

BioEthics: dynamics of its diversification and globalization

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Bioethics has never been unitary or homogeneous, and these are features that persist to the present day. It is, in fact, this original and identity-oriented pluralism that, in a dynamic of decades, has contributed to the understanding of the apparent paradox between the growing diversification of bioethics and the consolidation of its globalisation. That said, the latter is not to be confused with its geographic expansion, but rather leads to an aspiration to unity.

A dual paternity²

Since its birth in 1970-1971, in the United States, when it was introduced in the academic, scientific and professional discourse in a significant and prevailing way³, the neologism "bioethics" evidenced its dual paternity, thus attributing the same word with different features and scope.

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2 Expression suggested from the reading of Warren Reich, "The Word 'Bioethics': The Struggle Over Its Earliest Meanings, *Kennedy Institute of Ethics Journal*, 5 (1), 1995: 19-34, who explicitly refers to a "bilocated birth" of bioethics.

3 In this context, we are not referring to the very first formulation of the word 'bioethics', by Fritz Jahr, a German Protestant pastor, philosopher, and educator in Halle an der Saale, who, in 1927, publishes *Bio-Ethik: eine Umschau über die ethischen Beziehungen des Menschen zu Tier und Pflanze* (*Bio-Ethics: A Review of the Ethical Relationships of Humans to Animals and Plants*), because it did not have a direct influence on the emergence and structuring of what we now call "bioethics". However, the text then published in *Kosmos*, reflects an intellectual ambience and a philosophical orientation, demanding a new attitude of mankind towards the diversity of living beings, which gained expression in the first half of the 20th century and to which Potter will also belong.

For Van Rensselaer Potter, who coined the term in December 1970⁴, bioethics designated a “science of survival”, with relevant ecological meaning, by connecting the knowledge of living systems with that of values, comprising all living beings and ecosystems. This meaning became urgent when the post-World War II demographic explosion (Baby Boom) put unsustainable pressure on natural resources. For the obstetrician Andre Hellegers who, unaware of the previous use of the term, introduced it in July 1971⁵ with an unprecedented use, bioethics designates a multidisciplinary approach, of an ethical nature, in assessing the impact of biotechnologies on human health, therefore limited to the clinical realm.

The history of bioethics unfolded from this medical meaning only to recover its original environmental significance in the 1990s. From then on, both connotations evolved under the concept of bioethics.

Generally speaking, BioEthics focuses on the phenomenon of life (*bios*), to the extent that it is or can be humanly (artificially) manipulated, and insofar it is justified that life is, or should be (*ethos*), artificially handled. Therefore, bioethics also refers to a transdisciplinary perspective and to a multidisciplinary practice – which reinforces, as already mentioned, its original heterogeneity.

A dual nature

The dual paternity of bioethics also reveals it to be, originally and indissolubly, of a theoretical-practical nature, that is, of a dual nature. In fact, bioethics, having been set on a practical level, i.e. from the identification of new problems in need of innovative solutions, has sought and acquired an epistemological status by virtue of the consistency achieved on the theoretical level in which the modalities of intervention, reasoned and coherent, were formulated.

For instances, if we travel back, for example, to 1962, and to the establishment of the first hemodialysis centre in the world – the Seattle Artificial Kidney Centre –, we learn that, at that time, the number of candidates in a life-threatening situation far exceeded the capacity to provide care, requiring a prioritization of patients which, in turn, called for non-clinical selection criteria. This process, from practice – in the obligation to prioritize patients – to theory – in the need to formulate objective and tendentially fair criteria –, was developed by the first

4 Van Rensselaer Potter, North-American and biochemical researcher in oncology, publishes the paper “Bioethics, the Science of Survival”, in December 1970. This text would constitute the second chapter of the book *Bioethics: a bridge to the Future*, published in January 1971.

5 Andre Hellegers, obstetrician of Dutch origin, creates The Joseph and Rose Kennedy Center for the Study of Human Reproduction and Bioethics, on July 1st, 1971.

hospital ethics commission, in a time that we can consider as being the pre-history of bioethics.

Furthermore, if we consider separately both the level of practice and of theory, we recognize a clear heterogeneity. At the practical level, when we look at the cases or issues which have generated bioethics in different parts of the world, we find that they were quite diverse, in the common perspective of ethical concern in the face of the impacts of technological progress on human life⁶. In the United States, where bioethics originated, the major problem that triggered it was that of biomedical experimentation with human participants, and the growing public awareness of the atrocities committed against people and specific groups in the name of science. However, in the wake of the Nuremberg Trials and the establishment of the 10 principles legitimizing the participation of people in biomedical experimentation (1947), particularly the requirement of informed consent, there was a total neglect of these requirements in numerous biomedical research projects carried out in the United States. The public disclosure, in 1972, of the Tuskegee syphilis study and the persistent abuse of its vulnerable population was decisive for the emergence of a bioethical conscience, both at regulatory level – with the imposition of new rules for clinical research – and at institutional level – with the demand for the establishment of new institutions to guarantee the protection of research participants and ensure the quality of science.

In Europe, however, the vivid awareness of the human atrocities of the experimentation by Nazi doctors, but also of other similar earlier practices, dictated by a misplaced enthusiasm of scientific discovery, made the subject of human experimentation quite painful. Bioethics would emerge in Europe triggered by another reality: a surprising (almost magical) achievement of biotechnologies, in the generation of a new human life in a petri dish, through *in vitro* fertilization (IVF). We refer to the birth of Louise Brown in 1978 in the United Kingdom – the inappropriately named first test-tube baby. A few years later, in 1982, Amandine was born in France. Indeed, the issue of reproductive technologies was also decisive for the creation of national ethics commissions, not only *ad-hoc* but permanent, the first of which was established in 1983, in France⁷.

Bioethics first developed in Asia under North American influence and in the wake of the modernization or scientificization of medicine. Nevertheless, a ra-

6 The emergence of bioethics in different parts of the world is developed in M. Patrão Neves, "Bioética e Bioéticas", M. Patrão Neves, and Manuela Lima (coord.s), *Bioética ou Bioéticas na Evolução das Sociedades*, Coimbra, Gráfica de Coimbra/Centro Universitário São Camilo, 2005: 285-308.

7 The Comité consultatif national d'éthique pour les sciences de la vie et de la santé /CCNE was created by the President of the French Republic, François Mitterrand, following the birth of Amandine.

tional and secularly structured bioethics, anthropocentric and individualistic, progressing through increasingly restricted and technically-scientifically attested specializations, was poorly suited to this new geography. Of particular importance is the cultural and the community context, in which bioethical issues were debated, with respect for traditions, be it traditional medicine, the religiosity of peoples or the shared holistic conception of life. In Asia, bioethics has gradually assumed a profile marked by ethnocentrism and multiculturalism.

In South America, still resenting European colonization and with a long and diverse record of political revolutions, socio-political issues have become more relevant, in a clear distinction between “emerging problems” – new issues characteristic of a biomedical bioethics and related to the application of biotechnologies, such as reproductive biotechnologies – and “persistent problems”⁸ – lingering social and political problems that bioethics is beginning to awaken to as it expands to different parts of the world and that reflects the specificity of the environment in which they emerge. The focus here is on the widespread access of populations hampered by poverty or illiteracy to the benefits of biomedicine. Bioethics, in South America, assumes a profile marked by social claims, often politically driven.

In Africa, the most powerful triggering element of bioethics was that of human experimentation, in the recruitment of African populations for the development of clinical trials – particularly in the scope of experimentation with vaccines against AIDS and hepatitis –, having a double standard of procedures as common practice, characterised by the suppression, in Africa, of the ethical and legal requirements that framed biomedical research in Western countries, to which was added the absence of benefits resulting from research for local populations, in a predatory attitude.

At the practical level, we have witnessed a thematic diversification of bioethics and, consequently, a progressive expansion of its domain, co-extensive with its development in the world.

Also at the specific level of theory we find, from very early on, a multiplication of perspectives of analysis of concrete bioethical problems. The process of theorization of bioethics began in 1979, with the publication of *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress⁹, who proposed four *prima facie* principles – autonomy, non-maleficence, beneficence and justice – to be applied to the resolution of ethical dilemmas in the context of everyday biomedical practice. This model of reflection and intervention in bioethics, later called princi-

8 Volnei Garrafa, and Dora Porto, Intervention bioethics: a proposal for peripheral countries in a context of power and injustice. *Bioethics*, 2003; 17 (5-6): 399-416.

9 Tom Beauchamp, and James Childress, *Principles of Biomedical Ethics*, Oxford, Oxford University Press, New York, 1979.

plism, is still prevalent today under multiple expressions, insofar as it is still based on the enunciation of principles that the approach to ethical problems is framed.

Nevertheless, other theoretical and practical models quickly emerged in bioethics and entered into a dialogue that extends the present, adding new interlocutors, with new perspectives. Thus, while principlism adopts a top-down perspective in the application of principles to cases, other models advocate the importance of the inverse perspective, bottom-up in the standardization of procedures based on case analysis, as is the case with the casuistic model; still others emphasize the importance of virtues and the process of deliberation, in Aristotelian-inspired models; or the specificity of the clinical encounter and first-person narrative, in models of phenomenological and hermeneutic inspiration. Many other models were structured based on the common recognition of the need for a well-founded and solid theory, at the same time operational and effective, for the assessment of concrete cases and intervention, towards their satisfactory resolution.

At the theoretical level, we can confirm a multiplication of bioethical perspectives of analysis and, consequently, the construction of a broader and multifaceted vision of reality in its irrepressible dynamism, with growing inclusiveness and scope.

Meanwhile, we have also attested that bioethics, having been triggered by practical cases, quickly structured theories that substantiate, justify and advocate a standardized or normative action for other similar dilemmas, aiming for a fuller justice in the appreciation of a myriad of cases, concrete and unique, based on the same ethical criteria.

Institutional proliferation

This identity plurality of bioethics, which we have been successively pointing out, is reinforced by the genealogy of its institutionalization, that is, by the constitution of organisations dedicated primarily to it. Having emerged from a real need felt specifically at the professional and academic levels, but also in society at large, the institutionalization of bioethics begins with the creation of spaces, *fora*, for discussion groups, initially quite informal. From the outset the interconnection of different scientific and professional areas, namely medicine, theology and philosophy, is verified, as confirmed in the first bioethical institution, the Hastings Center, founded by theologian and philosopher Daniel Callahan and by the psychiatrist Williard Gaylin, in 1969. This is, to this day, an identity trait of bioethics advisory bodies. Personalities from different academic and scientific areas meet to discuss the best way to respond to the novel problems imposed on their professional practice by the biotechnological revolution. Later on, these discus-

sion groups were structured and developed into teaching and research centres, based in higher education institutions or in reference hospitals, well supported by specialised libraries.

These almost spontaneous think tanks were especially common in the Western world where bioethics was originally constituted. In other geographical-political spaces, this initial step in the broad development of bioethics did not take place. Far more frequently, its institutionalization began with the constitution of university and hospital centres.

This first type of bioethical institution, with very restricted scope, was followed by the establishment of clinical research ethics committees (initially termed Institutional Review Boards – IRB) and, later, by hospital ethics committees, dedicated to ethical issues within the scope of clinical care (initially termed Institutional Ethics Boards – IEB). In both cases, their constitution was originally dictated as a response to social contestation in relation to some mediated cases of offences committed against people in the context of biomedical research. Once again these institutions have arisen out of necessity, and always with a multidisciplinary constitution.

These first two types of ethics committees were implemented in multiple forms in different parts of the world: sometimes as distinct committees operating separately, as in the United States; sometimes as mixed or hybrid committees accumulating the function of both in a single body, as in many European countries; other times focusing only on the committee dedicated to clinical research, as is often the case in Africa.

The need to set up a multidisciplinary body to assess the foundations and regulate new practices in the context of biotechnological developments has also led to the establishment of national ethics committees, with the specific requirement of standardizing action guidelines. These national commissions were initially limited in mission and time (*ad-hoc*): the first to emerge was The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, established in the United States with the mission of formulating ethical principles for human experimentation. It operated from 1974 to 1978, having produced the Belmont Report; later, in 1982, the Warnock Committee was established in the United Kingdom with the mission of regulating the use of reproductive technologies and having produced the Warnock Report in 1984. The national committees evolved from *ad-hoc* to permanent, given the persistent nature and wide range of bioethical problems that were multiplying and becoming more complex, as well as gaining a broader scope of intervention.

It is important, however, to underline that these national ethics committees are not always of the same nature in different parts of the world: while European countries tend to have two such advisory bodies – one focused on clinical re-

search and the other dedicated to public policies, with the common aim of unifying procedures – other continents tend to favour the constitution of a single national ethics commission for scientific research, similar to what also occurs with local ethics committees, in both cases favoring intervention at the research level.

Subsequently, in the wake of the commitment to standardize practices, ethics committees of international scope were also created, invariably dedicated to procedures to be adopted in the face of the new possibilities brought about by biotechnologies and structured on the basis of more broadly consensual ethical principles. We refer to: the current Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO), established in 1985 by the Council of Europe and which produced the only Convention in this area that became legally binding to all States that ratified it, the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997)¹⁰; the European Group on Ethics in Science and New Technologies (EGE), created in 1991 by the European Commission, which regularly presents Opinions and Statements in various fields; and to two bodies created by UNESCO, the International Bioethics Committee (IBC), in 1993, and the Intergovernmental Bioethics Committee (IGBC), in 1998, which, among the Declarations produced, presented the Universal Declaration on Bioethics and Human Rights (2005)¹¹ adopted by the UNESCO. Opinions, Statements, Reports, Declarations, Conventions are all different types of ethical-legal documents (soft law) that these international bodies have produced on the most diverse bioethical issues, as they arise and require guidelines with maximum consensus, thus tending towards the unification of diversity.

In fact, bioethics has developed through a progressive diversification, also at the level of its institutions given their growing dissemination; paradoxically, this institutional proliferation has also progressed towards contributing to the unification of bioethics, in a process that, simultaneously, results in and reinforces the globalization of bioethics.

10 Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, <https://rm.coe.int/168007cf98>

11 UNESCO, Universal Declaration on Bioethics and Human Rights, <https://www.unesco.org/en/legal-affairs/universal-declaration-bioethics-and-human-rights?hub=66535>

Globalization of bioethics

Bioethics today is global – we say this without hesitation. And yet, the meaning of the statement is not unequivocal.

The expression “global bioethics” was introduced by the pioneer of bioethics Van Rensselaer Potter, in 1988, when he published *Global Bioethics, Building on the Leopold Legacy*¹². Here, he somehow reiterates his initial proposal for the constitution of a new discipline or science that combines the knowledge of biology with various humanistic knowledge and that establishes “a system of medical and environmental priorities” that guarantees the survival of mankind. Potter, not taking from the relevance he had always attributed to the ecological dimension of bioethics, as its original design, began to refer also to the medical dimension, that shaped the history of bioethics and which he included in his view of “global bioethics”. Indeed, for Potter “global bioethics” refers precisely to a conception of bioethics that encompasses its two historical dimensions: an “ecological ethics”, related to the long-term survival of man as a species, and an “medical ethics”, related to the well-being of the individual in the short term. This consists, chronologically, in the first meaning of “global bioethics”¹³.

Nevertheless, Potter, in explaining the designation “global bioethics” refers explicitly to the theologian Hans Küng, who vulgarised the expression “global ethics”, especially since 1990 with his work *Project for a World Ethics (Projekt Weltethos)*¹⁴. Here, Küng presents his fundamental thesis: it is urgent to develop a “global ethics” so that we can ensure the survival of mankind in the third millennium. The concern and commitment to build on of a new area of knowledge and practice which focuses on and promotes the survival of humanity in the future is the common project of Potter and Küng, even though their proposed pathways to achieve it are different. For Küng, this “global ethics” would present itself as a single *ethos*, as a set of principles, values, beliefs, ideals and utopias shared by all, or around which it would be possible to establish a binding consensus in order to guarantee not only peace among all peoples, but also an effective response, insofar as it is concerted, to the great problems afflicting humanity.

This goal of a “global ethics” could perhaps be realised in the specific field of bioethics through the common process of globalisation, which is often translated by the notions of “internationalisation”, emphasising the growing involvement of

12 VanRensselaer Potter, *Global Bioethics, Building on the Leopold Legacy*, Michigan State University Press, 1988, 203 pp.

13 M. Patrão Neves, and Walter Osswald, *Bioética Simples* (Lisboa, 2014), systematize three different meanings of “global bioethics”.

14 Hans Küng, *Projekt Weltethos*, München/Zürich, Piper, 1990.

professionals and academics from different countries, and of "universalisation", emphasising the identity of the same project being developed in various parts of the world. Global bioethics – in what will be its second meaning – is understood as a set of theories and practices that have been disseminated, expanded and implemented in numerous countries, or even throughout the world. This meaning accentuates the common aspects of bioethics in various geographical contexts, thus contributing to the construction of an identity for the expanding field of bioethics. However, although it favours its development in an increasingly wider area and takes into account the various contributions that different parts of the world can offer, this meaning adopts a standardizing perspective of bioethics, which is also sometimes denounced as homogenizing. In this sense, the unity attributed to an evolving academic-scientific, socio-professional and political-legal domain, which guarantees its identity, may also lead to the underestimation or even the suppression of specificities typical of different geo-cultural spaces and peculiar to different moral communities, which is a sometimes denounced as "Western bioethical imperialism".

These differences in the perception of bioethics and its development, arising from its implementation in different geo-cultural contexts are, conversely, intentionally and strongly accentuated in what has more recently been termed "local bioethics", that is, the ethical reflection specific to a geographic location or human community. In this second meaning, global bioethics would be merely the counterpoint to local bioethics.

It is important to advance towards the systematisation of a third meaning of global bioethics, understood as a superior point of view which, whilst taking into account the specificities of local bioethics, attempts to articulate them, without suppressing them, in a heterogeneous whole. This sense of global bioethics is set apart from the two previous iterations by the valorisation it places on the diversity of local bioethics and its respective contributions to thought and practice, that is more respectful of human beings in the diversity of their manifestations.

This perspective, which greatly enriches what we understand today as bioethics, risks, however, slipping into a purely eclectic level, thus failing to meet the challenge of the very same unity and coherence of thought and action that gives it validity and efficacy.

In truth, all different meanings of global bioethics are justifiable, and in themselves relevant and pertinent to a genuine and full understanding of bioethics: in the rigorous knowledge of its past, in the just interpretation of its present and in the perspicacious projection of its future. This being so, we should not ignore or neglect any of them, but rather promote their joint consideration, which only becomes possible if we understand global bioethics as an encompassing vision of the plurality of its developments in time and space – throughout its themes, pro-

tagonists, institutions, contexts –, in the demand for a unitary and integrating intelligibility that does not self-annihilate, but can be reinvigorated by its diversity.

It is not a question, then, of splintering bioethics into a plurality of heterogeneous meanings, or reducing it to a single homogeneous bioethics; nor is the alternative set between reducing plurality to unity and losing diversity or accepting plurality and losing identity. What matters is to discover or construct unity from and in diversity, in an irrepressible dynamic between its variables, like a kaleidoscope. This is what will most genuinely and fully correspond to the formulation of a global bioethics. Global bioethics is then that intelligible plurality of strands through which bioethics has evolved.