



Setting the Agenda for Urban Bioethics

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ABSTRACT *Urban bioethics has two goals. First, it aims to focus attention on neglected bioethical problems that have particular salience in urban settings. Three problems are highlighted: socioeconomic inequality as a major determinant of health inequality, the foundations of an ethic for public health, and the impact of social context on the therapeutic alliance between patients and physicians. Second, urban bioethics serves as a vehicle for raising deep theoretical and methodological questions about the dominant assumptions and approaches of contemporary bioethics. Demands for cultural sensitivity, so pronounced in the urban context, compel us to reexamine the central commitment in bioethics to personal autonomy. The multiculturalism of urban life also argues for a dialogic approach to bioethical problem solving rather than the monologic approach that characterizes most bioethical thinking. Although my brief for redirecting bioethics will resonate with many critics who do not consider themselves urban bioethicists, I argue that there are special advantages in using urban bioethics to expose the limitations of contemporary bioethical paradigms.*

KEYWORDS *Cultural Diversity, Cultural Sensitivity, Deliberative Democracy, Dialogic Bioethics, Feminist Practical Dialogue, Multiculturalism, Personal Autonomy, Public Health Ethics, Social Determinants of Health, Therapeutic Alliance, Urbanicity.*

THE TASKS OF URBAN BIOETHICS

These are exciting times for bioethical theory. The hegemony of the traditional Kantian and utilitarian models of justification in bioethics has been challenged by a variety of alternative theoretical approaches, each of which presents itself as a replacement for, or at least a supplement to, those well-entrenched theories. The field now is populated by a plethora of different schools of bioethics, which bear such varied labels as pragmatic bioethics, feminist bioethics, communitarian bioethics, and postmodern bioethics. Somewhat in the spirit of these recent developments, we propose to coin yet another expression: urban bioethics. On the face of it, however, urban bioethics does not seem to belong on the same list as the others. The term *urban*, unlike the adjective in those other cases, does not denote a distinctive theoretical perspective or appear to suggest a theoretical critique of traditional bioethics. Rather, urban bioethics seems more akin to clinical bioethics as it commonly is understood and practiced. That is, just as we can think of clinical bioethics as the activity of using well-established ethical principles to help resolve practical problems that arise in the clinical domain, it also seems that urban bioethics provides the same sort of normative guidance for problems that arise in an urban

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setting.* With this as our model of how to think about urban bioethics, fundamental questions about bioethical principles and the very possibility of doing bioethics in a culturally, ethnically, and racially diverse urban setting may get insufficient attention.

To some extent, of course, we are free to characterize the field of urban bioethics as we choose. But, we cannot characterize it just any way we want if we are to avoid the charge of arbitrariness. The field of urban bioethics will only have intellectual and conceptual coherence if there is some plausible rationale for employing the label *urban* to demarcate the various tasks it undertakes. I try to provide here such a rationale for the conception of urban bioethics I propose. More specifically, I suggest that urban bioethics can be used as a vehicle for challenging traditional bioethics and not only as a convenient shorthand for bioethical problems that tend to cluster in urban settings; I show that features of urban life make it especially suitable as a basis for mounting this critique. Part of what I show in this paper is that bioethics adequate for urban life is transformed bioethics. However, since the features of urban life salient for my analysis are not confined to urban contexts, there are also important lessons to be drawn from this investigation for our understanding of bioethics in general.

It might help now to compare my conception of urban bioethics to feminist bioethics. As Tong notes, all feminist approaches to bioethics share a sensitivity “to women’s moral concerns and to the ways in which being a member of a culturally disfavored gender . . . leads to women’s disempowerment morally and personally as well as politically, economically, and socially.”^{1(p51)} Thus characterized, feminist bioethics is distinguished from nonfeminist bioethics by the former’s emphasis on gender issues, just as “women’s health” is distinguished from mainstream medicine by its emphasis on health issues peculiar to women. But this shift of focus to so-called women’s issues is only one aspect of the feminist agenda. Feminist bioethicists, or at least many of them, also fault nonfeminist approaches to bioethics “for emphasizing rules over relationships, norms over virtues, and justice over caring.”^{1(p3)} For them, the problem with nonfeminist approaches is not just their neglect of the special concerns of women, but the philosophical and conceptual framework they bring to bear on bioethical problems in general.

Urban bioethics, as I conceive it, has something like the same dual purpose: to focus reflection on neglected bioethical problems that tend to cluster in urban settings and to subject dominant approaches to bioethical problem solving to critical scrutiny. Reflection on the urban context, I want to emphasize, is not the only way of raising these deeper theoretical and methodological questions. My brief for reconfiguring contemporary bioethics will resonate with many bioethicists who are disenchanted with the reigning paradigms in the field, but who would not call themselves “urban bioethicists.” They may argue that my critique, with which they mostly agree, sets an agenda for bioethics, not just urban bioethics. But, while I would not want to dispute this, I believe that the realities of urban life challenge our bioethical assumptions and methods in a particularly clear and forceful way. Urban bioethics, although only one standpoint from which to examine contemporary bioethics critically, has special advantages as a way of drawing attention to its limitations.

*I do not mean to suggest by this that clinical bioethics is understood commonly to involve the mechanical application of principles to cases.

BIOETHICAL PROBLEMS IN THE URBAN CONTEXT

In its most straightforward sense, urban bioethics can be defined as the study of ethical problems relating to medicine and health care that arise in urban contexts. The problems we encounter here also arise in rural areas (defined as fewer than 2,500 people per town boundary²). But, there is some justification for referring to these as urban problems since they are particularly prominent and prevalent in urban settings.

To understand better why urban dwellers confront the particular health problems they do, we need to identify the distinguishing characteristics of urban life. Although no two cities are exactly alike in terms of size, physical layout, population density, ethnocultural composition, and so forth, the definition proposed over 60 years ago by Wirth, a member of the famed Chicago school of urban sociology, is still serviceable: “For sociological purposes a city may be defined as a relatively large, dense, and permanent settlement of socially heterogeneous individuals.”^{3(p190)} This heterogeneity is due largely to the variety of different ethnocultural groups that reside in cities. These key “elements of urbanism which mark it as a distinctive mode of human group life”^{3(p190)}—size, density, and heterogeneity—define the context within which urban populations are subject to specific health risks and give rise to pressing urban bioethical problems. Particularly noteworthy in this regard is the presence in contemporary cities of large numbers of socially and economically disadvantaged people at risk because of their class, race, and economic status.

I briefly discuss three areas in which urban bioethics can have a significant impact: access to medical care, public health ethics, and the impact of urbanicity on the doctor-patient relationship.

From Access to Medical Care to Health

According to Hurowitz,⁴ the medical care system needs to define itself more narrowly than it has in the past. Although the terms *health care* and *medical care* are often used interchangeably, they are not synonymous. Indeed, access to medical care is only one of the determinants of health and, research has shown, a relatively minor one at that. There is substantial evidence from studies in the United Kingdom and other western European countries that differences in access account for only a relatively small percentage of variation in health status within a given population. More closely correlated with health, and more significant in explaining health differences between the advantaged and disadvantaged members of society, are socioeconomic factors that shape a person’s relative social advantage. These include income, education, and profession, and while no one is quite sure exactly how these operate, numerous studies have documented that the greater the inequality in socioeconomic status within a society, the greater the inequality in health status.⁵ Although this relationship is not simply a contrast between the health of the rich and the poor, the influence of poverty on health status certainly is significant, operating through such factors as inadequate housing, unhealthy diet and lifestyle, unclean environment, and unsafe living conditions. The proportion of city populations that reside in areas of high poverty—defined as census tracts where more than 40% of residents live in poverty—has increased dramatically in recent years in the US,⁶ and these areas have the highest concentration of these predictors of poor health status.

Since the inception of contemporary bioethics in the 1970s, writers in the field have argued at length about the right to health care and about its ethical grounding

and scope. For them, the problem of social justice in health care largely has meant the problem of ensuring equitable access to health care. The term *health care* as used in these discussions has referred only to medical care, that is, to the services that physicians, other health professionals, and health care institutions provide. In this way, the bioethical literature on justice and health care has paralleled the epidemiological research in this country on determinants of health status. Just as researchers in the US have been slow to recognize that socioeconomic factors are critical in the prevention of illness, bioethicists also have been slow to address the health implications of broader social problems of economic and social inequality and deprivation.

I do not want to minimize the significant problems of access to health care in the urban context. However, it is rare to find bioethicists, in their capacity as bioethicists, considering the problem of homelessness, for example, violence in the inner city, joblessness, or the inequitable distribution of income and exploring their connections to health. These problems are thought to fall within the purview of the social sciences or other branches of normative applied philosophy. Yet, if bioethicists are concerned about inequalities in access to health care because they result in inequalities in health, they cannot continue to ignore the distribution of social determinants of health. Like the proverbial nearsighted person who cannot see the forest for the trees, they do not seem to recognize that, while reforms aimed at universal access to medical care, improved quality of care, and cost control may improve the medical care system, they are unlikely by themselves to have a substantial effect on the considerable inequalities in health among different segments of our society.

It is one of the tasks of urban bioethics to get bioethicists to broaden their agenda to include attention to socioeconomic differentials in health and the various nonmedical factors that have a greater combined impact on health status than medical care. (Broadening the focus of bioethics to include social determinants of health also is argued by Brock in ref. 7.) The focus needs to be broadened to encompass not only a theory of health care, but also a theory of justice that assesses socioeconomic inequalities in terms of their impact on health. Until now, bioethicists have not pursued this inquiry since they have tended to view these larger social factors as a matter for those in the social sciences to investigate. To remedy this situation, bioethicists do not have to become social scientists. Rather, they must become sufficiently conversant with the vast body of empirical research on the social, environmental, and cultural determinants of health to be able to discuss the work of social scientists critically and integrate it with normative philosophical inquiry. Only then will they be in a position to make recommendations about the sorts of social policies governments should pursue to reduce health inequalities. This expanded agenda makes their job more complex, and training in humanistic disciplines like philosophy and theology alone will not prepare them adequately to undertake it.

Public Health Ethics

Public health issues are not confined to cities, but they often evidence themselves there and in large urban areas first. It is not surprising that this should be the case because the poverty and congestion of city life provide fertile breeding grounds for the outbreak and spread of diseases like polio, tuberculosis, and, more recently, acquired immunodeficiency syndrome (AIDS) and asthma. All modern public health measures, including those not directed to the containment of epidemics, have

in common an emphasis on populations rather than individuals and a concern with primary rather than secondary or tertiary prevention.

In a 1997 article, “Medicine and Public Health, Ethics and Human Rights,” Mann laments the absence of a coherent and clearly formulated ethic for public health:

Not surprisingly, medicine has chosen the language of ethics, as ethics has been developed in a context of individual relationships, and is well adapted to the nature, practice, settings, and expectations of medical care. . . . Public health, at least in its contemporary form, is struggling to define and articulate its core values. . . . [i]t seems evident that a framework which expresses fundamental values in societal terms, and a vocabulary of values which links directly with societal structure and function, may be better adapted to the work of public health than a more individually oriented ethical framework.^{8(pp8-9)}

The point Mann makes about the need for ethical discourse suited to the orientation and concerns of public health is well taken: The field of public health is in its infancy with respect to articulating an ethical framework for approaching health problems in population-based, preventive terms. (I omit discussion here of Mann’s controversial argument that the core values of public health are best expressed in terms of “human rights.”)

Consider the central conundrum of public health, what Geoffrey Rose aptly has dubbed “the prevention paradox”:

A preventive measure which brings much benefit to the population offers little to each participating individual. This has been the history of public health—of immunization, the wearing of seat belts and now the attempt to change various life-style characteristics. Of enormous potential importance to the population as a whole, these measures offer little . . . to each individual; and thus there is poor motivation of the subject.^{9(p38)}

Philosophers are familiar with the problem that arises from this paradox, the so-called free-rider problem. Since the individual stands to gain little from certain public health measures* and in fact may be put at some risk or inconvenience by them, it seems rational from the individual’s point of view not to comply and to rely instead on the general compliance of others if he or she can escape detection. If we think that nevertheless the individual ought to comply, we have to show why, despite the fact that it may not be in the individual’s interest to do so. The public health literature has not addressed these and related matters adequately, and until it does, it cannot provide a compelling ethical response to the individual who chooses to free ride on the cooperation of others.

I am not sure how best to formulate and justify Mann’s “framework which expresses fundamental values in societal terms.”⁸ Perhaps, as some have suggested, an answer can be found in the writings of proponents of communitarian ethics. Alternatively, Goodin¹⁰ has argued that the principle underlying public health practice is “protecting the vulnerable,” and that this principle can be justified in terms

*A good example of this is continuing direct observation therapy (DOT) for tuberculosis patients with low self-risk.

of promoting overall social utility. It is clear that, until this framework is provided, public health measures are open to the objection that Hoffmaster raises: "In a social, political and legal climate that extols individual freedom and individual rights, it is difficult to justify infringing on the liberties of persons, especially when doing so is supposed to be in their own self-interest."^{11(p322)}

Since so much of public health practice grows out of an acknowledgement of the causal relationships between urban interdependency and vulnerability on one hand and the health of populations on the other, it is appropriate for urban bioethics to undertake provision of the ethical foundations that public health is struggling to articulate. Combined with my remarks above, urban bioethics thus can be understood to involve broadening of the focus of bioethical inquiry in two ways: (1) from inequality in access to medical care to socioeconomic inequality as the principal determinant of disparities in health and (2) from the individualistic orientation implicit in much of medical ethics to an ethical discourse more appropriate to the population-oriented practices of public health. Indeed, the first two items on the urban bioethics agenda are interconnected for the practice of public health should be informed by consideration of the ethical implications of the societal determinants of health.

Impact of Urbanicity on the Doctor-Patient Relationship

In this era of managed care and frequent changes in employer-sponsored health insurance plans, it is increasingly rare even for patients who can afford private insurance to establish close, ongoing relationships with particular health care providers. Since rural and urban practitioners now function within constrained managed-care systems, this is not a problem for urban dwellers alone. However, distinct features of health care in the urban context present special challenges to the therapeutic alliance between physician and patient.¹²

This is partly due to the fact that, in comparison with their rural counterparts, urban health care providers are less likely to have long-standing and in-depth knowledge of their patients because of the character of social relations in urban settings. As Wirth notes:

The bonds of kinship, of neighborliness, and the sentiments arising out of living together for generations under a common folk tradition are likely to be absent or, at best, relatively weak in an aggregate the members of which have such diverse origins and backgrounds [as city dwellers].^{3(p191)}

The greater anonymity and transitory nature of urban compared to rural social relations makes it more difficult, although not impossible, for urban dwellers to form lasting and close relationships with their fellow urban inhabitants, and these broad features of the urban mode of life also condition and shape relations between patients and health professionals.

Second, the heterogeneity of city life presents its own obstacles to optimal patient care. Individuals from the diverse ethnocultural groups that populate cities often have distinctive religious and cultural beliefs that influence their understanding of health, disease, disability, and death, as well as their attitudes toward the roles of family, community, and health professionals in health care decision making. Physicians need to become familiar with the values, health beliefs, and language of the ethnic populations they serve if they are to be able to communicate effectively with them and provide quality care; this is especially important for the practicing urban physician.

Third, the stresses of city life, especially among the poor, often prevent patients from seeking out medical care or from forming stable alliances with health professionals. Stress is a health risk factor not only because of the multiple medical problems it can cause, but also because it interferes with appropriate surveillance of the patient over the long term.

These and other distinctive features of city life pose problems for the therapeutic alliance between patient and physician because of their potentially damaging effects on the establishment and maintenance of trust in the doctor-patient relationship. Trust is the bedrock of the doctor-patient relationship: Without trust in the skill, sensitivity, and dedication of one's physician or physicians generally, prospective patients may not engage with the medical system at all or, if they do enter into a treatment relationship, will be less than forthcoming in revealing important, but potentially embarrassing, information about their medical condition. Lack of trust also undermines the informed consent process for, without a framework of trust between the one who is being informed and the one doing the informing, patients will not listen to or will misinterpret what is said or will disregard the recommendations of their physician, however well intentioned and beneficial these may be. These reasons for valuing trust are well known from the literature on medical ethics. What urban bioethics contributes is not new understanding of the value of trust so much as an appreciation of how various characteristic features of urban life make trust such an imperiled good in that setting and suggestions for what can be done to shore it up.

In summary, urban bioethics reorients the direction of bioethical inquiry. Questions about the right to health care and equitable access to medical care become more marginal as attention is directed to conditions of social and economic deprivation that have an impact on health status and the apparent connection between social inequalities and health inequalities. Whereas bioethics formerly was concerned chiefly with the ethical dimensions of the individual doctor-patient relationship, questions about the character and ethical justification of population-based public health measures come to occupy center stage. At the same time, as I have shown, urban bioethics does not neglect the doctor-patient relationship. Even here, however, there is a difference from traditional bioethics. Unlike bioethicists in the past, who tended to talk about "the" doctor-patient relationship as a kind of ideal construction that could be isolated from its context, urban bioethics takes seriously the various factors in contemporary urban life that threaten that relationship and addresses the conditions needed for nurturing and sustaining a productive therapeutic relationship in the face of these challenges. The doctor-patient relationship as understood by urban bioethics is frequently an embattled relationship, and the trust on which it depends is both elusive and tenuous.

MULTICULTURALISM OF CITIES AND RESPECT FOR CULTURAL DIVERSITY

It has become almost a truism that modern liberal-democratic societies are characterized by an irreversible pluralism, that is, by conflicting and incommensurable conceptions of human good as well as metaphysical and religious conceptions. In multicultural societies such as the United States, there is the additional factor of diverse cultural groups coexisting, sometimes uneasily, within a regime of common political institutions. The implications of this pluralism for the possibility of forging social unity have been a major concern of a number of leading contemporary politi-

cal theorists, of which the most famous is Rawls in his recent work on political liberalism. However, its implications for the enterprise of bioethics have not been discussed with the same degree of thoroughness.

Cities provide an ideal context in which to address these issues since, unlike rural areas, heterogeneity is one of the hallmarks of urban life. A major factor contributing to the cultural pluralism of cities is the influx of foreign-born populations. From the central, southern, and eastern European immigrants of the 19th century to the more recent Asian and Hispanic immigrants, cities have long been magnets for populations fleeing economic and social hardship in hope of a better life in the US. Although cultural and racial diversity have now spread beyond the central city into suburbs, small towns, and rural areas, the percentage of foreign-born residents living in American cities has continued to grow significantly, and cities have become far more diverse since the 1980s.^{6(pp12–14)} These groups bring with them different cultural identities with distinctive sets of traditions and practices and distinctive intellectual and aesthetic histories.

Liberal-democratic societies espouse the principle of respect for cultural diversity, but what this comes to and, in particular, what this means for the design of social and institutional policy with regard to health care and for the clinical encounter between patients and health providers is not well understood.* (I use the term *culture* somewhat loosely here to refer to a shared system of values, beliefs, and learned behaviors that may be rooted to varying degrees in religious outlooks.) In taking up these matters, urban bioethics must examine critically the fundamental assumptions and deliberative practices of bioethics as we have come to know it. The rest of this paper suggests the questions that need to be asked and revisions that may be necessary.

An initial question about the principle of respect for cultural diversity is whether the object of respect is to be understood as the cultural group or the individual member of a cultural group. To ask this another way, when we act disrespectfully, who or what is wronged or insulted, a culture or an individual? The philosopher Wolf provides a rationale for this principle based on the liberal commitment to individual rights:

The insult . . . consists either in ignoring the presence of these individuals in our community or in neglecting or belittling the importance of their cultural identities. Failing to respect the existence or importance of their distinctive histories, arts, and traditions, we fail to respect them as equals, whose interests and values have equal standing in our community.^{14(p81)}

Most bioethicists who argue for the importance of respect for cultural diversity do so on similar grounds, which is not surprising given the general individualistic orientation of bioethics. They do not appeal to some notion of group or collective rights to anchor this ethical imperative for, in their view, respect for cultural forms of life and traditions in which identities are formed is supposed to serve the recognition of their members, not the group itself. There are exceptions, however. Pellegrino, for example, claims that “human beings, whether as individuals or aggre-

*For a helpful discussion of different kinds of cultural sensitivity, see ref. 13, which distinguishes between three conceptions of cultural sensitivity: semantic, instrumental, and principled. I alluded to the first two in my discussion of the impact of urbanicity on the doctor-patient relationship. Here, I am more concerned with the third, principled conception.

gates, are inherently entitled to respect,”^{15(p15)} and that it follows that there is an obligation to respect both cultures and the cultural identities of individuals. What he fails to acknowledge is that these two requirements may be in tension with each other and so may not always be satisfiable jointly.

Urban bioethics, as bioethics suited to the realities of city life, must address the problems of multiculturalism since multiculturalism is an inescapable fact of the contemporary urban experience. It must tease out the different interpretations of the principle of respect for cultural diversity and explore their implications for health policy and medical practice. In doing so, it will raise questions that bioethicists heretofore either have avoided or have treated rather superficially.

Let us then look more closely at the principle of respect for cultural diversity, interpreted in the manner of Wolf, as derived from the principle of respect for persons as equals “whose interests and values have equal standing in our community.” What does this principle entail? More specifically, is there an obligation to respect the cultural identities of individuals even if the traditions and practices that give those identities their content are in conflict with the dominant ethical norms of the adopted country? Suppose, for example, that it is part of a person’s particular cultural identity that women do not have the same rights and liberties, powers, and opportunities, as men. Both men and women in this culture have been socialized and conditioned to accept an arrangement in which all decisions not directly involving domestic matters, including those related to women’s health, are to be made by men. It would seem that a society that values autonomous choice, and health professionals who share this value, cannot cooperate with this practice for, although the women prefer this arrangement, their preferences have been shaped by expectations encountered since early childhood that significantly reduce their autonomy. Rightly understood, then, the principle of respect for persons as equals does not support, but actually may override, the principle of respect for cultural diversity.

This is but one example of a general problem confronting Western bioethicists (especially Western urban bioethicists) who take both patient self-determination and cultural diversity seriously: the apparent conflict between respect for the cultural identities of individuals and respect for personal autonomy. Different cultures may confer decision-making authority on parties other than the individual adult patient (i.e., on the patient’s male relatives, the patient’s family, or the patient’s community); in each case, it seems that the cost of deference to one of these modes of decision making is a diminished regard for the autonomy of the patient. One common response of bioethicists to this apparent dilemma has been to argue that, despite initial appearances, these alternative practices of decision making actually may have been chosen autonomously by the individuals who have been enculturated in these ways. Thus, Gostin claims:

It is respect for that human dignity that compels health care professionals to obtain the consent of patients in ways that are comprehensible and consistent with the person’s language, custom, and culture. The fact that individuals give deference to the views of family and community, and even prefer the therapeutic discourse to occur with family members, does not negate their individual assent to medical treatment or research.^{16(pp844–845)}

For Gostin, rigid adherence to formalistic requirements of informed consent does not necessarily demonstrate respect for personal autonomy. On the contrary, such

adherence may be “alienating and dehumanizing” to patients whose cultural identities have not been shaped by the individualistic ethic so dear to Western bioethics.

The appeal to personal autonomy—whether for critiquing deference to cultural diversity or, as in Gostin’s case, defending it—is hard to assess for its central notion is notoriously unclear. On one hand, we are all the products of socialization, and none of us would be autonomous choosers if we had to adopt our motivations *de novo*. Socialization cannot be equated simply with coercion. On the other hand, some patterns of socialization, like those that result in preferences for slavery and certain other forms of servitude, do deny individuals the capacity for autonomous choice. Respect for cultural identities cannot legitimate, for example, respect for the preferences of contented slaveholders and contented slaves. The implications of the principle of respect for cultural diversity for our relations with cultural minorities, in the light of our commitment to personal autonomy, remain a vexing question.

Recent feminist scholarship has done much to advance our understanding of the complexity of the notion of personal autonomy, and urban bioethicists who ponder the implications of multiculturalism would do well to familiarize themselves with their work.¹⁷ One distinction frequently drawn in the feminist literature is between content-neutral and substantive accounts of personal autonomy. According to the former, the content of a person’s desires, values, beliefs, and emotional attitudes is irrelevant to whether the person is autonomous with respect to them and the actions that flow from them. What matters is whether the person has subjected her motivations and actions to the right sort of critical reflection. According to the latter, either there are certain things an autonomous person necessarily values or there are constraints on the content of the desires or preferences that can be held by an autonomous agent. The proper response to multiculturalism will depend in part on which account of personal autonomy we adopt.

Individuals from different cultures may endorse the cultural identities constructed for them, and then we have to ask whether this is sufficient for autonomy. But, they do not always do so, especially in multicultural societies in which the preservation of cultural distinctness must compete with strong assimilationist pressures. K. Anthony Appiah, Professor of Afro-American Studies and Philosophy at Harvard University (Cambridge, MA), has written eloquently about the “tyranny” of cultural identity. His observations have quite general application:

What demanding respect for people *as blacks* or *as gays* requires is that there be some scripts that go with being an African-American or having same-sex desires. There will be proper ways of being black and gay: there will be expectations to be met; demands will be made. It is at this point that someone who takes autonomy seriously will want to ask whether we have not replaced one kind of tyranny with another. If I had to choose between Uncle Tom and Black Power, I would, of course, choose the latter. But I would like not to have to choose. I would like other options.^{18(p99)}

The danger to which Appiah alerts us is that, in our zeal to respect cultural diversity, we may overlook the fact that individual identities are not solely a function of cultural membership. A person’s individual identity has both a collective or cultural dimension and a personal one, and respect for cultural diversity can deny individuals options by presuming that their identities are “too tightly scripted” by the norms of their culture of origin. Whatever we decide about the limits of respect for cultural values and preferences that are wholly endorsed by the members of a cultural

group, respect for personal autonomy clearly requires at least this much: That we avoid sweeping generalizations about individual identity based on cultural membership and instead assess the impact of culture on individual identity case by case.

I have focused on the principle of respect for personal autonomy and on the problematic relationship between identity and autonomy to which multiculturalism draws our attention. This is not, of course, the only cherished bioethical principle that needs to come to terms with the facts of cultural diversity. Appeals to the principles of beneficence and justice will also have to recognize that people from different cultural or religious traditions may define “good” and, in particular, good health in different ways, and that in a pluralistic society, there may be diverse understandings of justice, fairness, and equality. (For more on the implications of multiculturalism for theories of just health care, see ref. 19.) But, the challenge of multiculturalism, which urban bioethicists in particular can ill afford to neglect, is not confined to a reexamination of the meaning and relevance of traditional bioethical principles. It also challenges bioethicists to propose a methodology for deliberating about ethical issues that genuinely is responsive to the frequent and often deep value disagreements that characterize a multicultural society.

FROM MONOLOGUE TO DIALOGUE IN URBAN BIOETHICS

Confronted with a significant disagreement between the beliefs and values of the dominant culture and those of some cultural minority about a health-related matter, health professionals and policymakers often resort to the following discussion-stopper: “Well, that’s how we do it here, and if you don’t like it, go elsewhere.” And, many bioethicists, even those with otherwise impeccable liberal credentials, seem to think that this is an adequate response. But, while there may be some matters about which there can be no negotiation—no liberal society can tolerate the ritual mutilation of children, for example—the attitude expressed in this reply is seen, often rightly, as contempt. This is especially likely to be the case if “the way we do things here” is presented as having universal justification and application when, in the view of the minority culture, these so-called universal values are no more than the reflection of a particular (dominant) culture. A different response to cultural disagreement, and one that seeks to blunt the charge of cultural imperialism, is to claim that, in deciding to adopt a new home, members of immigrant communities have rejected tacitly at least some of the traditions of their former home.²⁰ This response may be no more convincing to these members than the other, however, especially if the reason for their move was to escape economic hardship or political persecution.

In a culturally and ethnically heterogeneous urban setting, there is a multiplicity of cultural belief systems that influence individuals’ health beliefs and practices and that provide fertile ground for ethical controversy on a wide range of issues pertaining to medicine and health care. Those who find themselves confronted with this pluralism simply can assert the truth of their moral position and impose it with force on minority cultures that do not share their viewpoint. But, the recourse to force, while perhaps unavoidable in extreme circumstances, signifies either abandonment of or refusal to engage in the project of finding reasons that can convince not only within the dominant culture, but also across diverse cultures, and no liberal society can endorse it as a general method for dealing with disagreement. If a particular resolution of a bioethical controversy is to have moral authority or stand-

ing for those who occupy opposing sides of the debate, the reasoning that is used must be made accessible to those who have different cultural forms of life, and the conclusion that is reached must be justified in terms they can accept. In turn, this requires a reconceptualization of the nature of bioethical inquiry.

The practice of bioethics basically has been monologic in character. By this, I mean that bioethicists have taken their primary task to be that of working out the implications of allegedly universal ethical principles without regard for whether or how they are connected to the categories of discourse of particular communities. Bioethicists have not been completely indifferent to the problem of cross-cultural communication, of course. Typically, they have viewed this as a factor that complicates the application of universalistic principles of autonomy, beneficence, and justice and not as pointing to a basic defect in the methodology of bioethical deliberation they employ. Bioethics suited to the conditions of value pluralism characteristic of contemporary (urban) society, in contrast, must be conceived as a fundamentally dialogic enterprise.

The question of the adequacy of monologic bioethics is not likely to arise so long as we assume a culturally, ethnically, and racially homogeneous society with a shared system of values and beliefs and uniform ways of understanding illness and health care. But, the inadequacy of this approach is evident especially when we reflect on the pluralistic conditions of contemporary urban life. The virtue of dialogue in this setting is that it uncovers latent disagreements, if any, and allows disagreements to be formulated and debated in mutually comprehensible and accepted ways. These disagreements may take place either on the level of public and institutional policy or on the level of interactions between medical providers and their patients; in both cases, the solution to the disagreement may gain legitimacy by being derived through a process of dialogue.

The theory of deliberative democracy has gained prominence recently as the preferred account of the legitimacy of democratic procedures,^{21,22} and the essentially dialogic character of democratic deliberation makes it a useful model for thinking about the management of disagreement in a culturally heterogeneous society. Gutmann and Thompson²³ describe a number of important social purposes served by democratic deliberation. First, deliberation (or, more precisely, deliberation “that includes the voices of as many as possible of those now excluded”) promotes the legitimacy of collective decisions. Even when consensus cannot be achieved, the minority at least can acknowledge the relevance and appropriateness of the reasons advanced by the majority and so is more likely to accept its losses than if the majority had been victorious because of superior bargaining power. Second, and closely related to this, deliberation promotes the value of mutual respect, which is a more demanding notion than mutual tolerance, and thereby helps sustain a moral community in the face of conflict. Third, deliberation discourages moral rigidity and helps remedy the limitations of knowledge and understanding that often hamper unilateral decision making. These important goals are not served by a form of bioethical deliberation in which abstract and idealized principles are used to justify moral conclusions in splendid isolation from the realities of ethical and cultural diversity.

On the clinical level, something resembling what Jaggar has called “feminist practical dialogue,”^{24(p115)} broadened to encompass practical dialogue among persons with diverse cultural values, is an important part of the practice of urban bioethics. As Jaggar describes it, the ideal of feminist practical dialogue is that each woman listens attentively to opinions of others in the hope of working with them to forge a consensus position on the issue being discussed. Genuine dialogue does

not have as its goal gaining the agreement of others to a particular construal of some predetermined set of principles. Although this may be difficult enough, genuine dialogue is even harder: It demands that one be open to previously unseen perspectives that might come to alter one's former commitments and depends for its success on the practice of such virtues as responsibility, self-discipline, sensitivity, respect, and trust.

This notion of practical dialogue, as I conceive it, embodies the principles of deliberative democracy on a small scale and serves the same valuable purposes as the ones previously discussed. It has its limitations, however, when applied to situations involving health providers and patients from different cultural backgrounds, especially if they have little familiarity with each other's values, beliefs, and customs. The members of some cultural groups may find practical dialogue alien because it violates their conventions of discourse, or they may be unable to engage in dialogue because of language barriers or cultural misunderstandings. Nevertheless, provided that those who participate in this conversation continually remind one another of its limitations, there is at least the hope of achieving true consensus amid diversity.

CONCLUSION

The ideals on which democratic deliberation and practical dialogue are based are equal respect and consideration for persons; therefore, they offer a moral response to moral disagreements, including those rooted in divergent cultural forms of life. In setting an agenda for urban bioethics, I argue that we not only need to broaden the scope of bioethical inquiry to include consideration of the social determinants of health, public health ethics, and the impact of urbanicity on the doctor-patient relationship, but also need to understand why and how bioethicists have failed to take pluralism seriously and how this neglect can be remedied. Especially in urban society, in which pluralism often manifests itself in value disagreements that have significant implications for individuals' health beliefs and behaviors, bioethics can only hope to win widespread legitimacy if it adopts a pluralistic, genuinely dialogic method of moral deliberation.

There is no assurance, however, that dialogue, whether on the macro- or micro-level, will lead to consensus. When it does not, we have to ask whether a compromise is possible and acceptable, whether we simply should agree to disagree, or whether dialogue should be suspended at least temporarily and a "solution" imposed. The answers depend in part on the seriousness of the interests at stake in the controversy and on the urgency of adopting a common standard or policy in response to it. For example, different groups in our society are divided deeply over the practice of distributing condoms to high school students, yet many in the public health community believe that condom distribution has to be included in any effective program to control the spread of AIDS and other sexually transmitted diseases. How intractable disagreements rooted in divergent cultural or religious values are to be handled in the light of pressing public health needs is only one of the many problems that urban bioethics has to address.

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