Special Section: Open Forum

Bioethics and Social Studies of Medicine: Overlapping Concerns

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Polemicists and disciplinary puritans commonly make a sharp distinction between the normative, "prescriptive," philosophical work of bioethicists and the empirical, "descriptive" work of anthropologists and sociologists studying medicine, healthcare, and illness. Though few contemporary medical anthropologists and sociologists of health and illness subscribe to positivism, the legacy of positivist thought persists in some areas of the social sciences. It is still quite common for social scientists to insist that their work does not contain explicit normative analysis, offers no practical recommendations for social reform or policy making, and simply interprets social worlds. There seems to be a lingering assumption that normative analysis involves "philosophizing," and social scientists must squeeze explicit normative statements, assumptions, and convictions from their work if they are to be true to the standards of their disciplines.[1]

According to this boundary-drawing characterization of the division of academic labor, bioethics and the social study of medicine are distinguished by the descriptive or interpretive work of social scientists and the prescriptive work of bioethicists.[2] This gulf is sometimes characterized by the "is/ought" distinction or by emphasizing the difference between asserting values and describing social facts. In this overly tidy allocation of disciplinary tasks, social scientists engage in empirical study of social orders whereas bioethicists provide arguments concerning how matters ought to be. Ethicists make moral judgments. In contrast, anthropologists and sociologists study moral norms, social practices, and local moral worlds but do not offer moral judgments or make explicit recommendations for social reform or policy making. Social scientists use surveys, participant observation, grounded theory, ethnographic research, and in-depth interviews to describe social reality; however, they do not offer moral analyses of the social orders they describe. In juxtaposition, the routine task of philosophers and theologians is to apply moral principles or moral theories, make normative arguments, and evaluate social practices, professions, policies, and institutions. This sharp demarcation of disciplinary goals and standards is increasingly unhelpful and misleading.[3]

Situated Bioethics

One problem with standard accounts of the division of academic labor is that—criticisms to the contrary—many bioethicists are interested in understanding the social worlds within which practical ethical issues are situated.[4] Also, numerous social science critiques of bioethics fail to acknowledge how work in medical anthropology and medical sociology can be viewed as forms of bioethics. In

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addition, these influential social science critiques of bioethics ignore the considerable overlap in concepts used by both bioethicists and social scientists. Many terms and concepts are used by different communities of scholars; no one group of scholars can claim exclusive access to these interpretive tools.

To provide cogent moral commentary, bioethicists need to understand the ethical issues they propose to address. They must have some understanding of the institutional structures, social arrangements, and larger social worlds within which ethical issues emerge. Competent moral deliberation never simply involves the "armchair" ethical analysis of ethical issues through the decontextualized application of principles and theories. To make meaningful contributions to the analysis of such ethical issues as priority setting and resource allocation, end-of-life care, and patient–physician communication, many bioethicists attend rounds, meet with patients and their loved ones, draw upon ethnographic studies, familiarize themselves with important cases, utilize survey findings produced by clinicians and social scientists, pursue training in qualitative research methods, and draw upon publications in the anthropology and sociology of health and illness. Social scientists might have legitimate grounds for wishing that bioethicists were better trained in social science research methods. However, it is quite another matter to insist that bioethicists are indifferent toward the complex social worlds that social scientists explore.

Competent work in bioethics involves understanding and interpretation; it requires recognizing discrepancies between everyday social practices and official codes, policies, and standards. For example, bioethicists need to be aware of the distance between legal concepts such as informed consent and situated social interactions involving particular patients and clinicians. They must comprehend the role of organizations and institutional structures in generating ethical issues and fostering conflicts. They need to be cognizant of the practical consequences of disparities in power and social authority. Also, it is important that bioethicists understand the capacity of medicine to objectify patients and treat complex humans in a reductionistic manner. Many bioethicists appreciate the significance of cultural norms, ethnicity, socioeconomic status, gender, organizational structures, social context, language, and social history in shaping how particular issues are labeled, framed, experienced, and assessed by involved parties. Scholarship in bioethics contains many publications where ethnicity, culture, social inequalities, and gender differences are taken into consideration. Social scientists who attempt to characterize bioethicists as abstract deductivists focus on the most desituated, theoretical examples of philosophical bioethics and neglect more contextualist forms of moral engagement.[5] This style of criticism overlooks the many bioethicists engaged in more inductivist, situated forms of moral deliberation.

Common Concerns

Bioethicists address many of the issues and topics that concern anthropologists and sociologists of medicine and healthcare. For example, both bioethicists and social scientists are aware of the gap between idealized, conceptual models of informed consent and the messy, imperfect process of communication in particular clinical settings and research contexts.[6] Bioethicists and social scientists are concerned with how institutional routines can take precedence over the concerns of

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vulnerable humans. Both social scientists and bioethicists address the medicalization of human experience and the depersonalization or objectification of particular humans.[7] Bioethicists and social scientists both explore the expansion of disease categories, processes of medicalization, and the use of marketing techniques to "sell sickness."[8] Likewise, concepts such as health equity and health inequalities cross disciplinary boundaries.

We are at least two decades past the time when many bioethicists thought they could merely apply deontological or utilitarian normative frameworks to the complexities of specific social worlds. For all the criticisms that the principlist approach of Beauchamp and Childress has received over the years, it is important to note that even early iterations of their principlist framework acknowledged the importance of attending to the social contexts within which moral norms need to be specified, weighed, and interpreted. Bioethicists engage in normative analysis and often try to provide guidance to clinicians in the form of case commentary or policy development. However, competent work in bioethics is as concerned with interpreting and understanding social worlds as the research of any anthropologist or sociologist.

Values in Social Science Research

Just as a sizable body of scholarship in bioethics addresses issues and uses approaches familiar to social scientists, anthropologists and sociologists commonly confront and address moral considerations in their research. Although social scientists might recoil at being labeled moralists or ethicists, anthropologists and sociologists do not simply describe objective empirical realities in value-free terms.[9] The "crisis of representation in the human sciences" has made anthropologists and sociologists acutely aware of their role in shaping narratives according to constraints set by stylized traditions of research.[10] Research methods rooted in positivism—the notion that anthropologists and sociologists gather facts as though they are picking apples from trees—have been criticized for decades. Ethnographies of intensive care units, neonatal intensive care units, surgical floors, and organ transplant teams commonly contain powerful moral critiques of contemporary biomedicine. Anthropologists and sociologists frequently attend to the gulf between laws, institutional policies, and professional standards or ideologies and situated, local social processes.[11] Social scientists are adept at exposing hypocrisy and self-interest in the health professions.[12] Social science research on end-of-life care in intensive care units, oncology units, and other settings raises troubling questions about the "technological imperative," the "biomedical embrace," and the medicalization of death and dying.[13] Studies by sociologists and anthropologists of organ transplantation raise disturbing questions about scientific progress, medical hubris, and the dark side of scientific "progress." Though ethnographic work is not driven by standard philosophical theories of ethics, moral engagement and normative analysis permeate publications by anthropologists and sociologists.

Ethnographies as "Bioethics"

Though social science research is not reducible to ethnographic research methods, the genre of ethnography provides a powerful example of how normative

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dimensions can be found in social science research. True, social scientists rarely draw on the theoretical frameworks, rhetorical forms, and philosophical literature of bioethicists. Nonetheless, ethnography constitutes an important example of a moralizing genre offering critical commentary on biomedicine. Ethnographies, even when written in a style of "hard-boiled realism," frequently tell morality tales.[14] Heroes and villains might not be present—though sometimes it is not that difficult to spot the villains in social science narratives—but judgments about inequalities, injustices, and abuses of power are common.[15] Though ethnographies are not always explicitly normative, countless ethnographies contain tacit moral critiques of various facets of contemporary biomedicine. There is a normative, value-laden dimension to much of the work done by sociologists and anthropologists of medicine. Indeed, it is rather difficult to imagine what shape ethnographies of health, illness, or healthcare settings would take if social scientists were precluded from using value-laden terms and categories of analysis.

Guiding Presuppositions in Social Science Research

Many social scientists see themselves as debunkers of official pieties.[16] A common move by social scientists is to attend to the voices, perspectives, or worlds of the downcast, marginalized, and stigmatized and offer sympathetic interpretations of their experiences. This interpretive stance contains an implicit moral agenda; social scientists often offer frank insight into disturbing social realities rather than simply reiterating official orthodoxies. Whereas the marginalized are often treated with sympathy by social scientists, high-status professionals who cloak themselves in the language of altruism are frequently revealed to be self-interested social actors. This dual move of knocking high-status actors from their social pedestals and recognizing the decency and humanity of the marginalized is a moralistic act. The ethnographic tradition in medical anthropology and medical sociology would look much different if the typical strategy of the social scientist was to deride the marginalized and celebrate the powerful captains of industry and biomedicine. Though ethnographic works rarely include chapters on the political philosophy of their authors, many ethnographies are influenced by liberal egalitarian or social democratic interpretations of social order and social institutions. Most anthropologists and sociologists of health and illness are not trenchant supporters of laissez faire capitalism and the benevolent "hidden hand" of the market. Rather, a large body of work in the social sciences unmasks the harms generated by quests for profits and the prioritization of self-interest or professional interest over concerns for community goods. Although there is a difference between self-consciously, explicitly developing a political philosophy or normative framework and implicitly drawing upon moral terms and concepts, the tacit moral norms that guide interpretive work in the social sciences make this area of scholarship profoundly moralistic.

Acts of Interpretation

The very choice of research setting or research topic can have a moral dimension. Social scientists often study social worlds stratified by massive disparities in power between clinicians and patients or social authorities and the socially marginalized. Studies of language use and communication patterns in clinical

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settings commonly reveal the extent to which patient choices are overlooked, dismissed, or manipulated even when informed consent and patient autonomy are officially celebrated. The articulation of particular questions posed to interviewees and the ethnographer's selective use of statements from transcripts are value-laden exercises. Comments from patients are sometimes used to question the self-interested claims of doctors and scientists. Unguarded "confessions" or "backstage" remarks by healthcare providers can be used to challenge "official" statements within specific clinical worlds.[17] Even where anthropologists and sociologists are dismissive of bioethics or philosophy, evaluative terms and concepts commonly pervade qualitative research. Ethnography in particular, and qualitative research more generally, does not offer objective characterization of empirical realities. Voices of particular social actors can be emphasized or de-emphasized, taken as straightforward, trustworthy accounts or subjected to sharp critique. Ethnographers offer interpretations of particular social worlds. The act of interpretation involves moral judgment. Qualitative research draws on narratives told by situated actors; ethnographies are written by socially located interpreters who use language and concepts to make sense of the worlds they study. Most ethnographies are not breathless testimonials celebrating the good deeds of intensivists or glorifying the work of star surgeons, oncologists, and transplant specialists. Rather, ethnographies are often recognizable as profoundly moralistic texts that interpret and critically engage ethical issues related to medicine, health, and illness. The "gulf" between bioethics and the anthropology and sociology of medicine is exaggerated.

Beyond Polemics

The persistent criticism of bioethics by various social scientists emphasizes differences and underestimates the many ways in which concerns of bioethicists and social scientists overlap. Some bioethicists make similar errors when making broad judgments about the social sciences. Bioethics and the sociology and anthropology of medicine do not neatly divide along some putative fault line separating the "is" from the "ought" or "descriptive" from "prescriptive" research. Competent work in bioethics requires a rich, detailed understanding of complex social worlds, organizational routines, hierarchies, inequalities, and power structures.[18] Work by social scientists requires careful interpretation of social realities and critical social commentary.[19] As debunkers of orthodoxies and demystifiers of the status quo, social scientists are often attracted to issues that contain important moral dimensions. Written by particular, situated humans with specific concerns and interests, ethnographies rarely purport to provide a "neutral," "objective," thoroughly dispassionate view of social worlds. Rather, they often contain a strong—even if tacit—moral agenda.

Conclusion

Medicine, with its language of health and illness, function and dysfunction, normal and abnormal, has always included both "evaluative" and "descriptive" components.[20] Some words that describe particular aspects of reality also contain built-in normative judgments. Though there are times where we can usefully distinguish between more "descriptive" and more "evaluative" terms, the art of

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medicine involves both understanding and judgment. Similarly, bioethics and the social sciences do not neatly fall on different sides of "descriptivist/prescriptivist" or "fact/value" distinctions. Perhaps greater recognition of the considerable degree of overlap characterizing bioethics and the social study of health and illness might generate more productive discussions between bioethics and social scientists and contribute to richer, more thoughtful critical commentaries on medicine, health, and illness. A great deal of the criticism social scientists direct at bioethics is driven by the conviction that scholarship in bioethics is dominated by "principlism" and an abstract moral universalism. This account overemphasizes the significance of one style of moral reasoning and neglects the variety of approaches in bioethics. Perhaps as social scientists become more familiar with the diversity of approaches in bioethics, the range of topics bioethicists address, and the complex ecology of social settings within which bioethicists work, we will see fewer broad indictments of bioethics and more fruitful exchanges between scholars in bioethics and the social sciences.

Notes

1. Scheper-Hughes N. The primacy of the ethical: Propositions for a militant anthropology. *Current Anthropology* 1995;36(3):409–40.
2. Borry P, Schotsmans P, Dierickx K. The birth of the empirical turn in bioethics. *Bioethics* 2005;19:49–71.
3. Flyvberg B. *Making Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again*. Cambridge: Cambridge University Press; 2001; Nelson J. Moral teachings from unexpected quarters: Lessons for bioethics from the social sciences and managed care. *Hastings Center Report* 2000;30(1):12–7; Murray T. Moral reasoning in social context. *Journal of Social Issues* 1993;49:185–200; De Vries R, Turner L, Orfali K, Bosk, C. Social science and bioethics: Morality from the ground up. *Clinical Ethics* 2007;(2):33–5.
4. Ebbesen M, Pedersen B. Using empirical research to formulate normative ethical principles in biomedicine. *Medicine, Health Care & Philosophy* 2007;10:33–48; Borry P, Schotsmans P, Dierickx K. What is the role of empirical research in bioethical reflection and decision-making? An ethical analysis. *Medicine, Health Care & Philosophy* 2004;7:41–53.
5. Fox R, Swazey J. Medical morality is not bioethics—Medical ethics in China and the United States. *Perspectives in Biology and Medicine* 1984;27(3):336–60; Kleinman A. Medicine, Anthropology of. In: Reich W, ed. *Encyclopedia of Bioethics* (revised edition). New York: Simon & Schuster MacMillan;, 1995:1667:74; Kleinman A. *Writing at the Margin: Discourse between Anthropology and Medicine*. Berkeley: University of California Press; 1995; Lopez J. How sociology can save bioethics . . . maybe. *Sociology of Health & Illness* 2004;26(7):875–96; Rosenberg C. Meanings, policies, and medicine: On the bioethical enterprise and history. *Daedalus* 1999;128:27–46.
6. Zussman R. The contributions of sociology to medical ethics. *Hastings Center Report* 2000;301:7–11.
7. Conrad P. The shifting engines of medicalization. *Journal of Health & Social Behavior* 2005;46:3–14; Conrad P, Leiter V. Medicalization, markets and consumers. *Journal of Health and Social Behavior* 2005;45:158–76; Purdy L. Medicalization, medical necessity, and feminist medicine. *Bioethics* 2001;15(3):248–61; Verweij M. Medicalization as a moral problem for preventative medicine. *Bioethics* 1999;13:89–113.
8. Moynihan R, Cassels A. *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All Into Patients*. New York: Nation Books; 2005; Moynihan R, Heath I, Henry D. Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal* 2002;324:886–91.
9. Nelson J. Moral teachings from unexpected quarters: Lessons for bioethics from the social sciences and managed care. *Hastings Center Report* 2000;30(1):12–7.
10. Marcus G, Fischer M. *Anthropology as Cultural Critique*. Chicago: University of Chicago Press; 1986.
11. Marshall P. Anthropology and bioethics. *Medical Anthropology Quarterly* 1992;6:49–73.
12. De Vries R. How can we help? From "sociology in" to "sociology of" bioethics. *Journal of Law, Medicine & Ethics* 2004;32:279–92.

https://doi.org/10.1017/S0963180108090063 Published online by Cambridge University Press

13. Good MJ. The biotechnical embrace. *Culture, Medicine, and Psychiatry* 2001;25:395–410.
14. Van Maanen J. *Tales of the Field: On Writing Ethnography*. Chicago: University of Chicago Press; 1988.
15. Kleinman A. Moral experience and ethical reflection: Can ethnography reconcile them? A quandary for "the new bioethics." *Daedalus* 1999;128:69–97.
16. Bosk C. Irony, ethnography, and informed consent. In: Hoffmaster B, ed. *Bioethics in Social Context*. Philadelphia: Temple University Press; 2001:199–220.
17. See note 16, Bosk 2001.
18. Hedgecoe A. Critical bioethics: Beyond the social science critique of applied ethics. *Bioethics* 2004;18:120–43.
19. De Vries R, Turner L, Orfali K, Bosk C. Social science and bioethics: The way forward. *Sociology of Health & Illness* 2006;28:665–77.
20. Toulmin S. Ethics and "social functioning": The organic theory reconsidered. In: Engelhardt HT, Callahan D, eds. *Science, Ethics and Medicine*. Hastings-On-Hudson: Institute of Society, Ethics and the Life Sciences; 1976:195–217.

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