An anthropological exploration of contemporary bioethics: the varieties of common sense

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Abstract

Patients and physicians can inhabit distinctive social worlds where they are guided by diverse understandings of moral practice. Despite the contemporary presence of multiple moral traditions, religious communities and ethnic backgrounds, two of the major methodological approaches in bioethics, casuistry and principlism, rely upon the notion of a common morality. However, the heterogeneity of ethnic, moral, and religious traditions raises questions concerning the singularity of common sense. Indeed, it might be more appropriate to consider plural traditions of moral reasoning. This poses a considerable challenge for bioethicists because the existence of plural moral traditions can lead to difficulties regarding "closure" in moral reasoning. The topics of truth-telling, informed consent, euthanasia, and brain death and organ transplantation reveal the presence of different understandings of common sense. With regard to these subjects, plural accounts of "commonsense" moral reasoning exist.

(*Journal of Medical Ethics* 1998;24:127-133)

Keywords: Pluralism, casuistry, principlism, bioethics, diversity, anthropology

Bioethics in a pluralistic world

Contemporary moralists can be usefully divided into two major camps. One group of scholars asserts that notwithstanding the existence of significant cultural differences, there does exist a "core morality" possessed by the inhabitants of most, if not all, human communities. These scholars emphasize shared, universal, cross-cultural norms and values. Stephen Toulmin, Charles Taylor, Sissela Bok, and Martha Nussbaum, for example, develop such accounts of the commonality of human moral reasoning. In contrast, a second group of scholars emphasizes local narratives, the heterogeneity of cultures, incommensurable moral worlds, and a diversity of moral tongues. Stanley Fish, Stanley Hauerwas, Alasdair MacIntyre, and H Tristram Engelhardt, for example, depict the manner in which different modes of moral reason-

ing are embedded in particular historical traditions and interpretive communities. According to these scholars, inhabitants of distinctive moral traditions can reach radically different understandings concerning what constitutes reasonable moral practice. I suggest that while scholars emphasizing incommensurable modes of moral reasoning have influenced the writings of bioethicists, the regnant methodologies within the field of bioethics continue to emphasize the commonality of human morality. Both casuists and principlists, for example, rely upon "commonsense" understandings of morality that presume an expansive beachhead of shared moral experience. They assume that there is a common web of morality that can serve as a tacit backdrop for contemporary moral reasoning. However, instead of being guided exclusively by the image of the "web" of morality, bioethicists need better to recognize the presence of plural traditions, or "webs" of moral reasoning. By placing excessive reliance upon the conviction that there is a shared "commonsensical" understanding of paradigmatic cases, a common public moral discourse, and a bundle of widely accepted, "mid-level" moral principles and maxims, casuists and principlists fail sufficiently to address the significance of distinctive patterns of enculturation for the variable evaluation of what is regarded as "reasonable". In contrast, I argue that if serious attention is given to historical moral traditions, ethnicity, and the interpretive commitments found within various religious traditions, then the way in which reasonable moral practice is construed will often vary. A better awareness of the diversity of moral traditions can help bioethicists to recognize the limitations of their common methodological tools of reasoning and justification.¹

From moral foundations through wide reflective equilibrium to webs of moral reasoning

Clinicians within health care institutions throughout North America are encountering increasingly diverse, multiethnic patient populations.² Just as

patterns of immigration alter the milieu of health care delivery, so too has the multiplication of religious and moral traditions in North America fostered the presence of distinctive accounts of the meaning of suffering, autonomy, dying, illness, and health.³ American sociologist Robert Bellah discerns in this development a transition from a public moral philosophy to the contemporary existence of discrete "lifestyle enclaves".⁴ Whether or not they rejoice in this emerging plurality of cultural forms or lament the decline of a shared public tradition of moral reasoning, bioethicists need to attend better to the many kinds of differences that can influence encounters between patients and health care providers. At the descriptive, interpretive level of social analysis, bioethicists need to have a better sense of the plural religious and moral traditions that so often serve to structure conflicts over the morality of particular practices and policies. They should be more attentive to differences linked to ethnicity, culture, religion, gender, and socioeconomic status, because these differences can play profound roles both within clinical settings and within public-policy making arenas. At the level of normative analysis, bioethicists ought to recognize better the challenge plural moral traditions pose to the "commonsense" approach to moral reasoning that characterizes work by both principlists and casuists. Finally, bioethicists need to understand better the way in which the presence of distinctive local moral worlds throws into question assumptions concerning the morality of topics such as truth-telling, informed consent, euthanasia, and brain death. Addressing the subject of local moral worlds, or epistemic pluralism, requires responding to the anthropological, post-foundationalist turn that is currently underway in bioethics. It entails exploring both theoretical and practical issues related to the nature of multicultural settings. In addition, it demands the critique of standard methods used by bioethicists. The exploration of particular topics serves to provide a focus for the discussion.

Post-foundationalist bioethics

Within the last decade, the field of bioethics has witnessed the eclipse of foundationalist projects intended to develop a moral theory capable of providing the framework for the deduction of principles and rules that could then be applied to particular cases. This shift from the search for the foundations of morality was accompanied by a move towards a greater reliance upon the coherence of practical moral reasoning and common sense. Within the ambit of moral philosophy, this development was marked by John Rawls's

movement during the 1980s towards "political constructivism" and his notion of public reason emerging from an "overlapping consensus" of moral and religious traditions.⁵ Moral reasoning, according to this conception, involves the linkage between a rich tapestry of principles, intuitions and norms that together constitute a relatively stable, coherent, wide reflective equilibrium. For bioethicists, this shift was represented by the publication in 1988 of *The Abuse of Casuistry: A History of Moral Reasoning*, by Albert Jonsen and Stephen Toulmin.⁶ A similar change in approach can be found in the 1994 publication of the fourth edition of *Principles of Biomedical Ethics* by Tom Beauchamp and James F Childress.⁷ Jonsen and Toulmin, as well as many others developing casuistic lines of enquiry, emphasized the limited relevance of any singular, foundational moral theory, and argued that particular, specific responses to distinctive cases were typically viewed by participants in moral debates with greater confidence than the more abstract theoretical foundations and principles that ostensibly served to buttress particular judgments. Jonsen and Toulmin endorsed an analogical, rhetorical, topical approach that relied upon common sense to proceed from straightforward, "paradigmatic" cases to increasingly complex issues. Notwithstanding the criticisms that "casuists" and "principlists" sometimes direct towards one another, principlists such as Tom Beauchamp and James Childress also discarded their prior emphasis upon moral theory as the final source of justification for their mid-level principles, and asserted that the principles they defend can be justified according to a conception of public reason. Much like the casuists, Beauchamp and Childress claim that the principles they describe are embedded within "common morality". The guiding image of bioethics, then, seems to be shifting from that of the layer cake, with theories supporting principles that justify rules which lead to particular conclusions in specific cases, towards the image of the web, where the web consists of a rich, "thick" body of maxims, rules and norms that are a matter of shared public reason.⁸ The various threads of this web are mutually strengthening, with no one aspect providing a "foundation" for the other components. I seek both to develop and challenge this re-orientation towards practical forms of public moral reasoning by exploring the unity and singularity of "the web", and considering whether there exists a range of distinctive moral traditions within North America that is insufficiently recognized by the insights of both casuists and principlists.

While casuists and principlists provide many compelling reasons for questioning the Enlightenment assumptions of the foundationalist project, they, in turn, need to defend better their claim that the judicious exercise of common sense can achieve a consensus concerning a host of moral issues heretofore addressed by various antagonistic parties. Casuists and principlists alike too often fail to recognize the significance that differences labelled with terms such as ethnicity, religion, and culture can have in leading to divergent understandings of what constitutes justifiable moral practices, codes, or laws. Instead of attending to the distinctive, variable understandings of a host of moral issues, they place excessive reliance upon common assumptions supposedly accessible to reasonable people. In making such claims, casuists and principlists succumb to what art historian Ernest Gombrich called "the myth of the innocent eye".⁹ That is, they unreflectively and unreflexively assume that what they see as commonplace maxims, norms, principles, and "paradigmatic" cases will be viewed by others in a similar manner. They do not recognize the extent to which their moral imagination is contingent upon social history, religious background, and social status. A less innocent form of bioethics would recognize the way in which this background, tacit knowledge predisposes bioethicists to particular normative claims and styles of justification. The writings of casuists and principlists do not adequately reflect the multiethnic, heterogeneous character of patient populations within North America, then, because casuists and principlists unjustifiably assume that interlocutors will "see" cases and moral matters in a similar manner.¹⁰ Admittedly, Jonsen and Toulmin do recognize that not all participants in debates will weigh substantive arguments in the same manner. However, what they fail to address adequately is the way in which particular reasons, principles, and arguments can be of the utmost significance to some interlocutors, while they possess little or no significance for individuals informed by different moral traditions. These differences are not only discernible over time, as a moral tradition undergoes change. Instead, they can also be found in contemporary North America, where diverse moral traditions exist concurrently. Increased attentiveness to various differences suggests that "common sense" might well be considerably more variable than casuists and principlists suggest. If so, questions can be raised concerning the capacity of bioethicists working with principlist and casuistic methodologies to achieve "closure" or "normative equilibrium" concerning a host of moral matters. Of perhaps greater significance, the degree to

which participants within particular moral traditions are, or are not, capable of understanding and accommodating one another needs to become a topic accorded greater consideration by bioethicists. Clearly, particular accounts of common sense can be dominant in specific locales at certain times. Indeed, such accounts can remain salient for generations. However, what an anthropological attentiveness to difference reveals, is that what constitutes common sense can also vary from setting to setting, community to community. Significant clashes can occur when these alternative forms of "common sense" confront one another. To address the possibility of the presence of distinctive moral worlds, or divergent webs of moral reasoning, I briefly address the topics of truth-telling within the context of cancer care, informed consent, euthanasia, and brain death and organ transplantation.

Cultural differences within the health care milieu: truth-telling within cancer care in local moral worlds

First, I consider the subject of truth-telling within the context of cancer care. Within Canada and the United States, a marked shift in attitudes towards truth-telling and information disclosure within cancer care occurred over the last thirty years.¹¹ At present, most bioethicists, physicians, and patients in North America presume that cancer patients ought to be informed of their illnesses, except under the most unusual circumstances. Instead of exploring the basic norm of truth-telling, current debates tend to address the more nuanced question of the extent to which prognostic information ought to be made available to patients. In contrast, within nations such as Japan and Italy, it is still common for physicians and family members to conceal diagnoses of cancer, particularly terminal diagnoses, from patients.¹² These practices of deception and non-disclosure receive justification from several sources. First, patient autonomy is not accepted as an obvious, "commonsensical" norm. To the contrary, physicians and family members are expected to fulfil their familial, communal, and professional obligations by assuming responsibility for making decisions. Second, given the negative symbolism surrounding cancer within Japan and Italy, physicians and family members are understood to act in a caring manner by fostering hope and protecting patients from what is understood to be devastating knowledge. There exist, then, local moral worlds that make it sensible within Japan and Italy to withhold information and deceive patients, and to disclose information in North America. Why do

practices within cancer care in Japan and Italy differ from those found in Canada and the United States? What moral norms, community expectations, and patient-physician relationships exist within these distinctive settings that lead to patterns of disclosure and non-disclosure? What bodies of tacit knowledge exist that make it controversial to advocate lying and deception in the context of cancer care within North America, while making frank, open disclosure much less common in Japan and Italy? Furthermore, given these regional differences in attitudes towards patterns of communication, what should occur within clinical settings in North America when immigrants from such settings encounter dominant American mores? What ought to be the obligation of physicians, other medical caregivers, and families to patients in North America who come from nations where information disclosure regarding illnesses is not the norm? How should clinicians proceed when families within North America express cultural norms that lead them to seek to withhold information from their ill relatives, or when an ill individual reveals that diagnostic and prognostic information is not sought? In addition, what institutional guidelines might be crafted to address such situations? These are the kind of questions that are left unasked when bioethicists presume, as a matter of "common sense", that patients with cancer will want to receive diagnostic and prognostic information.

Informed consent, divergent conceptions of autonomy, and alternative understandings of medicine and healing

Just as most bioethicists within North America now assume that patients want to receive truthful information concerning illnesses, so too do bioethicists presume that patients want to make informed choices about the medical care they receive.¹³ Again, this conviction is dependent upon particular assumptions that are not held by all patients. First, current understandings of informed consent typically presume that patients want to make autonomous decisions for themselves. However, within many communities in North America, communal decisions, and hierarchical patterns of decision-making can take precedence over personal choice. Within such settings, there may be little room for any notion that particular individuals ought to provide their consent to treatment. Furthermore, even if individuals did wish to exercise personal choice, they may have little understanding of "Western medicine". Indigenous understandings of healing and illness

continue to exist in industrialized, developed nations, and individuals influenced by such traditions can sometimes have a very limited understanding of "biomedicine". Thus, any consent they did provide could not justifiably be called informed. Within some regions of North America the practical significance of the notion of informed consent is suspect for just these reasons. Similarly, in many "developing" regions of the world, social relations are often characterized by being much more communal than the atomistic individualistic urban centres of North America. How should patients from such communities be addressed, both in North America and elsewhere? What happens when legal principles impose requirements concerning informed consent within regions where Western medicine is little understood, and personal autonomy is not altogether salient? What discrepancies exist between actual practice, and institutional policy or law? Finally, what might be the dangers associated with discarding the practice of informed consent in some situations by respecting these cultural differences? Would such individuals thereby become at greater risk of encountering dubious forms of medical research and treatment? Again, these are the kinds of topics that remain unexplored when the notion of "informed consent" is seen as straightforward, uncontroversial, unproblematic, obvious good.

Euthanasia, autonomy, and the multiple meanings of suffering and death

Quite divergent attitudes also exist concerning the subject of physician-assisted suicide and euthanasia. There is little reason to think that casuistic and principlist approaches can reconcile different attitudes towards suffering, autonomy, and community. For some, access to euthanasia is regarded as a fundamental moral right based upon the principle of autonomy and the duty to relieve suffering. However, for others, the significance of autonomy is much more qualified due to an emphasis upon other norms such as the sanctity of human life and the sovereignty of God.¹⁴ Some individuals argue that the legalization of euthanasia would have a detrimental communal effect. Others challenge the language of autonomy with the rhetoric of community and the "public good". In addition, even though there may well exist widespread attitudes concerning the duty to alleviate suffering, there also continue to exist communities where suffering is interpreted as possessing religious significance. Within these settings, suffering can be construed as therapeutic or redemptive. Given the variability that can exist regarding the importance

of personal choice and the meaning of suffering, it ought to be a matter for investigation and discussion concerning the extent to which “common sense” and “practical reason”, using casuistic and principlist methodologies, can lead to a public consensus in North America concerning the euthanasia debate. What constitutes good reasons for particular practices and policies within one community need not be compelling within other settings. In regions with diverse populations, the “good death” may take multiple, rather than singular, forms.

Brain death and organ transplantation

Within North America, considerable suspicion exists amongst many communities concerning the morality of brain death and various forms of organ transplantation. Despite the existence since 1968 of clinical guidelines concerning the definition of brain death, many communities continue to challenge biomedical definitions of brain death.¹⁵ For participants within these communities, “intelligence”, “the soul”, or “the spark of humanity” extends beyond the brain. Consequently, medical definitions of brain death do not, for members of these communities, signal the cessation of meaningful human life. Furthermore, these groups often articulate significant concerns about the morality of organ transplantation. Many communities see organ transplantation as a highly invasive, aggressive mode of treating the human body. In many instances, these same groups have serious reservations about autopsies and surgery involving various parts of the body. Practical reasoning, then, is quite variable with regard to the topic of brain death and organ transplantation, and is dependent upon particular horizons of understanding. Under what circumstances might religious or cultural objections to brain death criteria be justifiable? Is it “reasonable” to define death in different ways? Do religious objections to clinical definitions of brain death have any merit? Current assumptions concerning the commonality of practical reasoning tend to hinder the exploration of such questions, by obscuring the way in which participants within different communities can have quite different understandings of “the soul”, corporeality, the significance of the brain, and the meaning of transplantation surgery.

Plural moral traditions: a cautionary note

When discussing the notion of a multifaceted web, or distinctive webs, of moral reasoning, there are different ways of describing the significance of cultural differences. Those seeking to defend the “commonsense” approaches of principlists and

casuists tend to argue that a core bundle of moral norms and principles exists across cultural traditions. However, different traditions accord greater weight to certain norms rather than others. For example, within some communities, particular emphasis might be placed upon the principle of autonomy, whereas other communities might recognize the significance of the principle of autonomy, yet generally place greater emphasis upon communal mores. Indeed, it might well be that analogies can be found in a variety of different moral traditions for moral norms that are commonly labelled in North America and many other regions with labels such as “autonomy”, “beneficence”, and “non-maleficence”. However, even if common principles, or recognizable analogs for such principles do exist, these norms are not self-interpreting. Background assumptions serve to predispose participants within various interpretive communities to accord particular norms a certain measure of significance. Where these principles or maxims are accorded different valences by different communities, any effort to achieve a practical resolution satisfactory to all interlocutors can be profoundly challenged. Even though a common lexicon of norms and moral categories can exist, where there is disagreement about the relative significance of these principles, there can be sharply divergent accounts of how particular cases should be addressed, particular topics should be explored, and particular claims should be justified. A great many disparities concerning moral matters are not characterized by the presence of radical disagreement or incommensurable accounts of morality. However, there are some topics where quite divergent accounts of reasonable practices would seem to be present. When this occurs, the contribution of casuistic and principlist modes of moral reasoning can be quite limited, insofar as there are different understandings concerning the features of the commonsensical. Variable understandings of common sense, then, can be important at different nodes of moral analysis. Distinctive interpretive communities, such as particular ethnic groups or religious bodies, can share common principles, yet reach different conclusions in particular instances because varying degrees of weight are accorded to specific principles. In other situations, “common sense” can differ with regard to general principles, insofar as the moral norms that are salient within one community might be insignificant to members of other communities. The greater the extent to which the mores of one community are viewed as unintelligible by members of another community, the greater the likelihood that significant and protracted disagreements concerning

moral practices and policies will arise. Admittedly, this discussion of different moral traditions is troubling insofar as it points towards a multi-perspectival account of moral reasoning where there exists a potentially infinite number of accounts of moral and immoral conduct. A discussion of this sort also risks exaggerating the significance of cultural, religious, and ethnic differences by suggesting that various local moral worlds can be incommensurable. I suspect, however, that in most instances of social interaction within contemporary clinical settings, at least a beachhead of mutual intelligibility is likely to exist. Furthermore, even though tacit presuppositions will be utilized to address various topics by interlocutors in clinical encounters, the common experience of witnessing individuals change their minds when their background assumptions are sufficiently challenged suggests that people do not inhabit closed, impermeable frames of reference. Thus, given that efforts at justification can alter understandings of what constitutes moral practice, this discussion should not be misconstrued as an effort to dismiss altogether casuistic and principlist modes of moral reasoning. To the contrary, I am proposing a more modest task that recognizes the limitations of commonsense modes of moral reasoning when traditions of morality can be quite variable. Though I will not develop this discussion here, a more sustained, detailed account would want to address, in great detail, questions concerning when particular understandings of morality should or should not be tolerated. While I, in drawing attention to religious, ethnic, and cultural differences suggest the importance of the value of tolerance in the face of various commonsensical accounts of moral practice, a more elaborate account would also want to explore the boundaries of the intolerable, the unjustifiable, and the immoral.

Conclusion: contemporary bioethics in pluralistic settings

Throughout North America, physicians, nurses, and other medical personnel now encounter highly variegated patient populations. Clinicians encountering these distinctive communities of patients can experience significant obstacles in communication and understanding. The challenge to dialogue and mutual comprehension is not simply limited to linguistic barriers. Rather, patients and physicians can experience distinctive social realities where they are guided by diverse accounts of moral practice. Despite the presence of multiple moral traditions, religious communities, and ethnic backgrounds, casuists and princi-

plists rely upon notions of common morality and commonsense modes of reasoning. However, the heterogeneity of moral and religious traditions raises questions concerning the singularity of common sense. Indeed, instead of discussing some singular, canonical notion of common sense, it might be more appropriate to consider plural traditions, or webs, of moral reasoning. This poses a considerable challenge for bioethicists developing public policy, clinical guidelines, or addressing the particulars of a specific case because the existence of plural moral traditions or social realities can lead to difficulties regarding "closure" in moral reasoning. To what extent is it possible to reach a common understanding concerning many moral matters when the preliminary starting points for normative analyses can be so variable and the sources for normative justification so divergent? The chief problem with the emphasis upon the commonality of morality in the methodological presuppositions of bioethicists is that it fails to respond in an adequate manner to the diversity of moral traditions. Despite the contemporary presence of multiple moral traditions, religious communities, and ethnic backgrounds, casuists and principlists both assume that there is a common web of shared moral experience that can serve as a taken-for-granted backdrop to contemporary moral reasoning. This conviction places excessive reliance upon the notion of a common morality. Within North America, there exist heated debates concerning multiple cultural traditions and the importance of cultural horizons for personal and communal identity. While anthropologists of medicine and bioethics are well aware of the contemporary presence of distinctive traditions of healing and moral reflection, most bioethicists have not paid significant attention to this growing body of scholarship. The widespread acceptance of the notion of a "common morality" reflects an ignorance of the challenge posed to principlist and casuistic modes of moral reasoning by plural traditions of "common sense". Admittedly, some scholars have addressed the broad theme of cultural differences. Unfortunately, all too often, efforts to foster attentiveness to differences in clinical settings have led to stereotyping particular populations or patients. While the development of a cultural checklist is unlikely to be of much assistance in the clinical setting, clinicians and bioethicists need to foster an anthropological sensitivity to differences. Clinicians and bioethicists, then, need to recognize better the presence of distinctive moral worlds, and to consider the implications of this diversity when they are utilizing particular methods and theories. Casuists and principlists both rely upon the

notion of a web of common sense within which public practical reasoning proceeds. However, they pay little attention to alternative understandings of common sense. Instead of assuming the singularity of common sense, it is possible to argue that, over time, multiple webs could develop, with correspondingly different notions of common sense. Alternatively, there may exist a single web, within which all human reflection takes place. However, this web might be so elaborate and variegated that human participants within particular communities could have only a rather limited appreciation of the claims made by participants from other communities. The topics of truth-telling, informed consent, euthanasia and brain death and organ transplantation reveal these differences, and suggest that, at least with regard to these subjects, variable accounts of public moral reasoning exist. Various possibilities for modes of moral reasoning within pluralistic settings can be mapped. Different scenarios can be envisaged in which participants within local moral worlds address the existence of divergent understandings of common sense. Such encounters might generate a sense of incomprehension based upon "incommensurable" narratives, lead to the defeat of particular moral traditions as envisaged by Alasdair MacIntyre in *Whose Justice? Which Rationality?*, or end with the recognition that despite different terminology there is little disagreement concerning substantive matters.¹⁶ Alternatively, such discussions could conclude, at least for a time, with the dialogic "fusion of horizons" discussed by Charles Taylor in his essay, *The politics of recognition*.¹⁷ Indeed, it is quite possible that any one of these scenarios could occur depending upon the communities involved, the participation of particular interlocutors, and the topics under discussion. What would be lost with such an awareness of the multiple possibilities involved in any public debate involving distinctive communities of moral reasoning, would be the convenient assumption that casuists and principlists already possess some authoritative method that can lead to the achievement of a public moral consensus based upon "common sense".

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