[26] How authoritative knowledge is produced and displayed in ethical consultations is a question that anthropologists could usefully address.

A grounded approach to bioethi i

The clinical case—the identified patient, other relevant decision-makers, even the parameters in a temporal sense (when illness began and when it ends)—is a manufactured product; a certain telling of the story amongst many other possible tellings.

Adapting this model for a more ethically neutral approach to health care decision-making might look like this (see box). That is, it would begin with aspects of decision-making and the values and beliefs guiding care.

How might ethical decisions change if “cases” came to be viewed as life stories, family events, or other ongoing narrative? A grounded approach that is informed by ethnographic information would reliably attend to the structural, institutional, and procedural barriers that worsen—and in many cases produce—ethical dilemmas in health care. Armed with this information, clinicians and institutions would at least have insight into problematic arenas requiring changes. A final case will demonstrate what we suggest.

Case 3

A doctor writes to an ethics committee requesting a discussion of patients who behave abusively to doctors and nurses. The committee, composed of doctors, nurses, social workers, chaplains, and community representatives, agrees that this is an important issue. The anthropologist present asks, “Who are the abusers?” The response from one prominent and respected physician is “generic scumbags.” The anthropologist suggests a survey in which, when a case arises, the following information is reported to a central source: age, sex, ethnicity of patient, medical condition, and circumstances/context when incident occurred. Committee members are not interested, deciding rather to ask for a consult with psychiatry on how to manage disruptive patients. For them, a key ethical issue is whether it is acceptable to call security for such a patient (with exceptions made for someone with dementia or on drugs).

Management of the abusive patients, certainly a reasonable concern, becomes the core issue of discussion. What we lack, however, is any data on precisely who these “abusers” might be (we might speculate on age, sex, insurance status) and in what sorts of situations abusive behavior might emerge. Eliciting and analyzing this information might then provide us with a means to address the fundamental, underlying causes of disruptive behavior, and therefore to identify possible structural factors implicated in these scenarios.

Closing

Bioethics is a field now dominated by premises of western philosophical thought; principles and rights-based approaches that have reinforced a “pervasive reductionism, utilitarianism, and ethnocentrism in the field.”[33] Originally bioethics was intended to empower patients in the context of a rights-based approach, which would allow patients to reclaim power from biomedical expertise. It is ironic that this effort to generate empowerment has had such mixed results.[34]

We suggest that incorporating an ethnographic approach in ethical analysis would challenge ethicists to pay greater attention to how moral concepts are embedded in social practice, and how biomedical practitioners and institutional patterns shape the production and experience of ethical dilemmas.[35]

Value neutrality is untenable in a "real world" bioethics. But anthropologists can effect change both directly (in communication with patients and practitioners) and by advocating for structural change that might have broader impact. For example, decentralization of primary care services might allow patients to develop therapeutic relationships and alliances that would limit disruptive behavior, and intake and consent-gathering procedures that incorporate a larger network of those invested might forestall later crises and disputes.

What we need are theories of bioethics that do not reproduce, in an unexamined way, the assumptions of a single cultural paradigm.

Endnotes

1 Arthur Kleinman,

(Berkeley: University of California Press, 1980). See also A. Kleinman, L. Eisenberg, and B. Good, “Clinical Lessons From Anthropologic and Cross-cultural Research,” 88 (1978): 251-258.

2 Ibid.

3 Cecil G. Helman,

that as a normative cultural practice, it should not be categorized as “abusive” (see Bettina Shell-Duncan and Ylva Hernlund, eds.,
[Boulder and London: Lynn Reiner Publishers,

29 Kathryn Montgomery Hunter, (Princeton: Princeton University Press, 1991).

30 Barry Hoffmaster, (Philadelphia: Temple University Press, 2001).

31 Helman, , 86.

32 Kleinman, , 58.

33 Marshall, “Anthropology and bioethics,” 49.

34 For an insightful discussion of this history see M.L. Tina Stevens, (Baltimore: The Johns Hopkins University Press, 2000).

35 See Bruce Jennings, “Ethics and Ethnography in Neonatal Intensive Care,” in , ed. George Weisz (Philadelphia: University of Pennsylvania Press, 1990), 261-273; and Marshall, “Anthropology and bioethics,” 53.

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The leaders of Southern Methodist University believe that a university does not fully discharge its responsibility to its students and to the community at large if it hands out knowledge (and the power which that knowledge eventually yields) without posing questions about its responsible uses. Through the Cary M. Maguire Center for Ethics and Public Responsibility, SMU strives to foster the moral education and public responsibilities of those whom it empowers by:

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Has created an Ethics Center Advisory Board of professional and community leaders;

Organizes local seminars, colloquia, and workshopr Orand ge31he