Ethic Theory Moral Prac (2011) 14:419–430
DOI 10.1007/s10677-011-9290-y

The Uses and Abuses of Moral Theory in Bioethics

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Abstract Moral theory is an important guide to bioethical decision-making, but it can confuse and mislead those who offer ethical advice to clinicians and researchers, delaying decisions that must be made in a timely fashion. In this paper I examine the ways moral theory can lead bioethicists astray. Absent a sensitivity to the empirical realities of ethical problems, moral theory 1) contributes to the disappearance of the persons caught in an ethical quandary, 2) focuses on the puzzle-solving rather than examining the conditions that generate moral problems, and 3) universalizes ethical dilemmas, overlooking local processes for resolving moral questions. Taken together, empirically informed moral theory and theoretically informed empirical research can help bioethicists transcend the is/ought problem in ethical work.

Keywords Empirical ethics · Is/ought problem · Sociology of bioethics · Upstream bioethics

What is the proper place of moral theory in the work of bioethics? Moral theory is born in the luxury of reflection and academic debate, in a world where scholars have time to refine their ideas and test them against the ideas of others. Bioethics has a more immediate task. Bioethicists who work in the clinic or on research ethics committees must make decisions in the moment; they cannot publish their opinion and wait for the considered responses of their learned colleagues. Yes, bioethicists call on moral theory in their deliberations, but they must translate the "ought's" of moral theory to the "is" of the situation they are called on to adjudicate.

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Bioethics lives in this tension between is and ought. Called upon to bring the insights of moral philosophy to the ethical dilemmas of medicine and medical research, bioethicists must nevertheless attend to the practicalities of situations they are confronted with. It is not enough to bring the elegance of a moral theory to the quandaries of medicine—bioethicists are held accountable for the consequences of their judgments. The demands of bioethics have expanded the field beyond moral philosophy, bringing in practitioners from several disciplines, theoretical to applied: theology, nursing, social work, law, medicine, literature, and social science. All those who do bioethics struggle with the is/ought problem, but among the many disciplines of bioethics, sociology is ideally situated to offer a meta-perspective, to consider the translation of ought to is, to examine the way moral theory is used, and abused, in the day to day decisions of bioethicists (De Vries 2010a).

1 Beyond is and Ought

Can one get an ought from an is? Moral philosophers say no! Empirically-minded social scientists say yes! Rather than extending and continuing this now tired debate, a sociological look at bioethics seeks to clarify the place of ought and is in bioethics. One way to do this is to consider the different ways social science approaches bioethical issues. In earlier work, I contrasted a sociology "in" bioethics and a sociology "of" bioethics (De Vries 2004). Sociology in bioethics uses the methods of social science methods to help ethicists answer questions they have about their work. The social scientist simply takes a question formulated by an ethicist and uses the methods that he or she knows well to help find the answer to that question. In most cases, an ethicist will call on a social scientist when the question at hand is perceived to be "sociological" or "cultural". For example, sociologists and anthropologists typically find themselves invited by ethicists to discover if this or that ethnic group *really* understands the terms of an informed consent document (and if not, they are asked to translate the idea of informed consent into culturally appropriate terms).

A sociology of bioethics begins with social scientific questions. Rather than starting with a question that an ethicist might have—e.g.. "How can we be sure that people are properly informed when they sign an informed consent document?"—a sociologist of bioethics asks questions about how the informed consent process came to be, how it developed and changed, what function the process serves, and what alternative methods for informing a patient or research subject and gaining consent might exist. Notice how the contrast between sociology in, and sociology of, bioethics turns attention away from the deceptively simple question, Can you get an ought from an is? Instead social science looks at the nature of an ought to discover where it comes from and which ought's are paid attention to and which are not.

This "outsider perspective" on bioethics—with its examination of how and why certain "oughts" are put into play—has not always been welcomed by practitioners. Looking at the work of American bioethics, sociologists Renée Fox and Judith Swazey (1984: 337–338) found a "cultural myopia", a "systematic inattention to the social and cultural sources and implications of its own thought." Daniel Chambliss (1996)—working from a similar sociological perspective—described how bioethics exerts a conservative influence on medicine:

> Talk of "ethical dilemmas" diverts attention from the structural conditions that have produced the problem in the first place. . . This is why so many hospitals can readily accept an "ethics committee" and its debates about ethical issues. . . [threats to

> powerful hospital staff are] contained by framing issues as difficult dilemmas rather than seeing them as symptoms of structural flaws in the health care system…. If ethical problems are not dilemmas, then what are they? . . they are the symptoms of occupational group conflicts in the hospital, in which moral arguments are weapons in the fight . . . Ethics committees . . . are useful . . . allies in those fights. (Chambliss 1996, pp. 32–33)

Bioethicists were offended. They view themselves as advocates for patients and research subjects, not as shills for medicine and the medical-industrial complex. Bioethicist Samuel Gorovitz (1986) accused these critics of "baiting bioethics," claiming that Fox and Swazey "offer no evidence to support their perceptions [of bioethics], except for a smattering of brief quotations…" Interestingly, he offers his *own* collection of citations in order to illustrate that their sociological characterization of bioethics is untrue.

In an effort to stop the quarreling between theoretically- and empirically-oriented bioethicists—to close the is/ought gap—Turner (2009), made a plea to move bioethics beyond the "misleading" and "unhelpful" "demarcation of disciplinary goals" that leads to "dichotomous thinking" and "polemical accusations." Turner argues that calling attention to the overlap between social science and bioethics will result in "fewer broad indictments of bioethics and more fruitful exchanges between scholars in bioethics and the social sciences." But is this the best way to move bioethics forward? I am persuaded that the interdiscipline of bioethics will be *more* productive if social science and bioethics do *not* get along. As an interdisciplinary endeavor, bioethics faces the danger of "undisciplined" work: when bioethics cherry-picks the insights of other disciplines, the distinctive intellectual histories of those disciplines get lost or ignored, creating a bland academic stew. Too close a relationship between bioethicists and social scientists will diminish the work of both the bioethicist and the social scientist. The theoretical-empirical tension can be productive. A separation between the disciplines of bioethics may allows for a situation where each discipline to can contribute to the understanding of the other, not simply accommodate.

This does not mean bioethicists and social scientists cannot work together. In their article, "Nobody tosses a dwarf: The relationship between the empirical and the normative reexamined" Leget et al. (2009) call for a new "ethical realism"[1] explaining how social science data can inform normative decisions and how norms can inform data collection. Their approach involves five steps that move between the empirical and the normative:

a. *The determination of the problem*. What counts as a moral problem? Who invokes moral values and in what terms are they framed? The first task for someone who wants to bring the normative and the empirical together is to clearly determine the problem to be explored: what is the problem, what are its normative and empirical dimensions.
b. *The description of the problem*. In describing an ethical problem normative ethicists will pay attention to the words used in the description, and social scientists will examine motives of the actors, the content of moral deliberation, and the impact of the of the social and cultural context of the deliberation.
c. *Study of different resolutions to the problem, including their effects and alternatives.* The effects (intended or not, foreseen or not) of, and possible alternatives to, different resolutions are morally relevant. Empirical research can provide an overview of the consequences of a decision or policy, but empirical data about consequences of actions cannot provide the ultimate answer about the proper way forward. Theoretical ethics is

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[1] This term gives a nod to the legal realist movement of the early 20th century (Schlegel 1995).

needed to compare and evaluate the moralities supported by data and those supported by normative theory.

d. *Normative weighing*. The work of normative ethics here is to make sure that the normative power of the data is put in its proper place. Statistical normativity does not equal moral normativity. In the end empirically-informed ethical theory renders moral judgment. But empirical research tempers ethical theory by bringing to light values present in the use of moral theory.

e. *The evaluation of the effects of a decision*. The final step involves the implementation of a decision and evaluation of the effects of that decision. Once a decision has been made, decision-makers must be sure that the decision has no unforeseen and unintended effects. This step may well lead to beginning the process once again, with the results of the decision being determined, described, studied, normatively weighed, implemented, and evaluated.

By underscoring the fact that you cannot get an ought *from* an ought and that you cannot get an is *from* an is, the work of Leget and his colleagues suggests an end to the is/ought problem. Norms do not come from nowhere. Norms are embedded in culture and in social structures and in language. The idea that an ought is some free-floating, non-empirical, detached value that has no connection to the empirical world is wrong. On the empirical side, Leget et al. remind us that all facts are embedded in normative ideas. When social scientists initiate an explorative study they choose a topic based in their ideas about what is important and what is not important. They analyze their data based on their often unacknowledged values.

2 Excursus: On the Morality of Method

The end of the is/ought debate calls attention to the unexplored area of the moral stance of academic disciplines. It merits a brief detour to consider this aspect of scholarly work. In order to illustrate the normative basis of academic work I focus on the embedded morality of my own discipline—sociology.

Several years ago, Howard Becker (1967) examined how sociology, in its attempt to understand social systems and cultures, adopted a perspective that challenges existing “hierarchies of credibility”. All social systems have hierarchies—some tall, and some relatively flat. One’s place in the social hierarchy confers credibility: those near the top of the hierarchy have more credibility than those near the bottom. Lay understandings of social systems rely on the credibility conferred by hierarchy—to discover how a system works, one should ask those with the most credibility. Sociology inverts this logic. Sociologists valorize the perspective of those at the bottom of the hierarchy. We believe that to gain real insight into how a social system works, one must ask those at the bottom of the hierarchy of credibility how the system works. A sociologist who wishes to understand how a hospital works, for example, will not ask the hospital administrator or the physician directors of hospital departments; the sociologist will include those people in her study, but will also be sure to interview custodians, nurses’ aides, nurses, and kitchen workers and will regard their reports as more telling (see e.g., Chambliss 1996).

Embedded in this method—upsetting hierarchies of credibility—are normative ideas about power, about truth, about veracity, about understanding. When sociologists begin their analytic work, they bring these norms with them. Although rarely recognized or admitted, this morality is built into the methods of sociology.

The same "morality of method" applies to philosophy and moral theory. Where social science valorizes the debunking of hierarchies of credibility, relativizing social situations and social systems, and taking the perspective of an outsider (Berger 1963), moral theory valorizes clarity and logic. Consider, as a case in point, the different ways that a moral theorist and a social scientist approach the problem of conflict of interest. For a moral theorist, it is important to be very clear about the definition of a conflict and the definition of an interest; only then can it be understood when a conflict of interest exists and when does it not exist. To a social scientist, understanding a conflict of interest requires understanding the structures of power, how things get paid for, and the corrupting influence of resources on the way work gets done in the clinic or in the laboratory.

3 The Uses and ab-Uses of Moral Theory

There are, of course, several moral theories that inform the way bioethicists do their work, including among others, principlism, casuistry, and care ethics. Most widely used is the principlist approach that seeks to guide ethical decision making by calling on the principles of autonomy, beneficence, nonmaleficence, and justice (Beauchamp and Childress 2008). A second approach to moral theory is casuistry, an inductive theoretical approach that examines cases and extracts from them relevant elements that lead to concepts and ideas that can be applied to solve a particular problem (Toulmin and Jonsen 1988). Care ethics offers another theoretical approach to thinking about and resolving ethical dilemmas. Rather than refining theoretical ideas from cases or applying principles in a more deductive manner, the focus in care ethics is on relationships and understanding how decisions about ethical dilemmas are generated by and will affect relationships (Walker 2007).

How can these theoretical ideas move from being used to being ab-used? Let us first consider the meaning of the word "abuse". The word is the result of combining two words: the prefix from Latin *ab* which means "off" or "away from", and from the Latin *uti,* "to use, employ, exercise and perform". The abuse of moral theory is something that *takes us away from its intended use*. The proper use of moral theory in bioethics is to find solutions to ethical dilemmas that are just (fair) and caring (respecting persons)—how does the application of moral theory in bioethics move us away from this goal?

In my examination of the work of bioethics, I find three ways that moral theory can be abused:

1. By causing the "disappearance of the person;"
2. By focusing on puzzle-solving rather than on the issues—structural and cultural—that generate ethical problems; and
3. By universalizing ethical problems.

3.1 Disappearance of the Person

Often when we rely on moral theory to solve ethical problems, we discover that the person caught in the moral problem disappears. This occurs in a way that is analogous to the "disappearance of the sick person from medical cosmology", described by Jewson (1976). Jewson demonstrates that as medical technology developed, the person became less and less relevant to medical decision-making and medical care. He describes the initial phase of modern health care as "bedside medicine", where technology was unsophisticated and the physician had to pay close attention to the sick person and his or her account of the symptoms experienced. As medicine began to understand illness as a product of internal organic events—using statistical techniques, autopsies, and newly invented "scopes" for looking into the body—a new period of medicine emerged, "hospital medicine." The sick person was translated into a person with a disease, and the disease was located in an organ system. A doctor with a collection of patients became a clinician collaborating with other clinicians in a hospital in the search for the causes and cures of diseases. The sick person was now viewed as merely the repository of organ systems and the report of symptoms was less important than the signs of disease that could be identified by the clinician. This trend was exacerbated in the third era of medicine—"laboratory medicine"—where physical examinations were replaced by microscopic examinations and chemical tests; clinicians became medical researchers. The sick person became even less relevant to diagnosis and care. Jewson (1976, p. 238) explains:

> The increase in social distance [between the doctor and the sick person] was accompanied by the erection of strong boundaries between the sick and the medical investigators. Indeed the character of social relationships in the era of Laboratory Medicine gave the community of medical investigators the appearance of an insulated intellectual cocoon. Specifications for membership were exacting and exclusive. Significant communication about the causes and cures of illness was confined to members of the group, legitimate publication outlets being reduced to a closely guarded few. The use of technical jargon and concepts served as a ritual mode between the established and the outsiders.

Jewson chronicles the transition from the care of persons—with lives and relationships intertwined in their communities—to the treatment of "cases". Rather than a living, breathing person in a social context, a person becomes an abstraction in the case.

Moral theory often makes this same move: persons caught in an ethical dilemma become interesting cases, abstracted by the use of technical jargon and concepts. This is nowhere better exemplified than in the way ethics has handled the issue of suffering. It can be argued that bioethics was created in an effort to relieve suffering—the suffering of uninformed research subjects enrolled in harmful experiments and the suffering of patients exploited by the medical-industrial complex. Given the origin of bioethics, it is remarkable that the field has given very little attention to the problem of suffering. The seminal work in this area was written by Cassell in 1991. He criticized both medicine and ethics for ignoring suffering and, more to the point, for ignoring the *sick person* in favor of treating a collection of signs revealed by the technologies of medicine. His important work has been both lauded and ignored. Little has been done to integrate this perspective into the field of bioethics, clinical work, or the training of the next generation of doctors.

3.2 The Focus on Puzzle-Solving and the Need for "Upstream Bioethics"

The focus on moral theory favors the solving of puzzles, not the examination of social structures. The academic challenge of solving an ethical dilemma bounded by a given set of circumstances becomes an intriguing game. The question becomes: can we find a way to slip through the horns of the dilemma? This displaces the important work of "upstream bioethics", that is, the identification of the sources of ethical problems "upstream"—in the social arrangements that generate the moral problems of medicine.

The Hastings Center Report regularly publishes ethical case studies: a case is presented and two or more ethicists describe how they would resolve the problem. Consider this recent example (Hastings Center Report 2010):

> Samantha is a pale and withdrawn 14-year-old brought to the emergency room by her mother. She is fatigued, nauseated, and has been vomiting. Her mother tells the physician on call in the ER that she's very worried; Samantha lately refuses to eat, has lost weight, has stopped going to soccer practice, and has missed several days of school. The doctor examines Samantha and then asks if she may speak to her alone. Samantha and her mother agree and her mother leaves the room, but Samantha is clearly uncomfortable. In response to the doctor's questions, Samantha says that she first menstruated at age 11, that her periods have been regular, and that she last had one 4 weeks ago. When the doctor asks whether she is sexually active, she admits that she had her first sexual contact right before her last period. She says it was consensual and that her partner used a condom. She then says that she knows she's not pregnant—she took a home pregnancy test the day before, and the results were negative. The doctor asks if she can test Samantha again, and Samantha starts to cry. "I already told you, the test *said* I'm not," she says. "I'm not pregnant!" The doctor looks at her ER sheet, which includes a list of tests commonly ordered as a result of the physical exam—complete blood count and culture, urine analysis and culture, x-ray, MRI, CT scan. She strongly suspects Samantha is pregnant and could easily order the test without Samantha's knowledge as part of her workup. Should she?

The two respondents (Bonifacio 2010; Janvier 2010) do a fine job of identifying and weighing the issues involved: the minor status of Samantha, the responsibilities of parents, the need for consent, the importance of getting the results of a pregnancy test, and research on what 14-year olds understand about medical procedures. They offer thoughtful and caring ways to approach Samantha to get the needed consent. What the ethicists do *not* do is consider the larger cultural and social environment, an environment that shapes the way children learn (or do not learn) about sexuality, access to contraception, access to and trust in physicians, relationships between parents and children.

Admittedly, these larger issues will not solve the immediate problem between Samantha and her physician, but if bioethics acts only as the emergency department for ethical crisis, it does nothing to reduce the production of ethical problems like these.

The contrast between "puzzle-solving" and "understanding of structures" points to the need for "upstream" bioethics. Bioethics as currently constituted waits until a problem arises and then brings its powers to bear on trying to solve that problem—in the case of moral theory, to puzzling out the problem, defining it clearly, and deciding which aspects should be addressed. What is needed is a re-focusing on the upstream causes of the ethical problems. McKinlay (1979) makes this point in "A case for refocusing upstream" where he challenges medicine to examine the political, social, and cultural causes of illness. Moral theorizing in bioethics leads us away from consideration of the political, social, and cultural causes of bioethical problems.

3.3 Universalizing Problems

Finally, the abuse of moral theory in bioethics is evident in the tendency to universalize rather than particularize solutions to ethical problems. When used by bioethicists, moral theory seeks to abstract problems, therefore eliminating all of the social and cultural peculiarities. This leads to an abusive situation where solutions are harder rather than easier to find, and the solutions offered become less relevant to the local context. This is well-illustrated in the movement of regulatory ethics from North America and Europe to the Global South (sometimes referred to as the 'developing world').

In a study of this process my colleagues and I (De Vries et al. 2010; De Vries and Rott 2011) identified a "missionary" movement in bioethics.[2] Like the Christian missionaries from Europe to North America that preceded them, bioethicists are intent on bringing the gospel—the "good news"—to those in the developing world. The missionary gospel is the New Testament story of salvation offered by the death and resurrection of Jesus Christ; the gospel of bioethics is "good clinical practice," the *Belmont Report*[3] and the *Declaration of Helsinki.*[4]

The metaphor of missionary work is useful for understanding the place of bioethics in the developing world. It is clear that bioethicists have followed—consciously or unconsciously—one important example from the missionary movement: the shift from "imported" to "indigenous" evangelization.[5] Beginning in the mid-nineteenth century and throughout the twentieth century, missionaries faced resistance from their host countries. In some places, most notably China, missionaries were expelled; in other places, missionaries were increasingly regarded as colonialists. Mission organizations responded to this turn of events with the notion of "indigenization." No longer would missionaries from the West be exported to other countries. Instead citizens from those countries would be brought to the West and trained to situate the missionary message in the local culture. This meant translating the gospel into local languages, using local organizational forms in the creation of churches, and adapting local customs to the teaching of the gospel. Over time, indigenization came to be called "contextualization," and it was described as an effort to protect, and be relevant in, local culture.

Although they do not use the term, those in the West who wish to bring the benefit of bioethics to the developing world have seen the value of indigenization. Indigenization is a solution to what Solomon (2006) describes as the "export problem," of Western bioethics—a problem that is unavoidable when bioethics, a creation of Western culture, collides with the systems of ethics found in local, non-Western cultures.[6] Pursuing the indigenization solution, bioethicists from the developing world are currently being trained in the United States (via the National Institutes of Health Fogarty International Center[7]), Europe (via the Erasmus Mundus Masters program in bioethics[8]), and the United Kingdom (via The Wellcome Trust[9]). Having learned the language and logic of Western bioethics, trainees return to their home countries to spread the "gospel" (Solomon 2006).

Use of the metaphor of missionary work makes visible interesting similarities in the work of missionaries and bioethicists. For the most part, the desire to spread the gospel begins with noble intent—the goal is to bring the benefits of developments in one part of the world to another part of the world where those benefits are not experienced or understood. Those benefits may be eschatological or existential, but in either case the

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[2] This research is more fully explained in De Vries and Rott 2011, from which this section is taken.

[3] http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.htm

[4] Current version available at: http://www.wma.net/e/policy/b3.htm

[5] See http://www.gameo.org/encyclopedia/contents/I54ME.html for a brief description of the indigenization movement in mission work from a Mennonite point of view.

[6] Solomon (2006) outlines three different forms of the export problem; temporal, local, and personal.

[7] http://www.fic.nih.gov/programs/training_grants/bioethics/overview.htm

[8] http://med.kuleuven.be/education/Bioethics/index.html

[9] http://www.wellcome.ac.uk/Funding/Medical-humanities/Grants/Biomedical-ethics/index.htm

motivation is to proffer aid and share lessons learned. But, as we have seen in some of the transactions between missionaries/bioethicists and the people they serve, noble intent is not sufficient to bring good results. An imbalance in power between would-be helpers and those to be helped creates a one-way flow of influence from “missionaries” to “locals” that not only diminishes the possibility of mutual enrichment, but also creates the possibility of unwitting harm.

How does the indigenization of bioethics promote the universalizing of ethical problems? A recent evaluation of a research ethics training workshop at a Nigerian University highlights the one-way flow of influence that universalizes western moral traditions (Ajuwon and Kass 2008). The authors begin their report by noting that “training in research ethics affords scientists, especially those from developing countries, the opportunity to contribute to ever increasing international debates on ethical issues…” (p. 2). Indeed, “international debates on ethical issues” *should* be informed by insights of those in the developing world. But just a few pages later we learn what the program actually accomplished: “Post-training improvements were found in participants’ knowledge of the principles of research, the application of these principles, the international regulations, and the operations of an IRB” (p. 8). Measured by its own evaluation metric, this program was focused on teaching Nigerians the wisdom of Western bioethics (“principles, the international regulations, and the operations of an IRB”), not on seeking wisdom from the traditions of Nigeria.

Arguing from a natural law perspective, Boyle (2006, p. 321) points out: “fragmentation of the pursuits of health around the world implies that no authority within any health care or biomedical community such as a medical association or expert group [can] qualify as having global bioethical authority… [U]ntil the world is much more integrated and unified, there will be no properly bioethical legislature or Supreme Court for the whole world.” We know that religious, legal, psychological, historical, and ethical differences have an impact on bioethical views both within and between countries (Bayertz 2006, pp. 220–3), but this fact gets lost in many ethics training programs in developing countries. Benatar (2005), a bioethicist from South Africa, chides those from the West who would “improve” the ethics of countries in the developing world:

> What should be avoided is the previous colonial mentality of wanting to study and improve others while oblivious of the need to address the more sophisticated and covert faults of Western researchers’ own societies. The desire to improve the behaviour of others should also be associated with awareness that one’s own exemplary moral behaviour might be more effective in promoting ethical behaviour and respect for human rights than […] attempts to change the cultural attitudes of others while neglecting our own adverse cultural attitudes.

The bioethical training indigenous people receive in the West typically involves review of ethical theories (described above) and in-depth discussion of critical ethical issues. These discussions offer the opportunity to apply ethical theory to real-life situations and allow students to practice the move from the theoretical to the applied. But what are the ethical issues covered in coursework of students from the developing world? Often students are asked to ponder ethical questions associated with highly sophisticated medical technologies such as the “Ethics of Reproductive Technologies” and “Human Genetics and Medical Technology”. In their evaluation of the John Hopkins African Bioethics Training Program, Hyder et al. (2007) suggest it has been empowering to students, but, significantly, they also indicate that the training is still too

Western-centric, lacking in curricula more appropriate to developing countries (675, 682; see also Marshall and Koenig 2004).

I am not alone in my concern about the direction of developing world bioethics. McGinnis (2007, p. 401) explicitly compares the indigenization movement in Christian missions with a similar trend in efforts to promote human rights. He concludes that ‘secular missionaries’ have a lot to learn:

> …an essential ingredient in the missionary strategy of evangelization is conspicuously absent in contemporary programmes of development, democratization, or peace-building. In particular, the extensive efforts devoted by Protestant missionaries to the translation of their Biblical message into local languages and symbolic repertoires bear little resemblance to efforts to transplant Western ideals of universal human rights or the institutional templates of democratic governance first developed in the United States and Western Europe.

In their discussion of the value of a “bioethics from below,” Rennie and Mupenda (2008, http://www.peh-med.com/content/3/1/25) suggest that “bioethics research and scholarship [revolves] around issues that, while fascinating and important, currently affect only a small minority of the world’s population” and argue for a move away from “a ‘90/10’ gap, i.e. a situation where 90% of discussions on bioethics in the literature and the popular media may revolve around issues affecting 10% of the world’s population.” They conclude with this interesting comment on the value of *two-way communication* between Western bioethics and bioethics in the developing world:

> …greater attention to ethical issues arising from biomedical research, clinical practice to public health interventions ‘far away’ might have a positive effect on bioethics ‘closer to home,’ potentially expanding the horizons of the field and enhancing its social relevance.

Clearly the current model of a missionizing, universalizing model of bioethics needs to be altered in a way that allows for a two-way conversation among equals. Bioethicists in the United States and Europe can learn a great deal from the ethical traditions of countries in the developing world, just as bioethicists in those countries can learn from the traditions of the West. And yet moral theorists continue to make the case for a “common morality.” This is an ab-use of moral theory taking us away from the work of moral philosophy to moral theory. Moral theory must be understood as the way we work out obligations to each other, *given a certain set of social conditions*, not given universal conditions.[10]

4 Moral Theory in Bioethics

Clearly, moral theory has a place in bioethics. As bioethicists sort out the problems they encounter in the clinic and in medical, social, and psychological research, the ideas and

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[10] Better to employ an approach that I call “distributive morality” where Western ethical ideas and ethical guidelines and regulations are used not in a way that imposes them on a local culture, but are used to open a conversation about moral standards and to stimulate a cooperative search for the moral traditions in a local setting that would undergird ethical regulations in that setting. In this way the regulations governing research and governing clinical transactions would be drawn from the local culture and reflect local moral conditions.

concepts developed by moral theorists are important guides for framing issues and making decisions. But faced with the pressure to make decisions in the clinic or regarding the ethics of research projects, moral theory can easily be abused. When the work of moral theory causes the person to disappear into moral abstraction, when intellectual puzzles become more important than locating and working to eliminate the structural and cultural sources of ethical problems, and when the desire to universalize moral problems leads to the ignoring of local moral traditions, moral theory is working against its own ends. Useful moral theory transcends the tired is/ought debate, abandoning insistence on developing moral ideas “from nowhere”, as if there is a place where moral theory can be created free from social influence to cultural values. Recognizing that ought’s are shaped by ises and ises are shaped by ought’s, will move us to more moral moral theories.

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