

Constructing the Human Dance of Meaning

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The *Cambridge Quarterly* has a history of presenting multidisciplinary perspectives in bioethics, welcoming a lively dialogue between clinicians, philosophers, theologians, social scientists, lawyers, and others on a range of bioethics concerns. This special issue of the journal focuses explicitly on contributions from anthropologists to the field.

In putting together this special issue I have particularly enjoyed the opportunity to revisit the breadth of methods and perspectives that anthropologists have to offer bioethics. Even in this small collection of four articles, the authors' analyses are based on a variety of strategies, including participant observation, an analysis of the text of an interview, and library-based research. What links the four articles is that each author, as an anthropologist, is concerned with bringing forth the meanings that are derived from particular contexts.

The work by Gelya Frank and her co-authors highlights the context of one patient's ethnic upbringing as it influences his beliefs about the meaning of end-of-life decisions. Donald Joraleman's discussion presents a number of the sociocultural factors that contextually influence how bioethicists and clinicians have, as cultural actors themselves, evolved the meaning of the concept of medical futility. Both Elisa Gordon and Lesley Sharp

take up the arena of transplant technology—though from different vantage points. Gordon's concern is with the culturally embedded prejudices about "race" that permeate transplant science, practice, and policies and contribute to discriminatory access to transplantation. Sharp's work is similarly focused on the consequences of prejudice. Her article critiques a rhetoric of equality that unwittingly blinds clinicians, patient support groups, and policymakers from an appreciation of the ways that ethnicity, and other social factors, ought to figure in policies about organ donations.

Anthropologists are trained in distinctive ways to perceive and reflect on the human dynamics of meaning-making. These approaches can and have enriched bioethics, as this issue's authors so well illustrate. Let me take a few minutes here to explain my own sense of some of the ways that anthropology's approach to meaning and context can contribute to bioethics.

One of our central assumptions in anthropology is that people rank values, judge right and wrong, define and delineate phenomena, decide between options for action, and generally make sense out of life in light of a complex interplay of factors, not all of which are we necessarily conscious. The human dance of meaning is "constructed"; it is the result of myriad verbal and nonverbal dialogues be-

tween ourselves, our social networks, our history, traditions, and beliefs, and our political, economic, and ecological environments. Some of these dialogues are inherited, most are in flux; some are easily stomachable, even pleasant and desirable, but others are contentious, disturbing. Some contexts that influence meaning-making are actually oppressive, and we may or may not be aware enough to be either in favor of (i.e., compliant) or in rebellion with dominant frames of reference.

This appreciation for the complexity of influences on human meaning can enable bioethics to situate the dilemmas of our work in broad relief. For instance, from an anthropological perspective, something like the bedside decision to withdraw mechanical life supports is never in itself a “clean” situation, but influenced by multiple forces. In bringing these influences to light, hopefully then, we will avoid being blindsided by them and consciously incorporate an understanding of their impact on our recommendations. As anthropologists we would wonder, for instance, about who is involved in such a bedside decision. And this question would lead to inquiries about who isn’t involved in the decision. And then we might ask why, and why not? This, in turn, could lead to an exploration of what considerations—moral, economic, social, and so forth—figure in the decision, and why. And again, we would be concerned about what considerations are not debated. Should they be included?

Once early in my work with a very careful and conscientious bioethicist trained in western analytical philosophy I was surprised to hear that he chose purposefully not to visit an infant during a consultation about withdrawing life supports. Nor did he speak directly with the young mother of the infant except during a formal meeting of the ethics committee. He preferred

not to bias his reasoning with what he considered to be any inappropriate emotional draw he might potentially feel if he witnessed the grief of this bedside scene. He would no more have considered this proper than would he consider issues such as the mother’s ability to pay for treatment or her ethnic background, education, or religion. He did speak for many hours with the clinicians involved in the case and read the infant’s chart, gaining an in-depth understanding of the clinical prognosis and the nature of the life-sustaining strategies under discussion.

I remember feeling astounded at the differences in our approaches. To me, as an anthropologist, the ethical problems in this case had more to do with communication, power dynamics, and the need for supporting this mother and her family and friends through a tragedy than with what seemed like abstract questions of principle and uncertain clinical predictions. What my colleague argued, however, was that the “ethical” decision in this case revolved around whether to withdraw, or not, the infant’s life supports. In his mind, these other dimensions were not questions of ethics.

I still wonder why not. The difference now is that I understand what I did not understand then: that my colleague’s approach was based in his disciplinary training. Like my own approach was for me, his approach was culturally meaningful to him, reflecting assumptions and methods that were learned and reinforced by his education and subsequent systems of merit. No doubt the clinicians and family in this case also brought their own cultural assumptions to bear on the circumstances and subsequent judgments.

From my anthropological perspective, it would have been crucial to begin with an understanding of where there was overlap and difference in everyone’s basic assumptions about the

infant's fate. I would want to know, for instance, about the position of this child's family with respect to the question of life supports. To do this we would have to know who they identified as family. Once this was established, we could explore what meanings each held regarding the infant's death or the possibility that she would be disabled if she lived. Knowing aspects of the family's socio-cultural background could be a starting place for exploring their feelings and opinions in these regards. Such information might well also inform the ethics consultant and clinicians about a range of appropriate strategies for communication with the family. In the likelihood of a lack of consensus among the infant's medical, nursing, and family caregivers, an

anthropologist might also help decipher ways to bridge between them, if possible.

As the field of bioethics has expanded from its early days of "principlism," there is increasing interest from many disciplines, philosophy included, in just the kinds of messy, contextual factors that I was raising in the above case. I think there is general agreement now about the value—however irksome it can be at times—of expanding bioethics into the ethics of such issues as emotionality, power and dominance, communication, cultural diversity, resource utilization, and finances. It is in the study of these realms that anthropology offers much for bioethics. The authors in this special issue demonstrate some of the ways this can happen most productively.