

BIOETHICS VIA AFRICOLOGY

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INTRODUCTION

Scholarly discussions have been coalescing on the topic of cultural diversity in global bioethics (for instance, Brodwin, 2001; Marshall, & Koenig, 2004; Chattopadhyay, & DeVries, 2008; Behrens, 2013). This analysis joins with the momentum and aims to forge an appropriate rubric for practice in regard to Africa. It calls for the careful adoption and adaptation of Euro-American bioethics principles,¹ and to indigenize them into the African context via the matrix of Africology, a.k.a. Afrocentrism. Efforts on the specifics of refocusing attention on core bioethics principles and values are a welcome development. More importantly, it would help to reflect the local color in various cultural climes and bolster the push to formulate an appropriate blueprint for bioethics practice that recognizes the multiplicity of cultures worldwide.

The movement for the fusion of ideas about cultural diversity in global bioethics has probably approached a critical mass of popular support. That effort has steadily been subjecting bioethics principles to closer and closer scrutiny and increasingly demanding that various cultural milieus be recognized and respected, so they can compose approaches that suit them (Alora, & Lumitao, 2001; Andre, 2002; Widdows, 2007; De Vries, Rott, & Paruchuri, 2010). It is a recognition of cultural relativity (a.k.a., cultural autonomy) – the understanding that individual and/or communal choices are shaped by the cultural environment in which people are raised and/or comfortable with.

This piece begins with a brief comment on the evolution of bioethics and its rapid spread in recent times. Second, a drug (Trovan) experiment is introduced to highlight the fact that despite gatekeeping efforts, it still exemplifies the controversy that can occur in international clinical trials. Specifically, this drug trial demonstrates disregard for research ethics provisions and contempt for local cultures. Hence, the third part of this chapter is a philosophical inquest into the experimentation. Forth, is a critical reexamination of the make-up of principlism which roots are in liberal individualistic tradition of Euro-America, and inherently unsuitable for multicultural settings. To wrap up, the analysis argues for an Afrocentric model, a fitting framework that upholds cultural relativity and addresses some of the deficiencies of principlism.

BRIEF BACKGROUND AND POTENTIALS

As a discipline, bioethics² is very young. It is still in its 40s, having emerged in the 1970s in the U.S. (and elsewhere) and catalyzed by biomedical landmark events that gave rise to for example, the Nuremberg Code (1947), the first Declaration of Helsinki (1964), the Belmont Report (1979) and the Council for International Organizations of Medical Sciences (1993). These are sets of ethical guidelines developed to regulate biomedical and social science research, particularly research with human subjects.

Being so young and with penetrating tentacles, it was only a matter of time before bioethics' formative ideology would encounter challenging scenarios at socio-cultural milieus outside of its birthplace and comfort zone.

Accounts of the origin of bioethics are varied. Martensen (2001) narrates that statesman Sargent Shriver, coined the word "bioethics" in his own Bethesda, Maryland living room one night in 1970. It was at the instance of meeting with physician André Hellegers, a Jesuit philosopher and then president of Georgetown University, and others, to discuss (President) Kennedy family's sponsorship of an institute for the application of moral philosophy to concrete medical dilemmas. Martensen however credits author and bioethicist Van Rensselaer Potter for conceptualizing bioethics "expansively" (p. 168). Another source, Irving (2000), locates the embryonic formation of "bioethics" in the 1960s following Congressional and Senate hearings which were called to "address an increasing number of bewildering problems being generated by medical research and the abuse of human subjects" (p. 54). Even so, the *Internet Encyclopedia of Philosophy* narrative seems authentic too. Crediting Sass' (2007) work, it claims the German theologian Fritz Jahr whose three published articles in 1927, 1928, and 1934, were the first to use the German term "bio-ethik" (bioethics). From then on, a new academic discipline was established, and gradually the commencement of

the practice of a new, more civilized, ethical approach to issues concerning human beings and the environment. Jahr famously proclaimed his bioethical imperative: 'Respect every living being, in principle, as an end in itself and treat it accordingly wherever it is possible (n.d.).

This would be the early beginnings of a watershed point when medical decisions made a radical shift to involve many people besides the physician and the patient: "... members of review boards and ethics committees, lawyers, bioethicists, regulators, and representatives of the courts. Before the mid-1960s, however, physicians' primacy in this area was virtually complete," (Rothman, 2009, p. 6).

As bioethics continues to berth at new places across the globe, an inescapable challenge remains how to adopt and adapt its principles. The key question of this exigesis is: what counts as an appropriate protocol for framing the implementation and institutionalization process to embed research ethics principles into the various social and cultural contexts of the world? It is here proposed that with respect to the African context, the principle of Afrocentricism may hold the answer.

For starters, it is acknowledged that the phenomenon of culture clash is always inevitable. That reality has been with humankind from the dawn of time. However, the concern has been that the pace of the new form of culture collision – globalization – is breathtaking. The practice of bioethics is not exempt, and questions have been raised as to what should be an adequate response (Ryan, 2004; Zwart, 2008; Levitt and Zwart, 2009). Besides the speed, globalizing influences are sometimes characterized by the assumed superiority of one culture over the other(s) – in this case, the West over the rest. Tangwa (1996) traces the root of this perceived dominance to technological advancement aided by intrusion in the form of imperialism, colonialism and neo-colonialism, of the Western world in non-Western worlds.

The scientific-cum-technological success of the Western world has, furthermore, made it to consider itself and to generally be accepted as an infallible oracle on all other spheres and all other matters. The Western point of view and Western philosophies and practices are everywhere loudly propagated (p. 185).

Further still, the fanfare of biotechnology's potential is tempered by the fear that the consolidation of scientific knowledge and expansion of biotech markets will indeed create new opportunities for marginalization and exploitation (Ryan, 2004, p. 167). Other analysts have sought to formulate principles that are germane to Africa (Jensen, K. & Gaie, J., 2010; Azetsop, J. 2011; Behrens, K.G., 2013).

The challenge of containing the interventionist force of Western³ practices in the deeply controversial issues of ethics of international research is perhaps well illustrated by the 1996 experimentation of Trovan drug on many pediatric patients in Kano, a northern Nigerian city. Fallouts from this event have continued to negatively impact lives in that city and even inspired a Hollywood movie, *The Constant Gardener* (Howden, 2010). The method used by Pfizer, Inc., seem to belong to a class rarely found since the atrocities of 1946-1949 in Nuremberg, Germany.⁴ The Trovan event refocuses attention not only on some of the troubling ethics of biomedical research that involve patient-subjects. It further raises the urgency to relate general norms or policies to particular needs and contexts. Such urgency is quite appealing and is the motivating factor for this work.

As multicultural efforts continue to re-evaluate core bioethics principles and values to reflect the local color in various cultures, the Pfizer-Nigeria fiasco and others like it,⁵ seem to have reset the debate several years backwards. The fact that this incident took place in the mid-1990s is not an indication that lessons from it have been learned; just as the half century-old Nuremberg or the Tuskegee⁶ episodes cannot be regarded as irrelevant today. Also, the citing of the 1996 Pfizer example does not just serve to illustrate the imposition of Eurocentric bioethics principles on Africa. Crucially, it also points to the arrogance, ruthless expansion, and exploitation of scientific knowledge and biotech markets by a global multinational corporation, in this instance Pfizer. Unwittingly though, events like this presses the urgency to develop some sort of blueprint for bioethics practice that recognizes cultural relativity within the multiplicity of cultures worldwide.

TROVAFLOXACIN TEST CASE

In 1996, concurrent epidemics of cerebro-spinal and bacterial meningitis, measles, and cholera were affecting children in Kano, Nigeria. The American pharmaceutical giant, Pfizer, learned of this outbreak in the news and dispatched a research team to a local hospital providing treatment. Pfizer administered Trovafloxacin (Trovan), a quinolone antibiotic, to many pediatric patients as part of its effort to determine the effectiveness of the experimental drug in treating meningitis. The drug had never been tested on children. All the children in the study were picked from among the long lines of people seeking care (Stephens, 2006, p. A01).

A Nigerian government investigative report blamed the drug trial for the death of 11 children; scores more suffer permanent disabilities such as brain damage, paralysis,

muteness/ slurred speech, and blindness (Stephens, 2006, p. A01). A series of lawsuits by the victims and the Nigerian government, filed under the US Alien Tort Claims Act, commenced in 2001 (Vogt, 2007). But they were all withdrawn in the Supreme Court in September 2010. Pfizer had struck a \$75-million out-of-court settlement for claims related to the experiment. Later that same year, Pfizer also offered to build a \$25-million hospital in the city, a gesture aimed to further appease the people (*Independent*, 2010).

The moves apparently stymied the chance to validate or disprove, a list of allegations which include that: Pfizer took advantage of the chaos from the medical crisis as an opportunity to quickly conduct the study (a potentially dangerous treatment) on young children, something it had been unable to obtain permission to do elsewhere; and that Pfizer obtained no assent from any of the children participating in the trial (or informed consent from their parents). Others are that Pfizer provided no explanation to the children or their parents that the treatment was experimental and that they were free to refuse it in favor of the known effective treatment available at the same hospital free of charge; and that Pfizer never received the necessary approvals (either from the Nigerian government or the hospital administration) to conduct the research, but when the FDA began an audit of Pfizer's Trovan records, suddenly a letter dated March 1996 surfaced stating that the hospital's ethics committee had approved the Trovan study; but the hospital never had an ethics board.

For the records, Trovan was projected to be Pfizer's next major profit gusher, estimated to net \$1 billion in yearly sales if approved by the FDA (Stephens, 2006).

While science cannot advance without experimentation, pursuit of narrow goals and populist economic motives have sometimes led to troubling behaviors by some scientists working for corporations with other agendas to undermine international research ethical guidelines and principles. And as gatekeepers continue to double down their commitment to regulate, researchers in such multinational corporations have sought out 'soft targets' elsewhere, including the developing world (Petryna, 2009).

ISSUES OF CONCERN WITH TROVAN

Before proceeding, it is apt to reflect on some troubling *prima facie* issues with this drug trial that have either received insufficient or no attention at all.

One, despite the lessons of history – recall the outrage which produced the Nuremberg Code, and the vow of 'never again under our watch' – when a clinical trial disaster recurs, we often return to the soul-searching question of, how did we get it wrong, *again*? There is a divide between treating others respectfully because one recognizes the need for their active engagement in and with one's work; and treating them respectfully because to do otherwise would be either morally wrong or instrumentally troublesome. It is misguided, that clinicians in the Trovan test case apparently chose not to demonstrate epistemic interest in their subjects.

To act with epistemic interest assumes the intrinsic value of persons. To do otherwise constitutes what Naomi Scheman (2009) has labelled an "ethical and epistemic threat to our moral community" (p. 110). It is an unfortunate fact that after all these years, vestiges of immoral and unethical practices which catalyzed the formulation of guidelines to protect human subjects, are inexorably rearing their heads. The 1996 Pfizer-Nigeria case

happened almost two decades ago, but its consequences are just as fresh. For instance, the scar of suspicion and erosion of trust are two prime factors that explain the failure of vaccination efforts in that part of the world. Many rural residents have repeatedly been uncooperative with government vaccination efforts. As a result, this Moslem-dominated area has harbored and witnessed the recurrence of preventable diseases like polio that have been wiped out in other parts of the world (Jegede, 2007). As recently as 2012, Nigeria accounted for more than half of all polio cases worldwide, according to WHO, but no cases have been reported in the last six years.

The argument here urges for a confluence of epistemology and research ethics. It is in this confluence that moral epistemology is whole and complete. It brings to the forefront the contexts in which objects and subjects of knowledge exist in both the laboratory and in clinical practice. To do otherwise will not only vitiate humankind's epistemic baseline, it also goes against liberal egalitarian morality that all human beings are one another's moral equals. This point is contained as well in the ethical guidelines for human subject research: *all humans* (emphasis intended) have equal basic moral status;

... they possess the same fundamental rights, and comparable interests of each person should count the same in calculations that determine social policy, and neither supposed racial differences, skin color, gender, intelligence, etc., negate their equal worth and dignity (Arneson, 1999, p. 23).

Two, relics of the discarded stereotypical mindset which regarded Africans as unsophisticated or primitive may be at play too as was the case with anthropological and social research of old (Tienou, 1991). Pfizer is not on record for expressing any of such erroneous stereotypes, but they are clearly implied in their actions; and actions speak louder than words. This mindset stems from the assumption that Africans are both unlikely to have equivalent word or phrase that translates to for instance, "informed consent," and as such lack the conceptual resources, hence, "epistemically inferior," to understand its philosophical import. Other writers have already offered arguments against the assumption that "informed consent will not be valued by such a culture as it is by ours" (e.g., Tollefson 2008, p. 39). The wrongness of dishonoring another is made worse by acting in a manner that shows that they can be dispensed with. It is intriguing that Pfizer (whose clout easily surpasses that of many individual countries) would apply trickery and deceptive tactics to recruit pediatric patient-subjects for the experimental drug. It seems insulting that Pfizer nursed no qualms to do in an African country something it couldn't do in the US or anywhere in the West.

This is reminiscent of the same argument that was made for the infamous AIDS experimental drug AZT in Thailand and parts of Africa (Tollefson, p. 42). As was apparent in the case of Trovan, it is suspected that informed consent was bypassed as was in the case of AZT because of the urgent nature of the situation. That seems inappropriate. Because disease outbreaks in Africa predominantly affect mostly uneducated and poverty-stricken populations, patient-subjects must not be duped to think that they are undergoing a treatment aimed to make them better. The deceptive part brings echoes of the Tuskegee experiment during which subjects were made to believe they were being

treated for a blood disorder condition or “bad blood,” but in fact, it was done merely to compile data on the effects of the spontaneous evolution of syphilis on black males.

The Trovan study took place at the same hospital where a team of *Médicins Sans Frontières* was already providing free treatment with Ceftriaxone, a gold standard antibiotic medication internationally recommended for treating meningitis (CNN Money, May 6, 2006). But, while some were getting other treatments, these kids were receiving a potent concoction that was yet unapproved. To think that all this might have been decided and rammed through with no input from the patient-subjects (and their parents; including the local system) elevates the concern even higher. It seems wrong enough to have used the instrument of informed consent to manipulate patient-subjects, how much more (as it appears) to circumvent international ethical guidelines in the course of this experiment. It is a betrayal and exploitation of children by those who are required to care of them at a time of desperate need.

Three, it is pertinent to highlight the element of responsibility here; the type that as a moral and socio-psychological construct, fuses with a relationship between one individual and another, between one social unit and another, and between a small social unit and global societal structures (brought about by globalization). Of the many ways responsibility can be conceived, the author is arguing for the responsibility that is embedded in ethical values and caring. It is that which is bestowed on a person (including a ‘legal person’, Pfizer)⁷ or that which a person feels as well as knows that he/she will be held up to or responsible for. It is therefore a moral and ethical duty for which one is liable and accountable (Bierhoff, & Auhagen, 2001).

This is critical because if everything is merely left up to the research ethics guidelines alone, sufficient brakes would not be applied to stem the unacceptable behavior in which some profit-motivated scientists might engage. This behavior apparently pervades despite the guidelines and the long-accepted standards that research involving human subjects is much tightly regulated by such gatekeepers as the US Food and Drug Administration (USFDA)⁸ and the National Institutes of Health (NIH).

Four – this point relates most directly to the Afrocentric rubric being proposed here – research agendas and trial protocols should always be set in consultation with the local communities concerned, taking into account the cultural, language, literacy, and socioeconomic differences that have impact on people's behavior and ability to participate (Wills & Tyeku, 2000). Likewise, to do this is to apply epistemic value to ethics of care as well as elevate the way clinicians regard those for whom they have ethical responsibilities.

The six-step “community permission” model by Diallo et al. (2005) – which seeks for *permission* and *approval* from the local authorities before biomedical studies

are conducted – seems to present a more practical and ethical appropriate approach. It is by engaging the local leaders and traditional healers (who can legitimately speak on behalf of the community), that disruption of traditional social structure and customs are reduced to a minimum.

A 2014 WHO publication *Guidance framework for testing of genetically modified mosquitoes*, bears this sentiment out. The design of this public health intervention tool for genetically modified mosquito, GMM, recommends that targets be set primarily to improve human health; and that the overarching ethical goal should be to respond to obligations to individuals being asked to participate as human research subjects and/or to communities being asked to host trials; while maintaining transparent and respectful channel of communication throughout and long after the trial period (p. 16). All in all, it marks a shift from considering ethics of research within the bare bones of Principlism; to considering ethics of research in a much broader sense. In multicultural environments, this approach includes an affirmation of the social capital concept via which development of mutually beneficial collective actions ultimately lead to the upliftment of households, communities and nations.

The GMM model for biosafety and ethics of engagement, reveals the need to improve the links between research and health care delivery and to promote the environmental, cultural, socio-political and economic processes that are involved to widen our understanding of the vicissitudes of the impacts of public health research, or any other research for that matter. Community engagement approach takes on a relational web: from the core, or traditional human research subjects, to their families, friends, neighbors, clan, and the social, spiritual and physical environments.

Quigley (2006) came to somewhat similar conclusions after analyzing 14 case studies and articles. Her work focused on research ethics issues in the conduct of environmental and public health research with Native American and other indigenous populations. With illustration, she proved how community-based participatory research practices can provide working guidelines to overcome past research harms.

REVISITING PRINCIPLISM

The set of four principles of bioethics and its many revisions even in Western research ethics practice, clearly point to some embedded deficiencies. For instance, Ryan (2004) has noted that, Principlism – the application of autonomy, non-maleficence, beneficence, and justice, to cases of medical decision-making or policy formation – has been subjected to serious scrutiny and undergone significant revisions through the years. It is a testimony to the scale of influence and the extent of criticism that has been levelled on the method since its inception. This is particularly evident in the many philosophical reversals of the Beauchamp and Childress' touchstone work, *Principles of Biomedical Ethics*. Given its relative short life since publication, that monumental piece

is now (2020) is in its seventh edition. It is a fact that buoys the argument being proposed here for an Afrocentric approach.

The philo-psychological make-up of Principlism stems from the individualistic tradition of Euro-America. But on the converging discussion about global bioethics, Andre (2010), has encouraged the growth and gelling of bioethics principles and concepts in a manner that both reflect the unity as well as the multiplicity of the cultural milieus around the globe.

Westerners bring bioethics along with Western medical education, which is often very warmly welcomed; and we bring it as hedges on the research we do in other countries, being painfully aware of how often and easily we have exploited vulnerable populations ... (p. 20).

Andre maintains that as a rapidly growing field the moral world and the ethical theories guiding the practice stand to gain if serious attention is paid to other cultures, enabling cross-pollination and crossbreeding of ideas.

Andre's view seems to add a twist to a study by De Vries, et al. (2010) which argues that when bioethics principles are transported abroad, for instance to Nigeria, some of the features (say, autonomy), tend to face fresh challenges in the new environment due to their cultural bearing. This is as true of bioethics principles as it is of the frequent face-off between universalist and relativist theorists. "Universalists believe in a universal application of ethical standards; relativists hold that ethical concepts can only be judged in terms of the society in which they appear" (p. 106).

Principles that express universalism, as is mostly the case in Western practice, are unlike those in much of the rest of the world which mostly sees the person not as a 'power-obsessed' individual, but an entity embedded in kinship, group and community (De Vries, et al. p. 170). Properly applied, the African worldview is all-encompassing, including that in which the people's ethics is rooted, and the societal activities which center on the promotion of vitality and fertility of human beings, livestock, and the land on which their livelihood depends.

Similarly, other analysts have stressed that while bioethics is traditionally practiced in the West within the four-corner-stone principles of autonomy, non-maleficence, beneficence, and justice; in other parts of the world, incongruities with these principles tend to emerge at the local level when their West-centric biases are subjected to closer examination (Wiredu, 1996; Diniz & Velez, 2001; Akabayashi, and Slingsby, 2003). But, Andre's 'fusion bioethics' is apparently not an either-or-approach; it retains universalism and principlism where they are suited but urges relativism in its varied forms—multiculturalism, care ethics, narrative ethics, and so on — to give a local color to specific circumstances. It urges for the adoption and adaptation of Euro-American ethical concepts and principles where they seem fit while pushing for other frameworks to sprout and blossom.

For comparison, Legaspi (2001) has testified to the inadequacy of Western bioethics principles in the East (i.e., Asia). He argued that the secular humanist bioethics that is

predominant in the West which attempts to address complex bioethical issues in a pluralistic society, presents difficulties in a health care setting immersed in a culture deeply rooted in a long religious tradition. He further suggests that these transcultural confrontations within the bioethics movement are fueled by the growing acceptance of the political tenets of liberal democracy. “The enduring transcultural dialogue within bioethics, promises to be one of the major challenges to the field’s future identity and influence” (p. vii).

A more forceful argument is underlined by the fact that global bioethics will succeed *only* to the extent that it is local. Recommending a “matrix of relationships in dynamic equilibrium of the cosmos”, Chattopadhyay and DeVries (2008, p. 109) insist that to find the common ground of morality across different cultures which acknowledges and respects other faiths and philosophical traditions, bioethics must expand its vision. Or as Turner, (2005) explains, attentiveness to the concept of culture can illuminate how patients, family members, and healthcare providers interpret illness, healing, and moral obligations.

In examining questions of bioethics curriculum development in non-Western settings, it has been cautioned that bioethics cannot be exported to other societies without the recognition of ethical pluralism. According to Broadwin (2001), it is a recognition of the co-existence of alternative and competing ethical frameworks, calibrated to different civilizational traditions and socio-political conditions without compromising the practical goals of bioethics education. Furthermore, “it is by making pluralism an explicit theme of bioethics education that we can correct some blind spots of conventional American bioethics as well as equip physicians outside of the West to negotiate clinical and policy conflicts in locally persuasive terms” (p.80).

Kukla (2014), has expressed concern about a rigid applicability of universal moral principles to particular cultural climes, as originally proposed by Beauchamp and Childress. Her position follows Veatch’s (2003) earlier suspicion that we could have a common morality, strictly speaking. According to Veatch, the basis of common morality theory, is rooted in the primitive, pre-theoretical insight that is shared by all human persons on such matters as taking a life (human or non-human). But, be that as it may, people at different times and places will articulate the norms in different language and interpret them in different theories, as in describing situations like killing in a just war or right to abortion. With many instances to show, the ‘just-ness’ of war and the ‘rightness’ of abortion are hotly debated in for instance, Euro-American tradition. “Certainly, people in different cultures will define the terms differently, will recognize different limits on the norms, and will construct different theories to account for their experience” (Veatch, 2003, p. 190).

Having made the case, a thematic framework with Africanized basis for bioethics – an Afrocentric perspective – is here proposed. The objective is to complement and guide the resolution and application of practices that often require a specific perspective.

AN AFROCENTRIC BOOST

Afrocentricism or Afrocentricity is a theoretical construct that provides the platform for

the mission in this essay. As an alternative to Eurocentricity or even Asiocentricity (Williams, 1976; Diop, 1978; and Asante, 1979), Afrocentricity defines the African “worldview and value system to which can be related all other central concepts, including those of religion, morality, and social organization” (Owusu-Frempong, 2005, p. 730).

Indeed, Afrocentricity predates and transcends the ‘Eurocentric materialist,’ and the ‘Asiocentric spiritualist’ philosophies. It maintains that “all modalities and realities are united and move in one grand manner, there can be no separation between material and spiritual, profane and sacred, form and substance” (Owusu-Frempong, 2005, p. 376).

Afrocentricity’s methodological approach centers on the idea that African persons as human agents, are engaged in their destinies within the context of their own historical experiences (Asante, 1993). In other words, it directs their attention to,

Language, folktales, root rituals and the symbolic boundaries and iconic signposts not only for locating a text but also for generating substantive discourses and debates that would guide the knowledge about self as African people and transmit the knowledge to future generations (Owusu-Frempong, 2005, p. 731).

Afrocentrism has sometimes been wrongly criticized as a theory too lost on self-conceit, closed-mindedness or even hubris. But critics miss out on some important point: it is one thing to be closed-minded in total rejection of other ideas, but it is something else to accommodate what you can while asserting your identity and worldview in a manner that serves your needs. In truth, to deny Afrocentrism is to deny cultural relativism. By inference, that is to declare that all cultural and life experiences are exactly the same. It is an assumption that flies in the face of reality. On the other hand, to say that ideological and philosophical worldviews vary from culture to culture is plainly a statement of fact that belabors the obvious. Within every cultural setting are such specific traits as symbols, beliefs, ethos, mores, and aspirations. In the context of this discussion, the methodological approach that relies on such cultural dynamics to analyze and deal with life experiences pertaining to Africa is simply Afrocentrism (or Africology).

One can hardly be faulted for asserting one’s identity and demanding that it be recognized as such. After all, it is neither a novel nor an exceptional move to do so. It merely raises the concern that the African worldview is subordinate to everyone else’s – particularly the Euro-American one (Hamlet, 1998). Hence, Afrocentrism is the insistence that Africans should exist on their own terms not on borrowed ones. It enables Africans to break free from the “unconscious adoption of the Western worldviews and perspectives, and their attendant conceptual frameworks” (Mazama, 2001: 387). In this instance, Africans would be able to think, orient and direct the rudder of their life in a meaningful, positive and constructive manner.

Afrocentricity can be summed up as a principle that balances on a tripod: “philosophical

ideal versus contextual determinism; scientific authority versus socio-political power; and scientific objectivity versus cultural subjectivity” (Mudimbe, 1985, p. 205). As such, there is the urge in the African thought to analyze African experience from a perspective that institutionalizes the themes of contextual determination and cultural non-inhibition (Nelson, 1997; Conyers, 2004).

To use the concept of personhood as an example; the function of staging substantive discourses about the self as an African ‘self’ (person) is unique because of the way it is delineated from the essentials of African culture and philosophy. The significance of this may be obvious given that the concept of personhood in bioethics is the fulcrum around which the vortex of activities swirls. A corpus of established literature has drawn sharp contrasts between the African and Euro-American perceptions of a person (De Craemer, 1983; Ikuenobe, 2006; Kaphagawani, 2004; Kelbessa, 2005; Mbiti, 1970; Menkiti, 1984, & 2004; Onyewuenyi, 1991; Owomoyela, 1991; and, Riesman, 1986). But, as Tangwa (2000) curiously notes, the Western conception of a person is appropriate only for the ascription of moral responsibility rather than for the ascription of moral worth. Conversely, the African perception of a person is drawn from the African worldview which incorporates “all the categories, stages, and modalities of a human being” (p. 42). That corporate being intimately belongs to a bio-eco-communitarian community, BEC, (Iyioke, 2018), which is made up of moral agents, non-human animals, ancestors, spirits, the gods, plants and minerals.

The Euro-American ethical theory, according to Tangwa (2000), seems to concentrate on the *object* of morality, the patient, to the neglect of the *subject*, the agent. This further conjures up the attribute in the Western culture of the principle of ‘might is right’ which characterizes Western imperialism, colonialism, domination, exploitation and monopoly commerce. “By concentrating on the patient rather than the agent, Western ethical theory successfully shifts critical ethical attention from themselves and their actions onto their victims” (p. 40-42). This, he concludes, is a value judgment that seems to be dictated by economic, scientific, and technological considerations. Ideally, the fusion of the efficiency of Western science and technology with the moral sensibilities of traditional Africa would be desirable. But, to complement each other, Western culture could empower African culture, and in return the African culture could humanize Western culture (Tangwa, 2000).

What has been identified here constitutes yet another reason why, in case of any lingering doubt, global bioethics requires a provision that enables it to always assume a local color wherever it is practiced.

Atrocities like the one in Nuremburg led to the Nuremburg Code, the DoH, the CIOMS, and others. But while the 1996 Pfizer drug experimentation pales in importance nonetheless, it could easily have been Nigeria’s Tuskegee or indeed Nuremburg experience given that humankind seem to have not fully learned from earlier historical episodes. At least two issues deserve attention, a) the persistent ethical problems with research involving patient-subjects, and b) the growing recognition that bioethics set of principles *cannot* be seen as a one-size-fits-all approach. The 1996 Pfizer-Nigeria case

– a biomedical blot which must not be overlooked – provides a formidable thrust to refocus on the task at hand, namely, the promotion of multiculturalism in global bioethics.

FORWARD LOOKING, BACKWARD LESSONS

Any attempt to formulate biomedical ethical guidelines that must reflect the burgeoning diverse world of bioethics is bound to encounter conceptual and theoretical challenges. In concert, challenges also arise with such guidelines in their practical and procedural application. As a first step, there is the need to articulate clearly the language and ethical imperative; secondly, there is the need to configure ethical guidelines to suit a specific time and place (Tangwa, 2004: 63). By implication, finding a middle ground between universalism and relativism presents instructive challenges that must be tackled.

Tangwa (2004, p. 64) suggests a set of cogent models, summarized thus:

- International ethical guidelines should be what they are – guidelines, or a set of frameworks for guiding particular actions, and not detailed ready rules of thumb. Just like constitutions, guidelines require interpretation. When articulated in general terms, it will make sense to variously situated cultural communities worldwide and, interpretations will be easily comprehended in familiar idioms, expressions and practices within any given locality.
- Biomedical research rules of thumb are best elaborated at the local rather than international level. To apply them in a particular situation, it must necessarily be shaped and colored by all the data furnished by particular contexts and perspectives. To attempt determining such details for one milieu from another milieu is to run the high risk of serious error.
- Clarity and conciseness are key in articulating specific ethical imperatives in order not to confuse or present cultural particulars as universal, or placing undue emphasis on the mood, manner, or vehicle for expressing an ethical imperative, to the detriment of the imperative itself. For instance, a guideline could be expressed in completely different words, concepts, and images for different communities – even using the same language (such as English) which has developed as many varieties as there are identifiable groups using it.

In the interest of clarity, the Afrocentric application of bioethics principles that is suggested here is intended to apply to *all* medical decision-making, policy formulations and practices particularly on the African frontier. The following computer science metaphor may help its further discernment: when West-centric bioethics principles are exported to be “installed” into a “system” or a “network” (such as the African continental sphere), it ought to have “plug-ins,” “snap-ins,” “extensions,” and “themes” – these are a set of software components that add specific abilities to the larger software application. In other words, it is like forging universal principles with a provision for relative or specific application. Afrocentricity enables the customizing functioning (e.g., plug-ins and snap-ins) of that application in locally appropriate ways. Note that add-ons are

meant to target end-users not the “software developers” and they come in handy for playing videos, scanning for viruses, and displaying new file types. Similarly, well-crafted Afro-centered principles will conform to the language, folklore, root rituals and symbolic boundaries of the African ways of life. Think of it as a framework that enables Africans to structure their experiences and interests and reconstruct their institutions to reflect their character.

While bioethics practice in Africa is generally the same as elsewhere, it must however be specifically shaped by the histories, mythologies, motifs, and ethos of the people who constitute the African cultural affinity. Afrocentric tool can weigh its internal dynamics against external constraints and strive for a creative synthesis and response to achieve a balance in bioethical application within the African milieu. For those who lament the lack of “human, institutional, infrastructural capacities, and a real African authenticity in bioethics” (Andoh, 2011, p. 67), you are urged to take up the gauntlet for the task ahead. It is up to Africanists to highlight and sufficiently develop the African theoretical bases upon which bioethics must be hoisted. For if African intellectuals do not confront the challenge of projecting their own conceptions to show case authentic African identities, specificities and approaches, they could be at the mercy of the enveloping force of outsiders. That would mean succumbing to a globalized view that is not at all global; which would be unfortunate.

CONCLUSION

It is argued here that bioethics practice, like many of mankind’s endeavors, is (or rather, ought to be) culture-bound. Like politics, all bioethics ought to be local. To accept the essence of cultural relativity theory, is to accept the conclusion that all cultures have some valid contribution. Thus, there is need to move away from the prevailing perception that modern bioethics is valid only if it is Westernized. With roots in West-centric philosophical tradition, but an emerging desire to take on a worldwide appeal, bioethics application in other parts of the world (e.g., Africa) must reflect the attributes of local emersion in a given environment. It is widely known that since the Nuremburg Code (with a few exceptions), what has passed as ‘international’ ethical guidelines to universalize and globalize bioethics practice has been to further advance the Western paradigm. But, other voices, perspectives and cultures should be encouraged and enhanced. Afrocentrism or Africology readily provides that voice on discourses about bioethics in Africa. It is yet another path Africa can succeed in breaking the strong global technologies of neo-coloniality that continue to prevent the possibilities of its agency (Jimada, 1992; Ndlovu-Gatsheni, 2013).

KEY TERMS AND DEFINITIONS

Afrocentrism/Africology: The African world view or the study of phenomena from an African perspective.

BEC: Bio-eco-communalism refers to the inseparability of the individual within his/her community and environment.

Communalism: Allegiance and relationship to one's immediate social or political group such as family, lineage, village, association, ethnic group and the society at large, rather than to one's selfish interest.

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¹ The four principles of bioethics (a.k.a., principlism) for mainstream practice are: respect for autonomy (i.e., what is best for the individual or a norm of respecting the decision-making capacities of autonomous person); non-maleficence (avoid harm towards the person or a norm of avoiding the causation of individual harm); beneficence (that we do good rather than bad or a group of norms for providing benefits and balancing benefits against individual risks and costs); and, justice/fairness (equal access under the law to information and treatment or a group of norms for distributing individual benefits, risks, and costs fairly).

² This chapter is authored from within the domain of bioethics, a branch of philosophy which itself is an intellectual and cultural phenomenon that rose from the ashes of medical scandals in the U.S. and elsewhere that seemed to culminate in the late 1960s and the '70s. Bioethics is a field of study defined here as the systematic study of the ethical and moral implications of new biological discoveries and biomedical advances in such areas as genetic engineering and drug research. Bioethics is bounded within the four principles of autonomy; fairness; non-maleficence, and, beneficence.

³ "Eurocentrism", "West-centrism" and "Euro-Americanism" are applied somewhat synonymously in this chapter and the reason may be obvious: while bioethics as a field took off in the U.S. clearly, its philosophical principles are Eurocentric (for instance, the deontological theories of Kant and Mill-Bentham utilitarian principles).

⁴ The Nuremberg experiments refer to the set of medical experiments in concentration camps mainly during World War II and the Holocaust in the early 1940s. As is now common knowledge, the atrocities were committed by Nazi German doctors on war victims including children of Jewish, Polish, Russian and Roman (Gypsy) origins, but had, and continues to have a worldwide impact. The crimes resulted in the prosecution of the perpetrators as war criminals before the Nuremberg military tribunal. American judges oversaw the legal proceedings during which 16 of the physicians were found guilty; seven were sentenced to death and executed in June 1948.

⁵ Quinacrine experiment was a method of sterilizing women by burning their fallopian tubes and upper uterus with acid. At the time of the experiment, it had not been approved by drug regulatory authorities in any country as studies had not yet shown whether it was safe or effective. But some individual doctors continued to provide this method to poor women in developing countries against international advice by the WHO, IPPF and other medical and scientific experts in the field. Read more here, <http://www.sciencedirect.com/science/article/pii/S0020729203900853>; http://www.jstor.org/stable/25662833?seq=1#page_scan_tab_contents;

⁶ The Tuskegee Syphilis Study (1932-1972) refers to the clinical experiment of 600 poor black sharecroppers (399 with latent syphilis infection, 201 without the disease) from rural Macon County, Alabama. For about 40 years the subjects were denied any genuine treatment and corned to believe they were being treated for a blood disorder condition or 'bad blood,' but in actuality, it was done merely to compile data on the effects of the spontaneous evolution of syphilis on black males. In return, the subjects got free food, basic stipends, medical care and burial insurance.

⁷ A legal person is an entity capable of legal rights and duties: an entity that can own, buy and sell, enter into contracts and sue for breach of contract, or otherwise have standing as a plaintiff or defendant in the courts. This legal sense of personhood focuses on what persons do rather than what they are. It allows that an entity may be a legal person without being a natural person like an individual human being. To be a person on this conception, does not depend on the stuff out of which one is made but only on that

“person’s” performance, specifically one’s performance in the space of social norms (List and Pettit (2011, p. 171).

⁸ For more, go to <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?cfrpart=50>
Additional details are here too: <https://humansubjects.nih.gov/>