PhD Dissertation

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PRAGMATIST BIOETHICS, THE RELEVANCE OF CONTEXT, AND SOME PROBLEMATIC SITUATIONS IN HEALTHCARE

PhD Dissertation

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Declaration

Candidate's Declaration

I hereby declare that this dissertation is the result of my own original work undertaken under the guidance of my supervisor; and with the exception of references to other people's work which have been duly acknowledged, this dissertation has neither in part nor in whole been submitted for another degree in this university or elsewhere.

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Supervisor's Declaration

I hereby declare that the preparation and the presentation this thesis was supervised in accordance with the supervisor of thesis laid down by the University of Szeged.

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List of Publications

Prior to the submission, portions of the dissertation and other related studies have been published in peer-reviewed journals while others are under review. This section lists these studies;

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Abstract

Bioethics has expanded considerably over the last few decades in the academic enterprise and policy arena. However, despite the progress, the history of bioethics exhibits methodological controversies among contributors in the field. Generally, the contention is related to bioethics' complex and contested relationship with philosophical theory, contributors' perspectivism, and a "reliance upon high-flying ethical theory," as well as "skepticism of the applied nature of bioethics," which further point to differences in interpretation of the logic and epistemology of morality and moral judgments. On the other hand, it is claimed that pragmatic ethics, mainly on the grounds of incorporating the components of different understandings of ethics, its interdisciplinarity, and its practical focus, avoid the controversies over the methods and goals of bioethics through a consideration of the context in ethical inquiry and serves as a method.

In this dissertation, I focus on investigating the methodological dimensions of bioethics while emphasizing topical issues in the field, including gestational surrogacy, healthcare allocation, rationing, and organ trade and trafficking in Africa. On the whole, I look at the methodology and goals of bioethics mainly, from the point of view of pragmatist ethics, following the line of John Dewey's ethics. I also investigate specific moral problems in bioethics to further illuminate the methods of pragmatic bioethics and show the practical usefulness for solving specific moral dilemmas arising in a particular context.

The dissertation is devided into seven chapters. In Chapter One, I discuss the background of the study and locate the problems of the study by showing the contested nature of the methodological terrain of bioethics. Further, I discus the disagreements about the logic and epistemology of morality, moral judgment and decision making, the nature of moral issues, and the practical goals of bioethics. Finally, I also look at how pragmatist bioethics avoids methodological disagreements in bioethics.

In Chapter Two, I examine the methodological dimensions of bioethics and show how a pragmatist approach and consideration of context are relevant in bioethical investigations. I also provide an overview of the recently introduced context-sensitive methodologies, theories, and principles of bioethics in the global South and East and show the relevance of context-based bioethical research and bioethical deliberations. Finally, discusing the epistemic ground of morality and the nature of bioethics, I argue that a pragmatist-empirical turn in bioethics can help us think about and make decisions about specific bioethical dilemmas.

In Chapter Three, I further discuss the meta-method of bioethics by examining Dewey's inquiry ethics and the case of gestational surrogacy. First, I mainly revisited Dewey's ethical inquiry method and pragmatist bioethics and then identified steps of pragmatist bioethical inquiry. Using these steps, I discuss the moral dilemma of gestational surrogacy at the level of a public issue that needs social policy and suggest pragmatic ways to come up with solutions. In the last part of this chapter, I undeline the significance of Dewey's emphasis on education, deliberative democracy, and institutions as the basis for solving bioethical issues arising in different societal contexts.

Next, in Chapter Four, I examine the ethical dilemma of healthcare allocation and rationing from a pragmatist ethics perspective, again mainly following Dewey's work. The moral dilemma of distribution always entails rationing: denying service to someone to benefit others. Such aspects of allocation and rationing and the normative-relational aspect of disease and health render the problem morally

controversial. It is not easy to reach on agreed upon principles of healthcare resource allocation and rationing applicable across different contexts. Hence, in this chapter, I argue that the moral challenges of healthcare rationing ought not to be addressed through an appeal to principles but rather through deliberation that embraces a more pragmatic and democratic approach to thinking with sensitivity to context. However, this does not mean that moral principles and values are unnecessary when allocating healthcare resources.

In Chapter Five, I further illuminate the methods of pragmatist bioethics and moral challeges of healthcare allocation and rationing by using the context of African healthcare systems and the COVID-19 pandemic. In the first part of this chapter, I critically review the African healthcare crisis's factors and suggest pragmatist means to address justice issues in healthcare allocation in the region. In the second part, I present the worldwide and Sub-Saharan African situations during the COVID-19 pandemic and examine the place of moral principles in the allocation and rationing of healthcare resources. In this chapter, I mainly argue for the relevance of going beyond principles through an appeal to ethical deliberation with a sensitivity to context regarding the acts of responding to the current healthcare crisis and pandemic.

In Chapter Six, I further illustrate the methods of pragmatist bioethics by assessing the situation of organ trafficking in Africa. Generally, in this chapter, following the steps of pragmatist ethical inquiry underlined in previous chapters, I discuss the case of organ trafficking on the continent. I also analyze the broader moral dilemma of organ trafficking in the moral philosophical tradition of bioethics and from the aspect of pragmatist bioethics. I look at the moral problem in Africa differently from other contexts by going beyond the mere moral dilemma of altruism and organ shortage, identified in mainstream ethics. Instead, I situate the issue within more systemic, structural, socioeconomic, and political problems in the region. In the final part, I identify solutions, which could be tested through ethical deliberation to control the issue of organ trafficking.

In the final chapter, I summarize and conclude the dissertation. In this chapter, I recapitulate the methodological and practical aims of the study and present a summary of the major arguments and conclusions drawn, in line with the problems and objectives of this study.

Keywords

Bioethics; Context-ethics; Pragmatism; John Dewey; Gestational Surrogacy; Healthcare Allocation and Rationing; Organ Trafficking, African Healthcare Systems; COVID-19.

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Chapter One

Introduction

1. Background of the Study

Marcus Düwell looks at the history of ethics and moral philosophy and categorizes the tradition into two aspects: the question concerning the perfection of our lives – the kind of person we want to be (e.g., virtue ethics and eudemonist ethics), and the question concerning our obligations and duties towards each other (e.g., contractarian ethics, utilitarian ethics, and deontological ethics). The first concern signifies pre-modern ethics while the second refers to modern ethics. Within the two categories of ethics, the idea of character development is the largest concern of pre-modern ethics, whereas the idea of moral principle and justification of our duties and obligations to others is the concern of modern ethics.[1]

Düwell's notion can be further connected with Adela Cortina's characterization of the development of moral consciousness, mostly in advanced societies. As Cortina claims, within the moral realm, moral consciousness is gradually formed with two levels of reflection and language: the morality of everyday life and the ethics or moral philosophy. The morality of everyday life (which can be called pre-modern ethics in Düwell's perspective) is the aspect of morality of everyday life shaped by religious and cultural values (Christian, Islamic, and Jewish moralities, as well as the moralities connected with different versions of Hinduism, Buddhism, Confucianism, and other indigenous religions, etc.). The level of ethics or moral philosophy represents the plurality of ethics we have from the tradition of moral philosophy (e.g., eudemonist, utilitarian, dialogic, etc.).[2] As a result, we can say that in our everyday life we are living in the world of plural morality and ethics.

One can possibly relate the existing controversies over the methods and aims of bioethics to Düwell's earlier classification of the history and tradition of ethics and Cortina's characterization of the

[1] Marcus Düwell, "One Moral Principle or Many?," in *Bioethics in Cultural Contexts Reflections on Methods and Finitude*, ed. Dietmar Mieth Rehmann-Sutter, Christoph, Marcus Düwel (Springer, 2006), 95.
[2] Adela Cortina, "The Public Role of Bioethics and the Role of the Public," in *Bioethics in Cultural Contexts Reflections on Methods and Finitude*, ed. Dietmar Mieth Rehmann-Sutter, Christoph, Marcus Düwel (Springer, 2006), 165.

development of moral consciousness. In fact, bioethics is an interdisciplinary field which exhibits a complex and contested relationship to philosophical theory due to contributors' perspectivism and "reliance upon high-flying ethical theory," and "skepticism of the applied nature of bioethics."[3] Micah Hester argues, in part as a backlash and in part as a continuous activity, that bioethics has gone through a transformation during the past decades. Bioethics has shifted its focus away from the 1980s' principlism and other moral theories in philosophy and toward new views and techniques to address moral issues in medicine and bioethics in general. Narrative ethics, casuistry, and the ethics of caring, for example, have all made progress in the discipline.[4]

Düwell also differentiates the beginning of bioethics, essentially on the basis of its independence from the big normative theories like utilitarianism and Kantianism. He adds that the most popular approaches in bioethics (e.g., the casuistic approach, a common morality approach, or the very popular four principles approach of Beauchamp and Childress) tried to avoid the impression that their normative judgments are dependent on only one normative ethical theory.[5] Moreover, Arras also claims that bioethics is essentially an American creation. American bioethics differs from much of European thinking, which is essentially based on applied ethics. Mostly, American-style bioethics abjured grand philosophical schemes in favor of pragmatic policy-making and democratic consensus. Indeed, for Arras, the marriage between pragmatism and bioethics seems to spring from this tradition of American thought.[6]

However, irrespective of considerable consensuses on its historical origin, contributors in the field provide different and often conflictual definitions and conceptions of bioethics, especially regarding its methods, theories, area of concern, and public role. For example, since the inception of the contemporary bioethics movement in the 1970s, Tom Beauchamp and James Childress' principlism has been the

[3]John Arras, "Theory and Bioethics," *The Stanford Encyclopedia of Philosophy* (Winter 2019 Edition), Edward N. Zalta (ed.), https://plato.stanford.edu/archives/win2019/entries/theory-bioethics/>.
[4] D. Micah Hester, "Is Pragmatism Well-Suited to Bioethics?," *The Journal of Medicine and Philosophy* 28, no. 5–6 (2003), 545-546.
[5] Düwell, One Moral Principle , 93.
[6] John D. Arras, "Pragmatism in Bioethics: Been There, Done That," *Social Philosophy and Policy* 19, no. 2 (2002), 29.

dominant methodological perspective. The essence of moral reasoning, according to principlism, is the identification, interpretation, and balance of "middle-level" moral principles such individual autonomy, beneficence, and fairness.[7] Yet, alternative methodologies including casuistry, narrative ethics, and feminism have subjected principlism to sustained criticism.[8] As Arras claims, this criticism has recently expanded to include the adherents of a "new pragmatism," who now stake their claim to methodological preeminence.[9]

Indeed, Düwell himself agrees with the contested terrain of bioethics. The controversy over the methodology and goals of bioethics, mainly in relation to the critique of principlism, essentially sprang from an objection to the abstract nature of applied ethics meant to comprehend the specificity, particularity, complexity, and contingency of the real moral issues of bioethics and medical ethics. Principle-oriented ethics is criticized for failing to offer solutions to practical problems which are contextually dependent.[10] In general, these criticisms stem from the appeal to aspects of context sensitivity in ethical judgments and decision-making, which is connected to the position of a more practical, empirical, and pragmatist ethics. So, the objections against principlism are a plea to fill in the loopholes of principle-based ethics in bioethics, primarily to fill the gap of applied ethics – often perceived as the deductive application of ethical principles to solve particular moral problems. However, in such an endeavor, bioethics needs a shift in methodology from applied ethics to empirical-contextual pragmatist ethics.

Indeed, from the pragmatist perspective, the shift in the methodology of bioethics is justified from the *logic* and *epistemology* of morality, moral judgment and decision-making, the nature of moral issues, and

[7]Arras, Pragmatism in Bioethics, 29; See also Bettina Schöne-Seifert, "Danger and Merits of Principlism: Meta-Theoretical Reflections on the Beauchamp/Childress–Approach to Biomedical Ethics," in *Bioethics in Cultural Contexts Reflections on Methods and Finitude* (Springer, 2006), 112; Düwell, One Moral Principle, 99.
[8]Arras, Pragmatism in Bioethicst, 30; Düwell, One Moral Principle, 94.
[9] Arras, Pragmatism in Bioethicist, 30.
[10]Albert W. Musschenga, "Empirical Ethics, Context-Sensitivity, and Contextualism," *Journal of Medicine and Philosophy* 30, no. 5 (2005), 467-90; Barry Hoffmaster, "From Applied Ethics to Empirical Ethics to Contextual Ethics," *Bioethics* 32, no. 2 (2018), 120; Simona Giordano, "Do We Need (Bio) Ethical Principles?" In *Arguments and Analysis in Bioethics*, ed. Matti Häyry, Tuija Takala, Peter Herissone-Kelly, and Gardar Árnason. (Brill, 2010), 37-38.

the practical goal of bioethics. Pragmatic ethics has two characteristics, according to Eric Racine: extreme empiricism and practice- or action-oriented ethics. In the first sense, pragmatism's ethics is based on experience and is linked to disciplines that study the workings of human nature (e.g., anthropology, biology, psychology). Bioethics has sparked a paradigm change in ethics in this regard, especially with the more recent empirical approach in bioethics. A clear focus toward action and outcomes is a second fundamental aspect of pragmatic ethics,[11] which according to Cortina signifies the public role of bioethics. Hence, on the epistemic grounds of bioethics, the rationality of moral judgment is grounded in the contextual embeddedness of a particular moral problem, which goes against the commonly accepted deductive reasoning in favor of non-formal reason: "observation, creative construction, formal and informal reasoning methods, and systematic critical assessment"[12]. Certainly, specific moral dilemmas in bioethics arise in a variety of situations, according to Hoffmaster, including the family, communities, institutions, and other sociological, economic, legal, and political backgrounds and worldviews. The pertinent facts and traits that a specific moral challenge melds within various contexts are critical for analyzing the issue as well as assessing and creating potential remedies.[13]

This dissertation aims at investigating the nature and dimensions of bioethics, emphasizing topical issues in bioethics, including gestational surrogacy, healthcare allocation and rationing, and organ trade and trafficking in Africa. Broadly, the study has two-fold objectives: methodological, focusing on the methodology of bioethics, and practical, examining issues in bioethics. From the methodological perspective, the study examines the methods and goals of bioethics, essentially from the aspect of pragmatist ethics, following the line of John Dewey. Studies reveal that pragmatic philosophy is particularly effective in this sense, owing to its interdisciplinarity and practical focus, which allows it to incorporate elements from other ethical perspectives.[14] Arras also appreciates the pragmatist

[11] Eric Racine, "Feature : Why Care about Pragmatism " *The JCB Voice*, 2012, 3.
[12] Barry Hoffmaster, From Applied Ethics, 119.
[13]Ibid, 25.
[14]S. M. Wolf, "Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism," *American Journal of Law and Medicine* 20, no. 4 (1994), 411-13; F. G. Miller, J. J. Fins, and M. D. Bacchetta, "Clinical Pragmatism: John Dewey and Clinical Ethics.," *The Journal of Contemporary Health Law and Policy* 13, no. 1 (1996), 27; Eric

reconsideration of bioethics, especially in addressing serious problems besetting the field, stemming from cultural diversity, which principlism has failed to address adequately. However, while the availability of many versions of pragmatism is a challenge to the approach,[15] Dewey's perspective to ethics is a promising method in the study of bioethics.[16] As a result, in this study, I use the writings of Dewey as a source of insight into the nature of ethics, to illuminate the fundamental aspects of a different social or contextual pragmatic paradigm and their significance in the investigations of particular issues in bioethics.

2. Problems and Objectives of the Study

In many parts of the world, bioethics has considerably expanded over the last few decades, not only as an academic enterprise but also as a prominent set of issues in the policy arena. Indeed, the discourses in bioethics are not limited to classrooms and conferences, but involve politicians, regulators, and many other stakeholders, as well as society at large. As a result, the process of debating bioethical issues and maybe reaching normative conclusions is a very sensitive and complex one even within a particular society. As Biller-Adorno claims, the issue is even more complex in a cross-cultural context. Within increasing globalization, reaching unified and harmonizing standards in bioethics may be demanding, yet this endeavor runs the risk of being perceived as 'moral imperialism.' As a result, a cross-cultural interpretation and understanding of bioethics concepts is seen as necessary in order to articulate a coherent, though limited, set of basic values or principles in bioethics.[17]

In connection with cross-cultural and multicultural bioethics, the overriding bioethics, namely principlism, is often charged as an approach based on Western society that does not tolerate exceptions to

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Racine, "Pragmatic Neuroethics: The Social Aspects of Ethics in Disorders of Consciousness," in *Handbook of Clinical Neurology*, ed. J.L. Bernat and R. Beresford, 1st ed., vol. 118 (Elsevier B.V., 2013), 358-72.

[15]Arras, Pragmatism in Bioethics, 34-36.

[16]Ibid, 40; Eric Racine, Feature, 2; Giulia Inguaggiato et al., "A Pragmatist Approach to Clinical Ethics Support: Overcoming the Perils of Ethical Pluralism," *Medicine, Health Care and Philosophy* 22, no. 3 (2019): 428; Miller, Fins, and Bacchetta, Clinical Pragmatism, 28; Irwin Miller, "A Pragmatic Health Care Policy Tradition: Dewey, Franklin and Social Reconstruction," *Business and Professional Ethics Journal* 12, no. 1 (1993), 47-50; Christopher Tollefsen, "What Would John Dewey Do? The Promises and Perils of Pragmatic Bioethics," *The Journal of Medicine and Philosophy* 25, no. 1 (2000), 77; Hester, Is Pragmatism Well-Suited, 546.

[17] Nikola Biller-Andorno, "It ' s a Small World After All: Cross-Cultural Discourse In Bno," in *Cross-Cultural Issues in Bioethics The Example of Human Cloning*, Roetz, Hei (New York, Amsterdam: Rodipi, 2006), 459-60.

the rule, usually coming from a non-Western context.[18] Tan Kiak Min argues that the predominant view of bioethics is based on Anglo-American thought. Hence, he suggests that for bioethics to be global and relevant to other regions, it needs to be contextualized to local cultures and circumstances. For instance, in the case of end-of-life care treatment, the practice of modern medicine in Asia and the West may be the same, but the ethical practices differ. For instance, Asians recognize the influence of the family and community on their decisions, especially in life and death situations. This can be clearly seen in the medical setting whereby family members typically involve on the issues of autonomy and best interest of the patient.[19]

Indeed, the debate about bioethics goes beyond the mere controversy over the issues of cultural differences and its celebration in bioethics, into a more sustained disagreement over the logic of morality and moral judgment. In this regard, the dominant principlist approach is also criticized on the grounds of its abstractness, the top-down deductive approach of its logic, and its lack of sensitivity to the consideration of context.[20] Quite contrary, Düwell argues against the charges of mainstream principles of medical ethics by Beauchamp and Childress. As he claims, Beauchamp and Childress are critical of moral principles, in the sense that mid-level principles, such as autonomy and avoiding harm to others, introduced in their approach are not like the principles of a normative ethical theory approach (e.g., in utilitarianism or the Kantian categorical imperative). Instead, he insists that four principles can be serious candidates for bioethical principles, since they are part of the common morality articulated as working principles. He further claims that these principles have contextually variant meanings, evident in the context of different normative ethical theories, making moral consensus possible.[21] Likewise, Schöne-Seifert claims that four mid-level principles that are considered to be *prima facie* binding have been continuously revised, together with the four canon principles so that it fits context-sensitive analysis and

[18] Simona Giordano, (Bio) Ethical Principles, 37-38; Mark Tan Kiak Min, "Beyond a Western Bioethics in Asia and Its Implication on Autonomy," *New Bioethics* 23, no. 2 (2017), 154.
[19] Mark Tan Kiak Min, Beyond a Western Bioethics, 159-161.
[20]Hoffmaster, From Applied Ethics, 121-125; Musschenga, Empirical Ethics, 470.
[21] Düwell, One Moral Principle, 106.

balancing.[22] Indeed, in response to the charges emanating from feminist bioethics, casuistry, and other approaches in empirical and contextual ethics, Beauchamp and Childress have continuously revised their approach through developing specific normative rules to solve conflicts of principles in light of specific contexts. They argue that principles have to be adjusted to one another and should be sensitive to cultural, economic, and political contexts.[23] Arras also claims that the recent versions of principlism have already incorporated the central lessons that the new pragmatist bioethics wishes to teach. That is why he doubts whether a new pragmatism can make a distinctive contribution to the methodological ferment within bioethics.[24]

However, contrary to Arras' position, I argue that the demand of context-sensitiveness, the appreciation of cultural differences, religious or contentious issues, and the sociocultural embeddedness of both ethical problems of medicine and the empirical/descriptive (sociological, legal, anthropological, etc.) nature of ethical investigations are not addressed in the manner in which ethics and morality are essentially described in pragmatist philosophy. For that matter, neither casuistry nor feminist approaches in bioethics surmount the charges posed against applied ethics – the critique of the logic of these theories. The perspectivism and "reliance upon high-flying ethical theory" in these approaches[25] is another element which, in this case, could make the pragmatist turn in bioethics a novel or genuine insight that addresses the controversy over the methods and goals of bioethics. Indeed, bioethical plights are diverse in terms of their appearance, and it is also a complex task to address them effectively. The reason can be related to the socio-cultural and economic factors or 'contexts' where issues arise, as well as the multifaceted nature of bioethical problems, which encompasses ethical issues in the life sciences, medicine, technology, the environment, and the lives of human beings. Hence, considering the nature of bioethical problems, we

[22] Bettina Schöne-Seifert, Danger and Merits of Principlism, 111-113.
[23] James F. Childress, "Methods in Bioethics," in *The Oxford Handbook of Bioethics*, ed. Bonnie Steinbock (Oxford, New York: Oxford University Press, 2007), 22.
[24] Arras, Pragmatism in Bioethics, 30.
[25] Arras, Arras, Theory and Bioethics, https://plato.stanford.edu/archives/win2019/entries/theory-bioethics/>.

may argue that bioethical problems require diverse and contextual moral reactions and responses relevant to the problematic situation.

In the first objective of this dissertation, I therefore focus on providing an overview of the recently introduced context-sensitive methodologies, theories, and principles of bioethics in the Global South and East and show the relevance of context-based bioethical research and bioethical deliberations. Justifications, deliberations, and moral actions are contingent, dynamic, and context-sensitive, because judgments and decisions concerning specific bioethical problems are socio-culturally embedded and institutional. Hence, in connection with this epistemic grounding of morality and the nature of bioethics, I assert the claim that a pragmatist- empirical turn in bioethics is relevant both in the theoretical-conceptual study of bioethics as well as in decision-making concerning specific bioethical dilemmas.

As presented earlier, Dewey's approach to ethics is remarked as a promising one in the study of bioethics. He is keen on forging an alliance between the social sciences and philosophy especially, in his analysis of ethics.[26] Dewey relates ethics in general with a mode of inquiry by providing the necessary steps of pragmatic ethical investigations.[27] Hence, as part of the second objective of this thesis, I take the discussion of the meta-method of bioethics further by taking Dewey's notion and the case of gestational surrogacy. Mainly, I look at the development of reproductive technologies and genetics – precisely the moral dilemma of gestational surrogacy at the level of a public issue that requires social policy. With this undertaking, I elucidate the significance of Dewey's emphasis on education, deliberative democracy, and institutions, as well as the role of agents as the basis for solving bioethical issues arising in different societal contexts.

Bioethics is essentially *biopolitics*, which is extremely difficult for political decision-making on legal regulation alone, especially regarding issues of biomedicine.[28] Primarily, it is difficult to reach a social

[26]Arras, Pragmatism in Bioethics, 40.
[27]Ibid, 33; Miller, Fins, and Bacchetta, Clinical Pragmatism, 33.
[28] Sigrid Graumann, "Experts on Bioethics in Biopolitics," in *Bioethics in Cultural Contexts Reflections on Methods and Finitude*, ed. Dietmar Mieth Christoph Rehmann-Sutter, Marcus Düwell, vol. 12 (Springer, 2006), 175-76.

consensus on solutions to those issues based on rules and principles in plural societies. One of the issues in bioethics which is very contentious in this regard is the ethical dilemma of healthcare allocation and rationing. In fact, the moral dilemma of healthcare allocation arises whenever we allocate limited resources, and rationing is a necessary action for distributing available resources.[29] In a broader sense, the moral problems of healthcare allocation especially, the issue of equity also embrace the issue of access to primary healthcare or minimum access to acceptable healthcare service.[30] In this sense, allocation always entails rationing – denying service to someone for the benefit of others, which makes decisions on allocation complex and controversial based on principles.[31] As a result, it is difficult to reach an agreed principle/principles of allocation and rationing applicable across different contexts. Moreover, allocation issues are connected with the essence of disease and health. Thus, as part of the third objective of this study, I look at the moral dilemma of healthcare allocation and rationing. I also examine the nature of the disease and the contextual and societal understanding of disease and health. Based on the analysis, I argue that the moral issues of healthcare allocation and rationing need to be freed from strict adherence to principles and instead moved toward deliberation that embraces a more pragmatic and democratic way of negotiating the distribution of resources.

Perhaps, one of the examples that would further illuminate the above moral dilemma of healthcare allocation and rationing is the context of Sub-Saharan Africa's healthcare system and the recent outbreak of the COVID-19 pandemic. Thus, in the fourth objective, I examine the context of Sub-Saharan Africa's healthcare systems, and the issue of healthcare allocation and scarcity in the region, as related to the pandemic. The recurrent healthcare crisis in Sub-Saharan Africa is related to the absence of consistent and homegrown healthcare policies on the side of the government, and the top-down and donor-led healthcare policies of each country. Equally, most countries in the region follow a top-down approach, as well as

[29] Norman Daniels, "Rationing Fairly: Programmatic Considerations," *Bioethics* 7, no. 2/3 (1993), 224-25; Govind Persad, Alan Wertheimer, and Ezekiel J. Emanuel, "Principles for Allocation of Scarce Medical Interventions," *The Lancet* 373, no. 9661 (2009), 423.
[30] A. Stefanini, "Editorial: Ethics in Health Care Priority-Setting: A North-South Double Standard?," *Tropical Medicine and International Health* 4, no. 11 (1999), 712.
[31] Leslie P. Scheunemann and Douglas B. White, "The Ethics and Reality of Rationing in Medicine," *Chest* 140, no. 6 (2011), 1626; see also Daniels, Rationing Fairly, 224.

rules of allocation and rationing, often imposed by, or copied from donor countries, previous colonizers, and declarations, policies, and initiatives from international organizations[32] such as the International Monetary Fund (IMF), World Bank (WB), United Nations Children's Fund (UNICEF), and World Health Organization (WHO). Hence, in the first section this chapter, I critically review reasons behind the African healthcare crisis and suggest pragmatist means to address justice issues in healthcare allocation in the region. I also look at the region's situation during the COVID-19 pandemic and examine the place of moral principles and the role of deliberation in the allocation of medical supplies.

The other case that can illuminate the relevance of context sensitivity in ethical decision-making and the over-all tenets of pragmatist ethics is the case of organ trade and trafficking in Africa. Indeed, the broader moral dilemma of organ trafficking is seen within the moral contestation of altruism as a rule of organ procurement and the resulting worldwide organ shortage. The incapability of altruistic transplant orthodoxy[33] to serve as an applicable foundation for a public policy is considered a driver of organ trafficking. In fact, utilitarian-inclined studies suggest regulated organ selling,[34] compensation for donations,[35] and non-directed paid donations[36] as practical alternatives to curb organ trafficking. However, in this part of the dissertation, I consider the situation of organ trafficking in Africa in a manner different from other regions. Certainly, the issue of organ trafficking in the region goes beyond the mere moral dilemma of altruism and organ shortage. Instead, in the region, organ trafficking is rooted within more systemic, structural, socio-economic, and political problems, grounded in the abuse of

[32] Gilbert Dechambenoit, "Access to Health Care in Sub-Saharan Africa," *Surgical Neurology International* 7, no. 1 (2016), 11; Margaret Whitehead, Göran Dahlgren, and Timothy Evans, "Equity and Health Sector Reforms: Can Low-Income Countries Escape the Medical Poverty Trap?," *The Lancet* 358, no. 9284 (2001), 833; see also Vasudeva N.R. Murthy and Albert A. Okunade, "The Core Determinants of Health Expenditure in the African Context: Some Econometric Evidence for Policy," *Health Policy* 91, no. 1 (2009), 61-62.
[33] Eytan Mor and Hagai Boas, "Organ Trafficking: Scope and Ethical Dilemma," *Current Diabetes Reports* 5, no. 4 (2005), 294.
[34] Megan Clay and Walter Block , "A Free Market for Human Organs," in *The International Trafficking of Human Organs:Multidisciplinary Perspectives*, ed. Leonard Territo and Rande Matteson Eds, (CRC Press, 2012), 52; Michael M. Friedlaender, "The Right to Sell or Buy a Kidney: Are We Failing Our Patients?," *The Lancet* 359, no. 9310 (2002), 973; James Stacy Taylor, "Autonomy, Constraining Options, and Organ Sales," in *International Trafficking of Human Organs*, ed. Leonard Territo and Rande Matteson (CRC Press, 2012), 155.
[35] L D De Castro, "Commodification and Exploitation: Arguments in Favour of Compensated Organ Donation," *Journal of Medical Ethics*, 2002, 142.
[36] Mor and Boas, Organ Trafficking, 299.

transplantation, and connected to transplant tourism and migration. Thus, in the fifth objective of the study, I intend to analyze organ trafficking from a pragmatist perspective and reflect on solutions to it, with the assessment of the context of transplantation, organ trade, and trafficking in the region.

3. Organization of the Study

This dissertation is organized into seven chapters, structured as follows:

Chapter One: *Introduction*

This chapter focuses on the introductory aspect of the study, and consists of the background, problems and objectives of the study, as well as the organization of the study.

Chapter Two: *Dimensions of Bioethics, the Relevance of Context and the Pragmatist Turn*

This chapter overviews the methodologies of bioethics, including the recently introduced context-based approach. The chapter further looks at the epistemic grounds of morality and the nature of bioethics and shows how a pragmatist-empirical turn in bioethics is relevant both in the theoretical-conceptual study of bioethics as well as for decision-making on specific bioethical issues.

Chapter Three: *John Dewey's Ethics, Pragmatist Bioethics, and the Case of Gestational Surrogacy*

The third chapter takes the discussion of the methodology of bioethics into Dewey's ethics and recent developments of pragmatist bioethics. It further takes the case of gestational surrogacy and illuminates the significance of Dewey's emphasis on education, deliberative democracy, and institutions as well as the role of agents as the basis to solve bioethical issues.

Chapter Four: *Healthcare and Healthcare Resource Allocation and Rationing: Pragmatist Reflections*

This chapter examines the moral dilemma of healthcare allocation and ratioing. It inserts the issues into the concepts and theories of healthcare systems, disease, and health, and shows how difficult it is to solve the moral legitimacy problem through a principle-based approach to healthcare allocation and rationing.

Instead, the relevance of the pragmatist approach to healthcare allocation and rationing through deliberation is investigated as a useful way to legitimately distribute healthcare resources.

Chapter Five: *The Context of Sub-Saharan African Healthcare Systems, Healthcare Allocation, and the Case of the COVID-19 Pandemic*

The fifth chapter focuses on examining healthcare systems' rationing during the COVID-19 pandemic in Africa. It exposes the situation of healthcare scarcity and the dilemmas of medical resource allocation in Africa by further reviewing of the reasons underlying the healthcare crisis in the region. In the more specific example of the COVID-19 situation, the chapter reflects on the relevance of following a pragmatist approach to healthcare rationing.

Chapter Six: *The Moral Dilemma of Organ Trafficking and Africa: Pragmatist Considerations*

The penultimate chapter looks at the context of organ trafficking in Africa by connecting it to the contemporary debates on the ethics of organ transplantation and organ trade. It further examines the situation of transplantation in the region and seeks some pragmatist solutions able to address the problem in the region.

Chapter Seven: *Summary and Conclusions*

In the final chapter, which concludes the dissertation as whole, the summary of the major arguments and conclusions are drawn in line with the problems and objectives of the study.

Chapter Two

Dimensions of Bioethics, the Relevance of 'Context', and the 'Pragmatist Turn'

2.1 Introduction

Bioethics is commonly viewed as an interdisciplinary field of inquiry that has emerged as an ethical enterprise in the second half of the twentieth century. The increasing diversity and complexity of ethical quandaries related to advances in natural science and technology as well as the new challenges to specific priorities and practices in medicine and life sciences have led traditional medical ethics to expand its horizons to bioethics,[37] which also includes issues related to animal ethics and environmental ethics. The involvement of physicians, philosophers, lawyers, sociologists, and others on the cusp of interdisciplinary dialogue on the issues emerging from medicine in the context of science and society is also the reason for the emergence of bioethics as a field of study.[38]

However, irrespective of considerable consensus on its historical origin, contributors in the field provide different and often conflictual definitions and conceptions of bioethics, especially regarding its methods, theories, and areas of concern. Marcus Düwell agrees with the contested terrain of bioethics. He maintains that "academic bioethics has an interdisciplinary character" and that there is "no agreement on what exactly bioethics is in the first place."[39] The absence of consensus on bioethics can also be related to the very fact that different ethicists and bioethics researchers approach bioethical problems with different methods, theories, principles, rules, and logics of bioethical decision-making and justifications. As a result, there are many different ways to think about bioethics, as well as many different methods and principles that people in the field have suggested as a way to do research and make decisions about certain moral issues in a societal and institutional setting.

[37] Christiana Z. Peppard, "Introduction," in *Expanding Horizons in Bioethics*, ed. Arthur W. Galston Christiana Z. Peppard (Springer,2005), xiii; see also Marcus Düwell, *Bioethics: Methods, Theories, Domains* (London and New York: Routledge Taylor & Francis Group, 2012), 11-19.
[38] Düwell, Bioethics, 21-22.
[39] Ibid, 2.

Moreover, bioethics is not an academic inquiry open only to bioethical experts. Neither can the concerns be delegated to experts in bioethics to find solutions acceptable to the general public. As Sigrid Graumann claims, bioethics is essentially *biopolitics*, the decisions of which cannot be completely left to politicians or bioethical experts alone. For instance, it is difficult to reach a social consensus based on rules and principles in the cases of pre-implantation genetic diagnosis, cloning, and germline interventions because of a plurality of interests, assessments, convictions, worldviews, and conceptions of the nature of human beings across different societies.[40] Indeed, as Biller-Adorno argues, the discourses in bioethics go beyond classrooms and conferences to embraces the voice and involvement of politicians, regulators, stakeholders, and the general public.[41]

In this chapter, I look at the horizon of bioethics, the controversy over different theoretical and methodological dimensions in bioethics, and bioethical problems. Mainly, I discuss the scope of bioethics and review some of the methods, theories, principles, and rules of mainstream bioethics in the West, as well as other recently introduced context-sensitive approaches to bioethics in the global South and East. In the final part, I examine how context ethics and pragmatism fill the gaps left by applied ethics and principlism approaches to bioethics. Finally, I propose the pragmatist turn in bioethical investigations and deliberations as relevant for the conceptual study in bioethics and for making morally "acceptable" decisions concerning specific bioethical dilemmas.

2.2 Bioethical Issues and the Horizon of Bioethics

Studies in bioethics categorize bioethical issues and dilemmas as “traditional” and “modern” problems of concern in ethics. The traditional issues of bioethics are inherited from the traditional issues of medical ethics, whereas the modern bioethical issues are related to advances in the natural sciences and technology. The traditional bioethical issues include biomedical problems concerning the beginning and end of life, notably issues such as abortion, euthanasia, and limiting the therapeutic life treatments and

[40] Graumann, Experts on Bioethics, 176-81.
[41] Biller-Andorno, It is a Small World, 459.

physician-patient relationships at micro-level healthcare systems and institutions. On the other hand, contemporary issues in bioethics include issues related to research on human beings, clinical trials, human genetics, and moral problems linked with misconduct in research on human beings in general. Further, ethical problems related to reproductive technology, organ transplantations, and healthcare resource allocations issues have emerged as problems of bioethics in the recent past.[42]

The horizon of bioethics is not limited only to medical issues; instead, it includes provocative problems of environmental ethics and technology.[43] Bioethical issues are complex, and the field of bioethics is robust and multidisciplinary in terms of its concern and approach of study. Thus, issues associated with rapid developments in the natural sciences and technology and their undesirable consequence on the environment and human beings' survival, such as nuclear waste, water and air pollution, clearing of forests, large scale livestock farming, as well as particular technological innovations like cloning and gene technology are also the focus of bioethical investigations. The problems that come from a specific situation, such as HIV/AIDS, genetically modified food, the rise of biomedical arsenals, and human embryonic stem cell research, are also significant concerns in twenty-first-century bioethics.[44] In general, we can claim that current bioethical issues arise from ethical problems of healthcare, life sciences, and biotechnologies.

Contemporary bioethical issues are, to some extent, cross-cultural and transnational in their scope of becoming a concern for the public as well as academic scholarship. Certainly, in the current globalized world, the moral concern of a specific region or society will become the concern of others, and it may soon become a problem for all the people around the world. This cross-cultural and transnational nature of bioethical problems can be related to the interactions between and within different cultures and

[42]Paulo Nuno Martins, "A Concise Study on the History of Bioethics : Some Reflections*," Middle East Journal of Business* 13, no. 1 (2018), 35-37; see also Akira Akabayash (ed.), *The Future of Bioethics: International Dialogues* (Oxford University press, 2014), v-vi.

[43] Düwell, Bioethics, 20; see also Christiana Z. Peppard, "preface," in *Expanding Horizons in Bioethics*, ed. Arthur W. Galston Christiana Z. Peppard (Springer,2005), xiii; see also Marcus Düwell, Bioethics: Methods, Theories, Domains (London and New York: Routledge Taylor & Francis Group, 2012), Xi-Xii.

[44] Tyler N. Pace, "Preface," in *Bioethics: Issues and Dilemmas*, ed. Tyler N., Pace (New York: Nova Science Publishers, 2010), vii-viii; see also Peppard, Introduction, xiii-xix.

civilizations, which is caused by the increasing interconnectedness of different cultures through globalization and metropolitanism. However, in terms of the degree of their seriousness as a concern in the academic field of bioethics or as a public issue, bioethical issues are not the same from region to region, nation to nation, and society to society.

The regional variation of bioethical issues, mainly in terms of their seriousness to a particular society, depends on the socio-economic and cultural elements, technological levels, and the overall background context. For instance, issues such as euthanasia, surrogate motherhood, organ transplantation, gene therapy, transhumanism, and other biomedical arsenals and emerging problems dominate the concern of Western bioethics. However, in developing countries, these problems concerns of bioethics to a lesser degree as compared to other issues that are more serious in these countries. For instance, issues of scarcity and sacrifices in healthcare, cross-cultural and transnational research in biomedicine, healthcare, and clinical trials[45], healthcare scarcity and sacrifices,[46] tropical and pandemic diseases, human genomics research,[47] antibiotic resistance bacteria,[48] and organ trafficking,[49] among others, are more germane in developing countries. Thus, bioethical issues are contextual, depending on their seriousness as a concern of a particular society or regions. From this, we may argue, regarding the goal of bioethics, that any efficient investigations, deliberations, and responses to bioethical problems must consider the local and global contexts and dynamics where the problems arise.

[45] Michael Igoumenidis and Sophia Zyga, "Healthcare Research in Developing Countries: Ethical Issues," *Health Science Journal* 5, no. 4 (2011), 243-50.
[46] C. Olweny, "Bioethics in Developing Countries: Ethics of Scarcity and Sacrifice," *Journal of Medical Ethics* 20, no. 3 (1994), 169.
[47] Jantina De Vries et al., "Ethical Issues in Human Genomics Research in Developing Countries," *BMC Medical Ethics* 12, no. 1 (2011), 1.
[48] James A Ayukekbong, Michel Ntemgwa, and Andrew N Atabe, "The Threat of Antimicrobial Resistance in Developing Countries : Causes and Control Strategies," *Antimicrobial Resistance and Infection Control* 6:47 (2017), 6.
[49] Nancy Scheper-Hughes, "Keeping an Eye on the Global Traffic in Human Organs," *Lancet* 361, no. 9369 (2003), 1645-48.

2.3 Methods, Dimensions, Rules, and Principles in Mainstreams Bioethics

Ethicists identify various reasons for the concern regarding methods, theories, and rules of bioethics, bioethical deliberations, and decisions. As Childress claims, one of the reasons is that theories are used to determine how best to guide human action. This concern mainly signifies the consideration of how well a bioethical theory, concept, framework, or perspective guides action, as well as the congruence with moral experience.[50] The concern of investigating and solving empirically pressing moral dilemmas under a relevant social context is another reason for bioethicists' focus on the methods and theories.[51] There are two categories of principal methodological approaches to current bioethical research and deliberations, namely, normative philosophical approaches and descriptive approaches. The normative approaches include consequentialist and deontological theories, or what Düwell calls "one-principle" approaches, and others such as the "pluralistic principlism," the "common morality approach," or agent-based ethics, the ethics of care, communitarian perspectives, critical feminist perspectives, and rule-based theories. On the other hand, the descriptive approach includes methods in bioethics such as the narrative, ethnological, and phenomenological approaches, as well as others that adopted methods from the fields of sociology, anthropology, and psychology. However, located between the above two approaches is empirical bioethics, a recent method in bioethics that bridges the normative and descriptive division through a sensitiveness to context in bioethical research and decision-making on particular bioethical issues.[52] In fact, as Hester and Wolf describe, this turn to the empirical approach in bioethics is necessitated by a pragmatist shift in the study of bioethics, which aims at reorienting the methods and goals of bioethics.[53]

The dominant theoretical perspective in this principle-based normative approach is principlism. It received its name after Clouser and Gert's critique of a principle-based approach to bioethics introduced

[50] Childress, Methods in Bioethics, 15-16.
[51] Michael Dunn and Jonathan Ives, "Methodology, Epistemology, and Empirical Bioethics Research: A Constructive/Ist Commentary," *American Journal of Bioethics* 9, no. 6-7 (2009), 93-95; see also Tenzin Wangmo and Veerle Provoost, "The Use of Empirical Research in Bioethics: A Survey of Researchers in Twelve European Countries," *BMC Medical Ethics* 18, no. 1 (2017), 1-10.
[52] Musschenga, Empirical Ethics, 467.
[53] Wolf, Shifting Paradigms, 395-41; Hester, Is Pragmatism Well-Suited, 556.

by Beauchamp and Childress in 1979.[54] Principlism is a theory developed after the Belmont Report in 1976, wherein a group of experts, including Beauchamp and Childress, presented three principles that guide behavioral and biomedical research involving human subjects. Later, Beauchamp and Childress helped consolidate the principlism theory. They included the three principles of the Belmont Report– respect for the person (autonomy), beneficence, and justice – and added the fourth principle of nonmaleficence. As Childress describes it, principlism is an ethical framework that incorporates consequentialist principles along with non-consequentialist ones without deriving one set from the other or reducing it to the other. As a result, the authors of this theory call it a 'pluralistic approach' to bioethics. Principlism is an applied ethics approach to the examination of moral dilemmas based upon the application of certain principles. A principle is a basic standard of conduct from which many other moral standards and judgments draw support for their defense and standing. Those four principles include several derivative rules, such as veracity, fidelity, privacy, and confidentiality, along with various rules such as informed consent and the duty to help others.[55] Here, I wish to further extend my discussion into these four principles of Beauchamp and Childress in order to provide a background for my later discussions and criticism against this approach in the upcoming sections of this chapter.

Autonomy, as the principle of biomedical ethics, refers to self-rule, free from control and interference by others. Especially in clinical medicine, it refers to having sufficient information for meaningful decision-making and choice regarding a matter. In negative terms, the principle of autonomy refers to having no control or constraints placed on one by others and the absence of deprivation of freedom of others. Positively, it signifies respectful treatment in disclosing information and fostering autonomous decision-making.[56] The principle of autonomy, as Beauchamp notes, includes various specific rules, such as

[54] Childress, Methods in Bioethics, 21-2.
[55] Childress, 22.
[56] Tom L. Beauchamp, "The Principles of Biomedical Ethics as Universal Principles," In I*slamic Perspectives on the Principles of Biomedical Ethics: Muslim Religious Scholars and Biomedical Scientists in Face-to-Face Dialogue with Western Bioethicists*, no. 2000 (2016), 94- ; see also James F. Childress Tom L. Beauchamp, *Principles of Biomedical Ethics* (Oxford University Press, USA, 2009), 14.

veracity, respect, confidentiality, consent, and the duty to help others. Any proper investigation and decision concerning a particular moral problem should consider these.

The second principle of biomedical ethics in the principlism approach is beneficence. The principle of beneficence asserts the duty to help others further their significant and legitimate interest. Mainly in the area of medicine, this principle signifies that one ought to prevent evil or harm so that one promotes good. Beauchamp claims that the principle of beneficence includes specific rules, such as protecting and defending the right of others, preventing harm from occurring to others, removing conditions that will cause harm on others, helping persons with disabilities, and rescuing persons in danger, to promote a patient's welfare.[57] As Beauchamp and Childress claim, ethical analysis of bioethical problems must consider these specific rules of beneficence in order to make judgments regarding the goodness or badness, rightness or wrongness, and acceptability or non-acceptability of a certain issue at hand.

The third principle is the principle of nonmaleficence. This principle is indirectly related to the principle of beneficence. It refers to the duty to refrain from causing harm, which is related to the age-old Hippocratic Oath of physicians and health workers. According to this principle, as a moral duty, one ought not to inflict harm on others. The principle of nonmaleficence includes several specific rules, such as do not kill, do not cause suffering, and do not deprive others of pleasure and freedom, do not incapacitate clients, do not offend, and do not deprive others of the good of life.[58] The fourth principle of bioethical principlism is justice, which focuses on the distribution of social burdens and benefits. Under the principle of justice, several rules are included, such as equal sharing, distribution based on need, distribution and sharing according to effort and contributions, and distribution and sharing based on merit.[59]

[57] Ibid, 98-100.
[58] Ibid, 97-8.
[59] Ibid, 100-103.

2.4 The Need for Context in Normative Bioethical Research

Morality is embedded in people's lives and the world they inhabit, and it is unbearable to relegate morality to an abstract theory or principles alone. Hester believes that in a moral investigation, there is a clear danger to start from high-level abstraction and theory, since at such a level no context exists. However, every bioethical problem that we confront always-already arises as a particular problem occurring in a particular society in some unique context. As Hester claims, inquiry in general, and ethical inquiry in particular, arises out of a given problematic situation which conditions our moral activities and decisions.[60] Depending on the type of moral issue that arises in a culture, moral considerations and ethical deliberations are contingent, dynamic, and contextual. Justifications and deliberations in bioethics are similarly variable, dynamic, and context-sensitive, because judgements and decisions about specific problems are socio-culturally rooted and institutionalized.

Scholars have criticized these mainstream approaches of bioethical principlism and traditional moral philosophies on the grounds of their abstract nature and lack of context in their application in bioethical research and practical decision-making. They call for the need to contextualize bioethics in the conceptual study of theories and principles as well as in the empirical-contextual investigations of solutions to specific bioethical plights. One of the objections against traditional bioethics and principlism stems from the gap between normative theories and practices. This objection can be further instantiated into various challenges proposed from different approaches to morality. For example, principlism and other approaches that borrow the method of applied ethics are criticized from the position that moral reasoning and the logic of ethics of medicine, bioscience, and technology do not necessarily involve a simple application of a pure theory or principle/s to specific moral problems or issues. In fact, bioethical principlism and other theory-oriented approaches to bioethics have received severe criticism from pragmatism. For instance, pragmatist naturalists and evolutionist pragmatists believe that actual moral problems are "contexted" or embedded in states of affairs of our living. Thus, they reject the deductive

[60] Hester, Is Pragmatism Well-Suited, 554.

justification of morals and the a priori metaphysics of moral principles applied in bioethics.[61] For example, Hester, from the pragmatist point of view, claims that it is impossible to move from general principles if we are not first acquainted with the specific features of the problem at hand. Thus, he remarks that any applicable ethical principle must arise out of the context if it is to have any meaning in the given situation.[62]

Moral decisions are not rule-governed in a straightforward manner with straightforward deductive logic, nor can it be captured by an algorithm. Instead, moral decisions are communally situated and intertwined with a multifaceted assessment of societal situations, rules, laws, traditions, religions, background philosophical beliefs, and specific situations. These contexts influence moral decision-making and judgments. Besides, the fast development of technologies and associated complexities of moral problems in our society have made the task of ethical investigation very complicated, by making bioethical problems incomprehensible when using universal rules or codes of conduct. This unfathomable nature of bioethical issues induces us to go beyond the traditional moral bioethical theories and seek for solutions with a broader multidisciplinary approach and consideration of diverse social contexts.[63] Thus, I agree with Hester that "any use of principles or classifications, then, can only happen given a specific problem and context."[64]

It is therefore unsurprising to hear mainstream bioethics referred to as "Western" bioethics in today's bioethics discourse. In its approach to ethics in general and bioethics in particular, "Western Bioethics" is frequently seen as secular, individualist, rationalist, and universal. This "Western" approach is contrasted with another strategy that tries to integrate religious principles, human connection specificities, and regional or local perspectives. As a result, it's no surprise that some "Non-Western" authors dismiss the

[61] Jonathan D. Moreno, "Bioethics Is a Naturalism," in *Pragmatic Bioethics*, ed. Glenn McGee, 2nd ed. (Cambridge, Massachusetts: The MIT Press, 1999), 9; see also Kenneth J. Ryan, "Review Paper: Glenn McGee, Bioethics and Pragmatism. Nashville: Vanderbilt Univer- Sity Press, 1999, 320," *Theoretical Medicine* 21. 6, no. 2 (2000), 624; Hester, Is Pragmatism Well-Suited, 554; D. R. Cooley, "Une Approche Pragmatique de La Bioéthique International Ou Multiculturelle," *Ethics, Medicine and Public Health* 3, no. 2 (2017), 270.
[62] Hester, "Is Pragmatism Well-Suited, 554.
[63] Hoffmaster, From Applied Ethics to Empirical Ethics, 119-125.
[64] Hester, Is Pragmatism Well-Suited, 554.

"Western" method as irrelevant or non-existent in their society.[65] Authors, especially from Asia and Africa, criticize bioethical principles in principlism, as they are not context-sensitive and have little effect on policy issues and ethical deliberation in these regions. For example, Azétsop and Rennie argue that the autonomy-based bioethics of the West prioritizes medical individualism and 'market force-based' healthcare. Further, these autonomy-based bioethics are, according to them, incapable of addressing some of the most pressing bioethical issues in healthcare services in resource-poor countries. The authors argue that "the real need in resource-poor countries is not then to mislead people with unrealistic promises of autonomy that very few people can indeed achieve, [but] to articulate moral principles and societal values that are oriented around the promotion of equitable access to healthcare which broaden the goals of medicine and public health."[66]

As a consequence, many scholars have developed alternative principles of bioethics which are context-sensitive and used to investigate bioethical problems based on the particular local and regional context where the problems arise. For stance, bioethicists, especially from the perspective of Asia and Africa, argue in defense of contextual bioethical theories and principles, and they suggest the relevance of context-based bioethical research and problem solving. They further claim that the predominant view of bioethical principlism is based on Anglo-American culture, and it has very little ability to solve particular bioethical problems in non-western societies.[67]

In the context-based reorientation of bioethical theories and methods, we can identify two significant positions on the relevance of "context" on bioethical principles and theories and bioethical research. In the first position, ethicists such as, Coleman, Andoh, Azétsop and Rennie, and Behrens believe in the

[65] Biller-Andorno, It's a Small World, 460.
[66] Jacquineau Azétsop and Stuart Rennie, "Principlism, Medical Individualism, and Health Promotion in Resource-Poor Countries: Can Autonomy-Based Bioethics Promote Social Justice and Population Health?," *Philosophy, Ethics, and Humanities in Medicine* 5, no. 1 (2010), 3.
[67] Kiak Min, Beyond a Western Bioethics, 154; Kevin Gary Behrens, "Towards an Indigenous African Bioethics," *South African Journal of Bioethics and Law* 6, no. 1 (2013), 32; Cletus T. Andoh, "Bioethics and the Challenges to Its Growth in Africa," *Open Journal of Philosophy* 01, no. 02 (2011), 74; see also Albert Mark E. Coleman, "What Is 'African Bioethics' as Used by Sub-Saharan African Authors: An Argumentative Literature Review of Articles on African Bioethics," *Open Journal of Philosophy* 07, no. 01 (2017), 31-47.

complete regionalization or cultural and societal specificity of bioethics. In the second position, authors such as, Ssebunnya, Fayemi, and Tan Kiak Min, among others believe in the universality of bioethics. However, they suggest a synthesis between the mainstream approach and some contextual, cultural elements.[68] In the first orientation, researchers draw on different theories and principles that guide bioethical analysis and deliberations by showing the regional specificity of bioethics, such as African bioethics, Asian bioethics, Western bioethics, and other specific cultural groups. In this respect, authors sort out theories of ethics other than the dominant theories and principles of bioethics developed in the 1970s. For example, some bioethicists in Africa claim that there is a need for the African framework of resolving moral dilemmas to arise in biomedical sciences and technology. Authors such as Coleman, Andoh, Azétsop and Rennie, and Behrens criticize the mainstream theory of bioethics as a model and framework developed from the Western cultural context. Thus, they develop an alternative African bioethical framework from the standpoint of African cultural elements. For example, Andoh claims that unlike the individual-centered culture of the West, African culture is community-centered. Thus, he argues about the need to move away from the individual-based bioethics of the West to the community-based bioethics of Africa. Andoh claims that the basic maxim, "A person is a person through other people" or "I am because we are," is a key recurring aspect of moral thought in Sub-Saharan Africa. He says, "I am because we are," is a traditional African belief. Only via others can I be a person, indicates that one's human identity is causally and metaphysically dependent on a community.[69]

Similarly, Behrens argues against the mainstream autonomy-based bioethical principlism of the West. He argues that the four principles from Beauchamp and Childress are incapable of addressing some of the most pressing bioethical issues in Africa. Instead, Behrens argues that when it comes to Africa, a principle based on the perspective of African communal solidarity ethics should guide African bioethics,

[68] Gerald M. Ssebunnya, "Beyond the Sterility of a Distinct African Bioethics: Addressing the Conceptual Bioethics Lag in Africa," *Developing World Bioethics* 17, no. 1 (2017), 22-31; Tan Kiak Min, Beyond a Western Bioethics, 154-164; Ademola K. Fayemi, "African Bioethics vs. Healthcare Ethics in Africa: A Critique of Godfrey Tangwa," *Developing World Bioethics* 16, no. 2 (2016), 98-106.
[69] Andoh, Bioethics and the Challenges, 70.

for which he claims the principle of harmony as a primary principle.[70] Further, Chukwunoko and colleagues, based on the study of the traditional Igbo society in Nigeria, posited communal living, respect for life and personhood, solidarity, and justice as the hallmarks of principles of African bioethics. They argue that bioethics is part of communal morality and not individual morality, which is based on the human relationship in African culture, cultural reminiscence, norms and habits, tradition and custom.[71] Likewise, Margaret Lock, in her ethnographic study about brain death in Japan, associates the resistance of the use of the recently introduced dead-donor rule for organ donation to the cultural element of the Japanese society. Lock claims that in Japan, the self is relational, and not individuated and atomized as in the West, with death viewed as an evolving process in which the family participates.[72]

The seriousness and controversial nature of specific bioethical dilemmas in particular regions of the world also demonstrates the contextual nature and regional distinctiveness of bioethics.[73] For example, Fayemi identifies the uniqueness of African bioethics in terms of its focus on moral issues around socio-economic problems, poverty, and other health-related problems. Olweny also states that scarcity and sacrifices of healthcare in developing countries is a more germane problem with which the principles of medical ethics are confronted, through the existing situations such as hunger, poverty, war, and ever-shrinking economies. Indeed, amid scarcity and shortage of medical supplies, the issue of autonomy becomes a secondary or may or foreign to be applied it in developing world setting. In many Asian countries as well as in Sub-Saharan Africa, what is more concerning, and thus a priority, is who receives access to modern medicine and how society can fairly deliver healthcare to all its citizens, rather than how one uses medical technology humanely. Hence, one may claim that bioethics as practiced in Europe, America and Canada is too far out of reach of developing countries in Africa, South America, and Asia. As Miles and Laar lament, most bioethical research does not address the issues of developing countries, but concentrates on

[70] Behrens, Towards an Indigenous African Bioethics, 34.
[71] FN Chukwuneke et al., "Global Bioethics and Culture in a Pluralistic World: How Does Culture Influence Bioethics in Africa?," *Annals of Medical and Health Sciences Research* 4, no. 5 (2014), 675.
[72] Margaret Locke, "Situated Ethics, Culture, and the Brain Death 'Problem' in Japan," in *Bioethics in Social Context*, ed. Barry Hoffmaster, vol. 16 (Philadelphia: Temples University Prsess, 2002), 116.
[73] Fayemi, African Bioethics, 105; see also S. H. Miles and A. K. Laar, "Bioethics North and South: Creating a Common Ground," *Ethics, Medicine and Public Health* 4 (2018), 59-64.

the developed world. Issues in developing countries are peculiar and should focus on improving healthcare (twenty-first century climate change, refugee movements, and disease vector migration) and disease control and prevention, instead of focusing on cloning, stem cell and other traditional bioethical issues.[74]

Nevertheless, different from the those who reduce bioethical methods and principles to specific regions, other ethicists for example, Ssebunnya, Fayemi, Tan Kiak Min insist on the need to integrate contemporary bioethical principles with other contextualized cultural elements of specific regions of the world. These bioethicists analyze the context of African and Asian bioethics, and they interpret the 'four autonym- based Principles of mainstream bioethics in light of the communal culture of societies in these regions. For instance, Ssebunnya argues against the motive for distinct African bioethics proposed Tangwa, Behren and other "ethno-centrist" bioethicists, and he urges for African bioethics to incorporate the universal elements and specific insights from regional contexts through empirical turn to bioethics. Ssebunnya claims that

> It is indisputable that bioethics as a discipline is essentially a universal pursuit that emerged out of concerns about the unprecedented biotechnological threats to the dignity of the human person. Thus, primarily, bioethics has a moral imperative and must be conceptualized and grounded in a matrix of moral values. Secondly, bioethics is actualizable through an action-guiding analytical framework that underlies empirical research ethics. This is the essential two- dimensional nature of bioethics that demands sustained reflection and articulation in light of lived human experience.[75]

The intention of the above discussion on regional reorientations in bioethics is not to pronounce the existence of distinctive African or Asian bioethics, as is said by many authors. Instead, it is presented to

[74] Miles and Laar, Bioethics North and South, 59.
[75] Ssebunnya, Beyond the Sterility, 30.

illustrate the shift in emphasis on context and the bioethical redirection we have in contemporary bioethical debates. However, I want to claim that the truth of morality, the epistemic ground of moral judgments and decisions, is subject to specific situations and contexts. Even though we share the basics of morality in common as humans (since our brains are structured similarly as a result of evolutionary adaptation), moral values, judgments, and decisions, the acceptance and denial of certain actions as morally right or wrong, are conditioned by the socio-cultural contexts in which they attempt to operate.

Those earlier theories which are proposed in defense of the regional specificity of bioethics are somehow justifiable, mainly on the grounds of alluding to the imperative of cultural specificity as a hallmark of morality and bioethics. Thus, apart from the dominant bioethical theories and methods, alternative suggestions inspired by the contextual analysis of bioethical concepts and problems in specific regions should be voiced within a discourse on bioethics, both for its pragmatist advantage to solve practical problems at the local and regional levels and to strengthen cross-cultural dialogues. Such an approach to ethics is mainly appreciated in multicultural bioethics. For instance, in his approach called "multicultural pragmatism" in bioethics, Cooley remarks that to make better decisions and take more effective action on bioethical problems when it comes to dealing with other nations and cultures, it is necessary to sufficiently comprehend alternative moral theories inspired by specific cultural elements.[76] In fact, one can say that the above regional orientations in bioethics are philosophically shaped by pragmatist ethics and an emphasis on context, which are discussed more in the next section.

2.5 Contextual Bioethics and the Pragmatist Turn

As I claimed elsewhere in this chapter, moral judgements and decisions about specific situations are ingrained in the socio-cultural and institutional milieu, so reasons, deliberations, and moral actions are situational, dynamic, and context sensitive. The recent emphasis on context in bioethical scholarship is, therefore, a turn to the empirical dimension of morality, which informs researchers to reconsider the broader context and its dynamism in ethical research. The philosophical background of “context-ethics”

[76] Cooley, A pragmatic approach, 277.

lies under the expanse of the pragmatist turn to bioethics. Of course, like other bioethical approaches, pragmatist bioethics is criticized, as it is subject to methodological and philosophical perspectivism.[77] However, pragmatist bioethics alludes to finding a workable morality with methodological flexibility and consideration of the social context and human evolution. Hence, it passes the criticism of philosophical theory dependence and perspectivism though the epistemological and metaethical significance of context in morality.

The focus on context tries to refocus bioethics from its a priori philosophical theory of principlism, as well as other moral philosophies in mainstream bioethics, into the realm of human experience. Its goal is to examine morality, moral judgements, and decisions, as well as the beliefs and values that drive them, within the context of social-institutional contexts and prevailing society moral norms.[78] In a number of settings, including social, legal, economic, and political underpinnings, as well as comprehensive worldviews, abstract ideas can be turned into practical behaviors.[79] So, an emphasis on context in bioethics has a double advantage, that is, in the theoretical-conceptual research, to find a workable principle concerning bioethical problems in certain contexts, and in our everyday life, to make workable decisions concerning moral dilemmas in a specific society. In fact, the double advantage of context is grounded in the complimentary nature of normative and empirical ethics. The moral question that confronts us in normative ethics, "how ought we to be," needs empirical data that reveals "how something is,"[80] especially for bioethical dilemmas which are societal and institutional in nature. Furthermore, context aids in the determination of our moral obligations, particularly in situations where an obvious duty in one state of affairs is not at all apparent in another,[81] which I believe is a challenge to the moral absolutism of mainstream bioethics.

[77] Arras, Theory and Bioethics, https://plato.stanford.edu/archives/win2019/entries/theory-bioethics/>.
[78] Hoffmaster, From Applied Ethics to Empirical Ethics, 121-123.
[79] Ibid, 119.
[80] Dunn and Ives, Methodology, 93.
[81] Moreno, Bioethics Is a Naturalism, 9.

In the study of bioethics, the emphasis on context is rooted in the pragmatist nature of the epistemology and logic of morality in general and bioethics in particular. In pragmatist bioethics, we can find different approaches to bioethics, and to me these approaches are complimentary, at least under their general aim and the theoretical underpinning of the discourse of bioethics. Indeed, as Arras notes, there are many versions of pragmatist bioethics which are essentially based on differences in the philosophy of pragmatism, including but not limited to, pragmatism as crude instrumentalism, old pragmatism, new pragmatism, and freestanding pragmatism.[82] As indicated in the introductory chapter, the availability of many versions of pragmatism in bioethics is also a challenge to the promise of the method of pragmatist bioethics. However, the fruits of pragmatism in general for bioethics are immense, in that it reorients bioethics, mainly in terms of its methods and goals. One such example is Susan Wolf's pragmatist bioethics, as she discerns a pronounced shift in both bioethics and health law away from the abstractions of analytical philosophy and toward a more clinically oriented and empirical mode of analysis.[83] Wolf supports empirical research projects that actually operate in the real world, making the transition from armchair theorizing to the clinic. As Arras claims, While Wolf's account of bioethical pragmatism tries to situate these recent developments within the larger context of traditional American pragmatism and the recent revival of pragmatism in the academy, her reliance on classical sources like C. S. Peirce, William James, and John Dewey is at best oblique and implicit. In this way, she is a free-standing pragmatist. For Arras, Franklin Miller, Joseph Fins, and Matthew Bacchetta, on the other hand, apply the classic canons of pragmatism to bioethics, particularly in the area of clinical ethics, with a focus on John Dewey. They emphasize the fundamentals of experimentalism, a view of moral principles as "hypotheses" or "presumptive," and Dewey's approach of moral fallibilism.[84]

Apart from different versions of pragmatism, pragmatist bioethics as a method is a singular approach in that many salient features make it free from philosophical perspectivism. This pragmatist bioethics can

[82] Arras, Pragmatism in Bioethics, 34-36.
[83] Wolf, Shifting Paradigms, 395-415.
[84] Arras, Pragmatism in Bioethics, 31.

easily be comprehended based on the “philosophical pragmatist” approach of Hester and the “evolutionary adaptation and neurophysiological” approach of Cooley. Both approaches show how the truth of morals operates in the communal forces, that is, in our everyday living in society, and reveal the pragmatic nature of morality. Hester approaches bioethics from the aspect of John Dewey’s, William James’, and C.S. Peirce’ philosophical pragmatism. In light of these philosophical backgrounds, he examines morality and bioethics through the categories of the role of intelligence and habits.[85] On the other hand, Cooley looks at pragmatist bioethics from inter-cultural bioethics’ perspective, with the approach of evolutionary adaptation and advantage, neurophysiology, and social science.[86] As a result, pragmatic bioethics is empirical rather than philosophical in nature. It does away with a priori deductive thinking, which results in standards that reflect more of an individual's abstract beliefs and principles than our collective life.[87] That is why, in contrast to the more traditional use of principles in a deductive and "mechanical" manner, the pragmatic method for moral problem solving is described as extremely inductive.[88]

Our daily moral behaviors are based on our habits and life purpose, according to pragmatic ethics. Habits are all-pervasive functions of experience that affect all parts of life. They are inclinations to act that have developed through time as a result of habituated responses to an ever-changing environment. Habits, according to Hester, let us live our lives more efficiently, as Dewey suggests. However, they also prevent us from recognizing the unique aspects of experience that distinguish our current circumstance from prior ones. The concentration on our objective, on the other hand, aids us in overcoming the perilous character of habits. Recognition of life's purpose aids in the development of intelligent habits by modifying our experiences through exposure to contexts, and so places the meaning of our concepts and experiences in perspective.[89]

[85] Hester, Is Pragmatism Well-Suited, 545-561.
[86] Cooley, Une Approche Pragmatique, 269.
[87] Cooley, Une Approche Pragmatique, 272.
[88] Ryan, Review, 320.”
[89] Hester, Is Pragmatism Well-Suited, 549.

Concerning the logic of moral judgment and decision-making, a priori categorical logic does not shape our intelligent purpose and choice of moral actions in terms of moral judgment and decision-making; rather, it relies on past experience to help determine possible consequences in life in light of the uniqueness of the current situation and future projections of our lives' ends.[90] Because of evolutionary adaptability and social conditioning, our minds/brains are constructed through habits. The social milieu or circumstances in which we find ourselves as social beings influence our values, sentiments, dispositions, and judgment outcomes. As a result, most of the time, our intelligent aim is not a private projection to live our best life, especially when it comes to morality, but rather the world of genuine human affairs necessitates social intelligence.[91] Morality is founded on fundamental impulses and needs that arise from a unique form of human social existence,[92] and the good is not a mere static thing, but a project which is undertaken not by isolated individuals but by social individuals, generally persons working together.[93] Hence, the epistemological foundation of morality lies in our habits and experiences, which are formed within our temporal existence, yet also has a neurophysiological or biological foundation.

The human brain and its natural working are the result of evolutionary adaption, and our morality is a byproduct of evolutionary adaption, which is reflected in our socialization. As Cooley claims, our brain structures help create and limit the morality we have, but socialization and learning further refines and builds up our morality and the good.[94] Therefore, there is no absolute or static good or bad in ethics and bioethics, contrary to the moral philosophy tradition. Goodness and badness are subject to evolution depending on the situation at hand. In the temporal nature of our existence, we always face a new good and bad, according to which the moral worth of something in our current situation is evaluated, based on our past experience and future projection in the context of the society in which we live our lives. Thus, as Moreno claims, from the pragmatist standpoint the "good, that which is desirable, is an ideal that helps

[90] Ibid
[91] Moreno, Bioethics Is a Naturalism, 11.
[92] Cooley, Une Approche Pragmatique, 275.
[93] Moreno, Bioethics Is a Naturalism, 11.
[94] Cooley, Une Approche Pragmatique, 273.

organize human energies, which are in fact engaged in continuous social reconstruction."[95] Morality's truth from such pragmatist perspectives is contested, investigated, and accepted or denied by the societies in which it operates. As a result, consensus is a crucial pragmatic action in moral deliberations, [96] which is possible through social intelligence – "a social intelligent response to a problematic situation requires, among other things, reliable information, an understanding of the problem, a plan of action, a purpose or 'end- in-view,' and a willingness to engage in a further reconstruction if the hypothesized approach proves unsatisfactory."[97]

I claim that this pragmatist view of morality places bioethics research on a new level as compared to the principlism approach of bioethics, which is founded upon the atomistic view of individuals and discursive rationality as a source of morality. As Hester says, pragmatist bioethics is methodological, not metaphysical since emphasizes purposeful inquiry and free and flexible habits. As such, it is methodology instead being a prescriptive theory.[98] As a methodology of bioethics, then, pragmatist bioethics seeks for what works in a given situation, with the ultimate goal of societal flourishing and growth as an end. Many pragmatist authors, then, mention several pragmatist considerations (frameworks) while doing bioethical research and deliberations at different levels and contexts, either in academic scholarship or at political and institutional levels, to undertake moral deliberations and seek practical solutions. The following, among others, are mentioned by different authors: a society's rules, practices, and customs; social intelligence; habits regarding the problem; rules and responsibilities related to specific roles which the agent plays at the time; claims others have on the agent; the maxims developed from the agent's previous judgments or habits; consideration of conflicting situations and balance of other mediated consequences; and measuring the importance of consequences in view of future projection.[99]

[95] Moreno, Bioethics Is a Naturalism, 11
[96] Hester, Is Pragmatism Well-Suited, 551.
[97] Moreno, Bioethics Is a Naturalism, 11.
[98] Hester, Is Pragmatism Well-Suited, 552.
[99] Cooley, Une Approche, 275; see also Holmes RL. *Basic Moral Philosophy*, (Belmont: Thomson Wadsworth; 2003); Hester, Is Pragmatism Well-Suited, 549-50.

2.6 Conclusion

In general, pragmatist bioethics attempts to draw on bioethics research and moral decision-making and judgments that work in a particular circumstance with the consideration of socio-cultural dynamics and the biological evolution of human nature. As discussed earlier, this approach in bioethics coincides with the emphasis on context in empirical ethics and is philosophically motivated by the reexamination of epistemology and logic morality from the perspectives of practice and experience. Hence, this pragmatist shift has theoretical-conceptual underpinnings in the philosophy of pragmatism, and it is a relevant approach for the theoretical-conceptual study of bioethics and decision-making concerning specific bioethical dilemmas arising in a particular context.

Chapter Three

John Dewey's Ethics, Pragmatist Bioethics, and the Case of Gestational Surrogacy

3.1 Introduction

John Dewey points out that ethical theories began among the Greeks to find a rational basis for regulating human conduct. In the Greek philosophical tradition, philosophers substituted custom with reason to provide objects of morality in the form of the absolute end or the good, or supreme law of morality. As Dewey claims, the tradition of moral philosophy and ethics has been all about a search for authority, a single final source of law, or an investigation of a single end, inherited from the Greek tradition. Dewey questioned the ultimate need for the single lawgiver or absolute end of the ethical theory tradition in light of historical and social changes in past societies, as well as the replacement of classical science's grand cosmic order with a strong emphasis on motion and change. He says that morality and ethics need to be rethought because there are so many different kinds of goods and ends and because moral problems and their solutions are so different from one situation to the next.[100] Dewey is critical of the prevailing moral theories, which he believes are mired in the classical and pre-scientific thought of morality. Miller and his colleagues view Dewey's remarks on ethics as a revolutionary endeavor that observes morality in terms of actions in which the goodness of an action is evaluated in a particular situation.[101]

Dewey's idea of ethics and morality is part of his comprehensive analysis of science, social, and political issues. He reconstructed moral thinking and its application to social policy, mainly by using the method of experimental inquiry. As he claims, this method shows the marriage between science and ethics. Miller and his colleagues argue that Dewey's approach to morality seems parallel to the utilitarianism of British empiricism on the ground of his insistence on moral experimentation.[102] Of course, Dewey admired utilitarianism, though he believes it must be liberated from its reliance on absolute moral theory. Dewey

[100] John Dewey, *Reconstruction in Philosophy* (Mineola, New York: Dover Publication INC, 2004), 161-63.
[101] Miller, Fins, and Bacchetta, Clinical Pragmatism, 35.
[102] Ibid, 36.

appreciated utilitarian ethics in particular because of its attempt to bring morality to human achievement, the making of morality natural and social, its emphasis on institutions, and its stress on human welfare.

Nevertheless, Dewey is critical of utilitarianism, since he believes utilitarian ethicists overlooked morality in terms of passive satisfaction of desires and did not apply experimental inquiry to find out the workable moral solution with its emphasis on seeking an absolute rule of morality.[103] As a result, Dewey urges the reconstruction of utilitarianism to focus on social welfare and human enhancement rather than its primary focus on individual satisfaction. He believes that utilitarianism has to be emancipated from the elements of the Greek tradition and reconstructed into a moral pluralism wherein the diversity of human ends and actions fuels moral goods' plurality.[104]

Dewey thinks that there is no absolute morality; instead, he believes morality is about evaluation or judgment, realized through our experience. Regarding moral theories, Dewey developed a pragmatic conception of moral principles as a guide to moral deliberation during the process of ethical inquiry to answer the problematic situation. As Dewey claims, moral theories and rules function logically as hypotheses, as presumptive guides to our conduct in the situation.[105] In this regard, shifting the burden of moral life away from fixed rules and absolute ends and toward the detection of moral situations eliminates moral theory controversies. It brings morality and the valuation of actions into contact with the exegesis of practices. Dewey thinks that actions are always specific, concrete, unique, and individualized; he also thinks that judgments must be unique.[106] Dewey mentions health as an example. He shows how to live healthily is up to the individual's experience, such as their disability situation and the future projection of their living situation. The term "health" cannot be understood as a separate good or a single end in a universal way. Health is understood in multiple dimensions and has several ends and means to achieve it. Therefore, analyzing health in terms of a single good in the absence of context is a gruesome erroneous inherited from the moral philosophy tradition's absolutist morality. Finally, Dewey says that it is

[103] Dewey, Reconstruction in Philosophy, 180-81.
[104] Ibid, 180-85.
[105] Ibid, 169-71.
[106] Ibid, 165-67.

important to be able to adapt to the problems that keep coming up in a social setting over time by not being rigid with your moral beliefs.[107]

In the book Rec onstruction in Philosophy, Dewey sorts out four critical remarks concerning ethics and morality. First, Dewey alludes to the discovery of moral solutions through experimentation. He claims morality is about solving problematic situations by going against the sanction of reason and all scientific, moral, material, and ideal distinctions. Second, Dewey believes in the equality of goods that might be suggested as good for every particular situation. He avoids the gradation of values inherent in the tradition of ethical theories, believing that the good which is primary in a specific condition is an absolute good for that specific situation and it cannot be compared to another good in another situation. For instance, the good of health in one situation cannot be equated with the good of the economy, nor can it be seen in a universal absolutist way in terms of universal goods such as happiness, freedom, or pleasure. Third, Dewey believes that a person's characterization as good or bad is a temporary matter that cannot be reduced to a person's fixed quality. Instead, he believes that our values and personalities change based on our daily actions in-view-of the future. Fourth, against the static and absolutist view, growth and improvement are the ends of actions and related human moral derivations. Dewey claims growth itself is the moral end rather than fixed ends in traditional ethics, such as justice, honesty, and other moral categories in moral theories.[108]

Several studies show that Dewey's pragmatist turn to morality is substantial in the study of bioethics. His pragmatic ethical inquiry method is mainly an imperative to provide workable solutions for bioethical problems appearing in different contexts.[109] Tollefsen claims that the bridge between classic pragmatism and bioethics made in recent years is promising, despite some perils inherent in Rorty's approach to anti-

[107] 166-169.
[108] Inid, 174-77.
[109] Arras, Pragmatism in Bioethics, 40; Eric Racine, Feature, 2; Giulia Inguaggiato et al., A Pragmatist approach, 428; Miller, Fins, and Bacchetta, Clinical Pragmatism, 28; Miller, A Pragmatic Health Care Policy, 47; Tollefsen, What Would John Dewey Do, 77; Hester, Is Pragmatism Well-Suited, 546.

realism in ethics and the good.[110] Inguaggiato and his colleagues also take the example of clinical ethics, and they argue about the difficulty of answering problems of clinical ethics consultation within pre-given rules and principles of traditional ethics. They claim that an approach that stands on pre-given principles disregards the situational dynamics and plurality of different societies and their diverse backgrounds. Instead, they argue in defense of the pragmatist turn in bioethics as valuable for clinical ethics support (CES). Inguaggiato and his colleagues list the following four elements of pragmatist ethics: 1) moving our attention from theory to the solution of a real practical problem, 2) avoiding dogmas, 3) focusing on the cash value of our morals and institutions, and 4) striving for intersubjective solutions. These elements suggest a "dilemma method" based on facilitating moral case deliberation as a mechanism to solve clinical ethical problems.[111] Miller and his colleagues also claim that Dewey's approach to pragmatic experimentalism in ethics is essential to approaching health care and clinical ethics. They also argue that his ethical inquiry method is indispensable to finding workable moral solutions with the consideration of context.[112] Moreover, Irwin Miller says Dewey's perspective on democratic community, the analysis of social frames in "view-of-the-end" and "social experimentalism" are valuable in the study of public policy and health care.[113]

In the subsequent sections of this chapter, I identify the necessary steps and frameworks in the ethical inquiry method and pragmatist bioethics and show its application to a particular gestational surrogacy case. Based on this method, I examine the ethical-legal problems related to surrogacy, raised basic principles, hypotheses, facts, and arguments both in defense of and against gestational surrogacy, and reflected on possible pragmatist solutions. In the final part, I show the significance of Dewey's emphasis on education, deliberative democracy, and the role of institutions as the basis for solving bioethical problems arising in different contexts.

[110] Tollefsen, What Would John Dewey, 77.
[111] Inguaggiato et al., A Pragmatist Approach, 428.
[112] Miller, Fins, and Bacchetta, Clinical Pragmatism, 28.
[113] Miller, A Pragmatic Health Care, 48-50.

3.2 Dewey's Pragmatic Ethical Inquiry Method and Recent Developments in Pragmatist Bioethics

Dewey relates ethics to the mode of inquiry in general. He reconstructed morality in light of empirical science, providing the necessary steps for pragmatic ethical investigations. Recent studies on bioethics methods also show that Dewey's ethical inquiry method is relevant to analyze bioethics' epistemology and the nature of ethical judgments and solutions. Furthermore, Dewey's inquiry method is a practical or instrumental experimental inquiry method that integrates science and ethics. It's said that Dewey's method of integrating ideas came from the influence of Hegel, Peirce, and Darwin.[114]

Dewey suggests that when the consciousness of science is thoroughly impregnated with the consciousness of human value, the split between material and moral, and the division between science and ethics, will be destroyed. In this case, the distinction between naturalism and humanism will be avoided and seen on similar epistemic ground.[115] Dewey redefines science from a body of knowledge to a more practical scientific method. He defined science as the dynamic activities of observing, describing, comparing, inferring, experimenting, and testing in order to find a solution to a perceived problem. Dewey conceptualizes 'scientific' as a "traditional method of controlling the formation of judgments about some subject-matter."[116] Thus, for Dewey, to have a scientific attitude toward the problem detected is to have a critical or inquiring and testing attitude regarding challenging situations. From the logic of judgment, it is the capacity to accept a statement as a conclusion with a critical understanding of the underlying premises or statements. In short, Dewey defines a scientific attitude as a search for the antecedent of the consequent.[117]

Dewey observed that judgment in science is not independent and detached; instead, it is a unified system within which every statement guides us to make other assertions. Dewey thought of science as an activity

[114] Miller, Fins, and Bacchetta, Clinical Pragmatism, 29-32
[115] Dewey, *Reconstruction in Philosophy*. 173.
[116] John Dewey, *Problems of Men* (New York: Philosophical Liberary, 1946), 212.
[117] Ibid, 216.

to build an order of judgments in which each one helps decide the next one.[118] Like judgments in science, moral judgment is governed by the same inquiry process and order of judgments. As Dewey claims, in a situation in which the distinction between science and ethics is destroyed, anything that is thought to be a problem in a given situation is intelligently sought through validation, demonstration, and experimentation. Every moral situation is unique, as a given moral problem arises in a specific temporal and spatial situation. That is why Dewey argues that the weight of the valuation of moral situations does not rest on universal principles but on our intelligent understanding of a problematic situation based on evidence and the ability to transform the situation and reconstruct it with a more satisfactory moral solution.[119] For the classic pragmatists such as William James and Dewey, human life and its struggle are marked by two basic categories: experience and intelligence. As Tollefsen shows, in Dewey's sense, experience helps us understand our existence, and intelligent inquiry helps us change our situation and rebuild it with a better experience.[120] Dewey analyzes intelligence in terms of inquiry. In general, Dewey's inquiry method consists of the following steps: observation of the situation's detailed makeup, analysis of its various factors, clarification of what is obscure, discounting of the most insistent and vivid traits, tracing the consequences of various modes of action that suggest themselves, and treating the decision reached as a tentative hypothesis until the supposed consequence is squared with the actual consequence.[121]

The moral question arises in the context of a specific problematic situation. It arises when the prevailing system does not adequately answer the problem, or some kind of deficiency or evil exists in the situation. As Dewey claims, every moral problem is unique since it arises in a specific context. As a result, every unique problem has a distinctive solution, or it has a particular good. A new problem in a new situation doesn't need to be solved by the same judgments and pre-existing moral principles that have already been used to solve previous problems. This new problem needs a new solution. However, this does not mean

[118] Ibid, 217-29.
[119] Dewey, Reconstruction in Philosophy, 169-78.
[120] Tollefsen, What Would John Dewey Do, 81.
[121] Dewey, Reconstruction in Philosophy, 164.

previous moral judgment or moral experience is irrelevant to solving the present issue. Instead, as Dewey claims, during moral judgment about a particular problematic situation, pre-given moral principles or previous judgments can serve as a hypothesis for the intelligent inquiry of a unique moral problem. Morals, Dewey believes, are not a catalog of acts or rules to be used like drug store prescriptions; instead, they need a specific inquiry method to locate the difficulties and evils and solve them with concerted deliberations.[122] Rules and principles in ethics are not decisive and final; they have the working hypothesis's logical status to solve the problematic situation. Traditional rules and principles endure so long as they help address the problematic situation of the time. The test of moral rules begins whenever there is a situation of moral uncertainty.[123]

As Miller and his colleagues argue, Dewey's ethical inquiry method is an instrument of human adaptation in social environments. As a method, it is directed at problem-solving in a given social context in which associated human agents are concerned about evaluating conduct as good or right and figuring out solutions through openness to deliberation. The ethical inquiry uses intelligent thought to solve problems arising in humans' interactions with the environment. For Dewey, the process of finding an everlasting solution to ethics is impossible, but inquiry arrests moral responses and surveys the problematic situation for a better solution. Hence, intelligent inquiry frees humans from instinctual and abstract solutions and takes them to another level of consciously looking for the best solutions. This intelligent inquiry or problem-solving activity is part of the problem-solving activity in our everyday life such as in professional work, and experimental and theoretical science.[124] Irwin Miller outlines Dewey's method of social reconstruction and ethical inquiry method in six steps: critical discontent with the problem, fact-finding, problem identification, option suggestion, the publicity of problems and proposed solutions, reasoned deliberation, and finally, putting into action the selected option.[125] In the book How We Think, Dewey listed these steps as: a) figuring out what is bothering you, b) finding the problem, c) coming up

[122] Ibid, 169-70.
[123] Miller, Fins, and Bacchetta, Clinical Pragmatism, 39-41.
[124] Ibid, 32-5.
[125] Miller, A Pragmatic Health Care, 53-5.

with possible solutions, d) debating them, and e) more observation and experimentation, which leads to whether or not you accept or reject the idea.[126] For Dewey, moral problems are part of social policy issues. Any social policy does not come into existence as fully formed; instead, it results from evolution, a social inquiry with face-to-face dialogue in the local communities' forums. Likewise, moral judgments and moral decisions are the results of social intelligence in which solutions to felt moral difficulties are figured out through concerted dialogues with multiple agents.[127]

In their recent study, Inguaggiato and his colleagues have also developed further Dewey's steps of ethical inquiry and pragmatist bioethics into clinical ethics settings in the form of a moral case deliberation system (MDCS). In the study, they identified MDCS in nine steps: recognition of the particular issue; presentation of the case or facts or experiences; articulation of moral dilemma in either A or B choices; identification of possible adverse effects of either choice by participants; clarifying the details of the cases with further doubts coming from the presenters and stakeholders; analysis of values and views by giving cash value; looking for alternatives by creatively rethinking the situation; dialogical inquiry or intersubjective understanding and consensus; and finally, setting the final solution and putting them in action.[128] Furthermore, based on Dewey's ethical inquiry method and other pragmatist bioethics methods, several studies in this area have identified various categories and frameworks of pragmatist bioethical inquiry. For example, given the bioethical issue under investigation, considering the societies' rules, practices, customs, and habits regarding the problem is essential. This background context is critical to undertaking moral experiments. However, there are also other substantial things to consider while examining a moral problem at hand from the pragmatist perspective. For instance, the participants and stakeholders involved in the ethical deliberation, the rules and responsibilities related to specific roles of the agent at the time, the claims of other stakeholders about those agents, and the maxim developed out of

[126] John Dewey, quoted in Miller, Fins, and Bacchetta, Clinical Pragmatism, 33; see alsoJohn Dewey *How We Think: A Restament of the Relation of Reflective Thinking to the Educative Process* (D.C. Health and company: Lexington, Massachusetts: 1933), 107-115.
[127] John Dewey, *The Public and Its Problems* (Denver: Alan Sallow, 1954), 143-172.
[128] Inguaggiato et al., A Pragmatist Approach, 431-35.

the previous moral judgments of agents' habits are essential in the process of ethical inquiry. Measurement of the effects of different solutions, including the effects that are mediated, is also important in bioethical discussions and investigations to find the best solution for a specific problem.[129] Thus, in the next section, I use those fundamental steps and frameworks mentioned in the previous chapter to analyze the moral dilemma of gestational surrogacy as a public policy ethical challenge in different societies.

3.3 The Case of Gestational Surrogacy

Modern advances in reproductive technology and genetics have enabled infertile couples to conceive through a variety of medication techniques and third-party reproduction agreements. The medication techniques include lifestyle modifications, medical/surgical treatment of underlying conditions, and fertility medications through assisted reproductive technologies (ARTs). Common ARTs include intrauterine insemination (IUI), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), ovulation induction (OI), artificial insemination (AI), donor conception, intrafallopian gamete transfer (GIFT), and preimplantation genetic diagnosis and screening (PGD & PGS).[130] Most ARTs use third-party arrangement techniques such as the use of sperm donors, egg donors, embryo donors, embryo transfer, and surrogacy arrangements.[131] Depending on the kind of disease, patients make third-party agreements using one or two arrangement techniques. A patient with an infertile egg, for example, may use an egg-donor arrangement technique to become pregnant; however, male same-sex couples must make additional third-party arrangements for natural or gestational surrogacy agreements.

In addition to surrogacy options, modern surgical transplants have also provided uterus transplantation as an option for women with no uterus or an abnormal uterus. The recent advance in the bioengineered uterus is also the future option for reproductive medications. Patients' choice of ARTs depends on their

[129] Cooley, Une Approche, 275; see also Holmes RL. *Basic Moral Philosophy*, (Belmont: Thomson Wadsworth; 2003); Hester, Is Pragmatism Well-Suited, 549-50.

[130] The American Society for Reptoductive medicien, "Third-Party Reproduction Sperm, Egg, and Embryo Donation and Surrogacy," 2018, 3-14, https://www.reproductivefacts. org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact- sheets-and-info-booklets/third-party_reproduction_booklet_web.pdf.; see also Alexa A. Nardelli et al., "Assisted Reproductive Technologies (ARTs): Evaluation of Evidence to Support Public Policy Development," *Reproductive Health* 11, no. 1 (2014), 1-14

[131] James M Goldfarb, *Third-Party Reproduction: A Comprehensive Guide* (New York: Springer, 2014), Vii; see also The American Society for Reptoductive medicien, Third-Party Reproduction, 3-17.

infertility conditions, the safety and efficacy of the technique, and treatment availability. For example, a patient who cannot carry a baby because of no uterus or an abnormal uterus may choose gestational carrier arrangements. If a couple wants to have a baby from their gametes, the patient will undergo the IVF medication process. Other techniques, such as preimplantation genetic diagnosis and screening (PGD & PGS), or embryo freezing, may be conducted to increase the chance of fertility, check the genetic balance and hereditary diseases, and choose the sex of the baby. The common ethical problems raised against reproductive technologies are the moral issues underlying assisted reproductive medication therapy and third-party arrangements. For instance, in the case of medication of a patient with no uterus or an abnormal uterus who wants to have a baby, ethical issues related to PGD and PGS tests such as the choice of the sex of the baby, genetic modifications, the disposal of excess embryos retrieved during the process, the expensiveness of the medical service, insurance coverage of the medication, and other issues might be raised. Some ethical issues about surrogate motherhood are discussed in terms of third-party arrangements. Surrogate mothers can be exploited, and vulnerable people can be exploited. The best interests of the child are also discussed. Brokers and fertility clinics are also discussed.[132] Thus, ethical issues raised against ARTs and third-party arrangements are not straightforwardly a single moral problem, as a single case contains multilayered problems. Similarly, there are many different moral questions about gestational surrogacy, related to different ARTs being used.

These days, gestational surrogacy's ethical issue is becoming an issue in every society worldwide as a newly public policy dilemma or as a specific case-based moral problem where it is already legal. In Australia, Israel, Canada, and some states in the USA, including California, the UK, Belgium, Greece, South Africa, India, Ukraine, Russia, and Iran, surrogacy is permitted or not banned legally. However, the recent advances in reproductive technologies worldwide have also made gestational surrogacy a new ethical problem for other countries in the global south. In both situations, Dewey's pragmatist inquiry

[132] Elizabeth S. Anderson, "Is Women's Labor a Commodity?," *Philosophy & Public Affairs* 19, no. 1 (1990), 71-92; I. Glenn Cohen and Eli Y. Adashi, "Made-to-Order Embryos for Sale - A Brave New World?," *New England Journal of Medicine* 368, no. 26 (2013) 2517-19; Kavita Shah. A, "The Ethics of Hiring a Gestational Carrier," in Third-Party Reproduction: A Comprehensive Guide, ed. James M Goldfarb (New York: Springer, 2014), 85-92.

method and recent pragmatic bioethics methods are vital to effectively understanding the problem and figuring out ways to come up with solutions. As I stated earlier in this paper, the first step in Dewey's ethical inquiry method and pragmatic bioethics, in general, is the identification of the problem, the felt difficulty, or the recognition of the concrete problematic situation. This step is about becoming cognizant of a problem in a particular society that needs a solution/s. In the case of this study, the problem is gestational surrogacy as an ethical or moral challenge to public policy. The problem may arise in a concrete situation in the clinical setting, or it may arise as a challenge to a particular society's existing social public policy. In either way, the felt difficulty—the ethical issues associated with surrogacy—is diagnosed into various strands of moral problems. To better understand the felt difficulty or the problematic situation related to surrogacy from Dewey and pragmatist bioethical inquiry, it is vital to see in light of real case scenarios or past experiences of the problem. For this purpose, I have chosen the two typical cases: Anna Johnson versus Mark Calvert (1993) and Robinson versus Hollingsworth (2005) in the USA, and the case of transnational surrogacy in India.

The case of Anna Johnson versus Mark Calvert is a 1993 California Supreme Court case (1993) between Anna Johnson and the Calvert family in California State. The case happened after the IVF technique's advent as the best option for infertile couples to have a baby, yet the legal and ethical issues were not clearly stated in California State or the USA. Mark and Crispina Calvert are couples who wanted to have a baby. Crispina Calvert was able to produce eggs but was unable to carry a baby. Anna Johnson heard about this case and agreed to offer a surrogacy service for the Calverts. On January 15, 1990, Mark, Crispina, and Anna signed an agreement that an embryo created from the sperm of Mark and the egg of Crispina would be implanted in Anna and carry the baby. In the agreement, in return for the service, the Calverts pay Anna $10,000 in a series of installments, the last to be paid six weeks after the child's birth, and another $20,000 in life insurance. Based on the agreement, the implantation was done, and Anna got pregnant as planned. As time went by, however, the relationship deteriorated between the two sides. Anna complained about the abandonment during pregnancy and complained that she did not get enough

insurance. In July 1990, Anna sent to Mark and Crispina a letter demanding the balance of the payments or else she would refuse to give up parenthood rights. In between, the Calverts took the case to the California Supreme Court for a lawsuit seeking a declaration that they are the unborn child's legal parents. In the process, the child was born on September 19, 1990; in the meantime, the court's blood test excluded Anna as a genetic parent. Finally, the court decided parenthood rights for the Calvert family and visitation rights for Anna, a gestational mother. Genetic testing was the court's essential criterion for deciding in favor of the Calvert family.[133]

The case of Robinson versus Hollingsworth (2006) is different from the former case in terms of its context of appearance and third-party arrangement style. Donald Robinson and Sean Hollingsworth are married same-sex male couples who wanted to have a child. they decided to seek a surrogate mother, and the woman they found close to them was Robinson's sister, Angela Robinson. Angela moved from another city to New Jersey to live near her brother, Donald Robinson, in New Jersey. Finally, Angela decided to carry their baby as a gestational carrier and signed a contract with Sean Hollingsworth to relinquish her parental rights to her brother and husband after birth. Based on the agreement, Sean Hollingsworth provided the sperm, and an anonymous donor supplied the egg from the infertility clinic. The process of pregnancy was successful, and Angela Robinson gave birth to twin girls in 2006. In the meantime, however, Angela Robinson complained that she was coerced to sign the agreement, and she felt uncomfortable with raising the children with a same-sexual couple due to her religious belief. Then, she sought custody of the children and challenged the contract in court, saying that their agreement was invalid. However, while the court claims the surrogate mother has a legal parenthood right to the children, based on the principle of the "best interest of the child," the Superior Court of New Jersey (2006) decided to give the father full legal custody in 2011.[134]

[133] The Supreme Court of California, *Johnson v. Calvert*, (1993), https://law.justia. com/cases/california/supreme-court/4th/5/84.html.
[134] The Superior Court of New Jersey, *Robinson v. Hollingsworth*, 2006; https://cases.justia. com/federal/district-courts/new jersey/njdce/1:2013cv00101/283596/5/0.pdf?ts= 1411592738.

The other case that would present the felt difficulty of the moral problematics of surrogacy beyond the "context" in the USA at a more international level is transnational surrogacy. In the last three decades, advances in health technology and the globalization of health-related practices have contributed to the progressive expansion of international health tourism. Transnational surrogacy is a new phenomenon that has become common in recent years in many developing countries. A commercial transaction takes place between a gestational surrogate who lives in another country, typically a low- or middle-income country, and another contracting patient, who is usually from a high-income country. People from countries such as Israel, Australia, Canada, Mexico, Denmark, France, Germany, and China travel to other countries for commercial surrogacy arrangements. In this regard, even though it is illegal since 2019, India is the commercial surrogacy hub, attracting many visitors from high-income countries. Reports in 2015 indicate that more than 25,000 children are thought to have been born through surrogacy in India. More than half of them are for foreign parents.[135] A search for superior medical expertise, low-cost surrogacy, and finding legal permission in other countries are reasons which motivate the couple to search for a surrogate in another country or jurisdiction.[136] However, when we look at India's case, low-cost surrogate mothers are the primary factor motivating patients from high-income countries to travel to India for surrogacy services.

The USA's and India's earlier cases give us a clear picture of gestational surrogacy's legal and moral problematics. For this study, those cases provide us with clues to the steps in Dewey's ethical inquiry method and recent methods of pragmatic bioethics. Specifically, it gives a chance to locate and define the felt problem by presenting facts or experiences without sticking to abstractions or theories. This step helps articulate the moral dilemma into either A or B choices for the pragmatic inquiry's next step.

[135] Virginie Rozée, Sayeed Unisa, Élise de La Rochebrochard, "Gestational Surrogacy in India," *Population and Societies* 537, no. 9 (2016), 2.
[136] Ari Z. Zivotofsky and John D. Loike, "Cultural Influences on Transnational Gestational Surrogacy," *American Journal of Bioethics* 14, no. 5 (2014), 44-46; see also Jeffrey Kirby, "Transnational Gestational Surrogacy: Does It Have to Be Exploitative?," *American Journal of Bioethics* 14, no. 5 (2014), 24–32

In actuality, there are two kinds of surrogacy arrangements: traditional surrogacy and gestational surrogacy. Traditional surrogacy is the oldest arrangement in ART, in which a surrogate woman who carries the baby is genetically related; the egg is from the surrogate mother. Artificial insemination (AI) of male sperm is the most commonly used method to get pregnant. However, in gestational surrogacy, the surrogate woman is not genetically related to the baby. In this case, IVF techniques are used for the surrogate mother to carry a baby. Women with no uterus, abnormal uterus, recurrent miscarriage, failed IVF embryo implantation, women with poor obstetrical history (OB), and same-sex couples choose either of the gestational agreements to have a baby.[137] Depending on the type of disease, gestational carrier arrangements may be combined with other third-party arrangements like embryo donations, sperm donors, and egg donors. Moreover, unlike traditional surrogacy, gestational surrogacy needs long treatment cycles and medication procedures to impregnate the woman and avoid multiple pregnancies. Genetic testing during the middle of the pregnancy and selective fetal reduction through continued genetic testing are also done to check the baby's health status and avoid twin pregnancies. Gestational carrier arrangements are made through the involvement of different infertility agencies, clinics, families and friends, the surrogate women, the clinic, the physician, and possibly the lawyer as a legal advisor. All of these arrangements are made to help couples realize their ambition of having a child, and the surrogate woman is compensated for her services. Another factor is the infertility clinic's economic motive, which is part of the deal in the surrogacy arrangements.

Given the earlier facts and experience of surrogacy, we may raise ethical and legal problems and opportunities. The following are the major ethical issues surrounding surrogacy: the moral status of the surrogate mother; the interest and parenthood of the child; the societal culture and public interest; the natural desire of the infertile couple (or a single mom or dad) to have a baby and enjoy the happiness of procreation; the ethical appropriateness of the ARTs. Thus, the presentation of facts, observations, and experiences of the problem allows us to articulate the moral dilemma and available choices in the form of

[137] Goldfarb, Third-Party Reproduction, 63.

either A or B choices. Based on Dewey's pragmatic inquiry method, this is the third step of ethical inquiry. In this step, surrogacy's broader moral and legal dilemma is raised and scrutinized by presenting basic principles, hypotheses, and facts supporting or against gestational surrogacy. Here, as Dewey claims, ethical principles and theories have the status of hypotheses, which aids in deeply understanding the moral dilemma and, in the end, to come up with possible solutions. Now let us see some arguments against and in defense of surrogacy and revisit different societies' cultural and legal attitudes. These arguments are essential to show how Dewey's method and its recent developments are vital to addressing gestation surrogacy as a moral challenge to public policy or guiding decision-making at the clinical level.

As I claimed earlier in this chapter, in Dewey's approach to ethics and the pragmatist ethical inquiry method, ethical investigations, deliberations, and decisions depend on social intelligence. In the process of ethical judgment, the various viewpoints of agents, stakeholders, individuals, and groups are challenged, scrutinized, and accepted or denied through concerted discussions. Similarly, the morality of gestational surrogacy as a new societal challenge or as a particular case in a social system where it is already legal cannot be decided through theoretical abstraction in a monological way. Instead, it should be presented to public scrutiny through dialogues with multiple agents in the public space. As a new challenge for society, the problem may be presented for deliberation on whether gestational surrogacy should be permitted or not in "Y" state or society. In the context where gestational surrogacy is legal, particular moral cases may be a challenge for moral deliberation either in clinical or court cases. For instance, in the clinical setting, the denial and acceptance of the application of "X" patient in need of the service of surrogacy, the compensation of the surrogate mother, the equity of the service, and the vulnerability of the poor and disadvantaged section of society might be raised for moral deliberation. In pragmatist ethical inquiry and Dewey's approach to ethics, such kinds of problems are not decided by individuals alone or by a single institution; instead, they need "social individuals" of various viewpoints to come to a table and negotiate about the "good" with consideration of the context and the future growth of the whole society as the moral end. Notably, it needs experimentation through publicity and vitality.

The demand for surrogacy and the associated moral problems have become pressing social problems for many countries. Established social orders may not always be feasible to answer emerging problems related to medical options at the time. That is why surrogacy cases are arising in different countries and challenging the established order of reproduction. Thus, revising the social order by devising a new form of social policy against the accepted order may be at the front door of every country. Surprisingly, a study by Agarwal et al. indicates that infertility affects an estimated 15% of couples globally; males account for 20–30% of infertility cases; the remaining 70%–80% of cases are related to females.[138] Surrogacy services and arrangements are required for the majority of patients who require ARTs and third-party arrangements.[139] Given the number of patients affected by infertility and other reasons, in the pragmatic ethical inquiry under the third step, surrogacy arrangements can be raised as beneficial. In this regard, many reasons may be raised in defense of surrogacy's being permitted under certain conditions and setting it as a social policy option with institutional flexibility.

For the purpose of this study, I have raised the major arguments mentioned by both camps. The aim is not to argue for or against gestational surrogacy, but to show the relevance of pragmatist bioethics for ethical deliberation. Especially in the ethical and legal debates concerning surrogacy, those who support surrogate motherhood raise four main arguments in defense of rightness and permissibility. Concerning Dewey's approach to ethics, these arguments are presented for discussion in the process of public deliberation. The first argument in defense of surrogacy is related to the shortage of children available for adoption and the difficulty of qualifying as adoptive parents. In this case, both gestational and traditional surrogacy may give some couples a chance to raise a family. The second main argument is related to human rights. Significantly, some liberal feminists claim that surrogacy arrangements, either voluntary or commercial, protect the right to procreate and freedom of contract as autonomous beings to use one's

[138] Ashok Agarwal et al., "A Unique View on Male Infertility around the Globe," *Reproductive Biology and Endocrinology* 13, no. 1 (2015), 1.
[139] Nayana Hitesh Patel, Yuvraj Digvijaysingh Jadeja, Harsha Karsan Bhadarka, Molina Niket Patel, Niket Hitesh Patel, and Nilofar Rahematkhan Sodagar, "Insight into Different Aspects of Surrogacy Practices," *Journal of Human Reproductive Sciences* 3, no. 11 (2018), 212.

bodies and the reproduction of children without harming children. This argument is often associated with women's reproductive autonomy who cannot become pregnant or successfully carry pregnancies. The idea is further extended to the claim that denying surrogacy is like denying women the happiness of procreation, which is natural.

When technology is available, one might say that a woman has the right to use her body in any way that does not hurt anyone else.[140] Further, reproductive liberty can be argued to be both a constitutionally protected right based on privacy and an ethical imperative due to its unique place in an individual's meaning, dignity, and identity. Thus, in a more liberal political sense, we may claim that if it does not harm the baby or the surrogate mother, having a baby through a surrogate arrangement may fulfill reproductive autonomy.[141] The third argument is related to the labor of the surrogate mother. Some surrogacy supporters claim that the surrogate mother's labor is an expression of love, a kind of philanthropic activity in which a woman gives to the infertile couple the joy and happiness of having a baby. For radical liberal feminists, women's labor service extends to women's freedom to contract for labor and use of their bodies. These theorists associate surrogacy more with the commodification and selling of labor than with an altruistic impulse. The final defense of surrogacy, especially commercial surrogacy, is related to the surrogacy analogy with other third-party reproduction arrangements and social parenting. The claim is that commercial surrogacy is not different from other methods of assisted reproduction, such as egg donation, sperm donation, and social parenting, such as adoption, wet-nursing, and daycare. Thus, based on the view of liberal feminists, in a system where these methods are accepted as moral and legal, one may claim that gestational surrogacy should be permitted as moral.

Although surrogacy seems beneficial to all parties, there are complex social, ethical, moral, and legal-cultural issues.[142] Thus, in pragmatist ethical inquiry, a social policy option that prohibits surrogacy is

[140] Anderson, Women's Labor, 74.
[141] Kavita Shah. A, The Ethics of Hiring, 86-87.
[142] Anderson, Women's Labor, 71-92; see also Zivotofsky and Loike, Cultural Influences, 44-46; see also Akande Michael Aina, "An African Perspective on Surrogacy and the Justification of Motherhood," *Bangladish Journal of Bioethics* 8, no. 3 (2017): 18–25; Nayana Hitesh Patel *et al*, Insight into Different Aspects of Surrogacy,217.

presented as the second alternative for ethical deliberation. In this case, one can raise various objections against surrogacy, partly due to ethical and partly due to legal problems. These problems are sparked by the debates regarding the appropriateness of surrogacy, both its means and its end. These ethical and legal concerns are thematized in terms of ethical principles. Autonomy, or reproductive autonomy, is the first principle and objection against surrogacy. Critics suggest that reproduction, by its nature, is relational and social as it introduces the relationship between parents, a child, and a society. Thus, reproduction and surrogacy are not personal issues, nor can they be understood in terms of private autonomy; rather, they are seen through a social lens.[143] Pregnancy and childbirth are social events, and family value is appreciated, and the bond between the mother and child is established during pregnancy. In this case might be against the social system. It may be argued as a system that destroys the natural love and relationship between the mother and the child.

The strongest objection raised against gestational surrogacy is the one Anderson calls the "commodification argument." Anderson claims that the voluntary surrogate mother's boundary is being replaced by commercial surrogate motherhood for the past few years. She claims that commercial surrogacy and the commodification of women's labor present women and their reproductive abilities (including the child) as objects to be commoditized with the market values set by the intended parents and the broker. Anderson further claims that surrogate arrangements invade mothers' natural labor and degrade the value of being a mother.[144] In the surrogate arrangement, contracting couples value a child more than the gestational carrier. The gestational mother's body is treated as property, restrictions such as diet and exercise are controlled, and her behavior is strictly regulated during pregnancy.[145] Surrogacy commercialization primarily degrades children by reducing their status to commodities.[146]

The other objection raised is that the surrogate mother's payment is decided by the intended baby's price value rather than the women's surrogacy service. This critique further connects baby-selling with

[143] Kavita Shah. A, The Ethics of Hiring 86-7.
[144] Anderson, Women's Labor, 75.
[145] Kavita Shah. A, The Ethics of Hiring, 87.
[146] Anderson, Women's Labor, 75-80.

gestational surrogacy.[147] The other criticism raised against gestational surrogacy is that gestational arrangement exploits women's labor, especially those with lower socio-economic status. In this regard, studies indicate that in surrogate arrangements and embryo selling, the poor and low-income sections of society are exposed to exploitation, coercion, injustice, and other related physical, social, and psychological problems.[148] Studies shows that the recent rise in transnational surrogacy is exploitative, which puts women in low-income countries at risk.[149] Women undergoing surrogacy face both physical and psychological burdens. IVF surrogacy medications result in hormonal manipulation to synchronize the commissioning woman's and the surrogate woman's menstrual cycles and prepare the surrogacy. Different medicinal therapies and minor surgical processes conducted to implant the embryo also cause problems for the surrogate mother's physical health. Living arrangements, including restrictions on sexual intercourse, restrictions during pregnancy, and limited family interactions, result in psychological health problems for the surrogate mother. Women undergoing surrogacy also face social stigma by equating them with sex-workers.[150]

The other criticism that would be raised from the angle of ethics and the law is that surrogacy distorts the traditional understanding of parental rights into something more like property rights.[151] In legal terms, in the case of surrogacy, parental rights, which are traditionally decided by legal and biological parenthood, would become a problem with the gestational mother's parental rights. Further, kinship relationships with a child born in surrogacy are also a contending issue.[152] For instance, in India, kinship is transferred with blood and labor, and a child born through a gestational arrangement can have a kinship relationship with

[147] Ibid; Kavita Shah. A, The Ethics of Hiring, 87-8.
[148] Cohen and Adashi, Made-to-Order Embryos, 2517-18.
[149] Jeffrey Kirby, "Transnational Gestational Surrogacy: Does It Have to Be Exploitative?," *American Journal of Bioethics* 14, no. 5 (2014), 24.
[150] Ibid, 28; see also Cohen and Adashi, Made-to-Order Embryos, 2517-2519
[151] Anderson, Women's Labor, 76.
[152] Hal B. Levine, "gestational Surrogacy : Nature and Culture in Kinship, *Ethnology*, 42, no. 3 (2013), 173.

the gestational mother. Undue inducement through big money, coercion in payment, and less compensation are also raised as objections against gestational surrogacy.[153]

Based on Dewey's ethics and pragmatist bioethics, the support and objections raised above regarding gestational surrogacy are expected to be forwarded in the course of ethical deliberation. We would raise those arguments to put gestational surrogacy in the form of "either A or B" options for further dialogue. In this regard, surrogacy's permission with clearly stated codes of ethics, laws, and public policy may be considered the first option. Alternatively, depending on the context where the moral problems arise, complete prohibition of surrogacy with strict moral and legal control of infertility medications, infertility clinics, brokers, and surrogacy tourists may be presented as the second alternative for ethical deliberation. To minimize ethical-legal problems and risks raised by the supporters of the second option, other options such as, giving the surrogate mother the option of keeping the child after birth, imposing stringent regulations on private surrogate agencies, or replacing private surrogate agencies with a state-run monopoly on surrogate arrangements may be suggested in the course of ethical deliberation. In fact, the first option may be suggested as a possible ethical solution, especially in a country where surrogacy is legal, medication options are already available, and society's cultural values accept gestational surrogacy. Also, other particular issues like individual cases of patients in the clinical setting, exploitation of the poor, equitability of access to the service, and other related issues concerning the baby's rights and interests may be put for deliberation. During deliberation, legal and public policy solutions would be presented for further examination by various agents, stakeholders, professionals, and the community. In the case of contexts where transnational surrogacy is a challenge, restricting medical visitors, greater international regulation, and oversight,[154] public education and enabling choice, enhanced protections, and empowerment reforms of society as a whole and those who are exposed to surrogacy[155] may be suggested as alternatives for further discussions. However, the second option may be suggested if the medical

[153] Kavita Shah. A, The Ethics of Hiring, 88-89.
[154] Zivotofsky and Loike, Cultural Influences, 45.
[155] Kirby, Transnational Gestational Surrogacy, 24.

context does not allow surrogacy or if surrogacy activity contradicts the cultural value of a society's cultural-legal systems.

As I presented earlier in this chapter, after presenting solutions and alternatives in the fourth and fifth steps of pragmatic ethical inquiry, problems and suggested solutions are publicized to the general public. In particular, the fourth step helps to clarify the details of the cases with further doubts coming from different sections of society. Regarding gestational surrogacy, the suggestions of various stakeholders, such as agents, patients, experts, physicians, cultural and religious groups, lawyers, ethical experts, policymakers, and the general public, will be consulted. At these steps, suggested solutions will be tested by publicizing them, and we will consider other alternative solutions coming from stakeholders, agents, and the general public. Social experimentation is useful to identify which solution best fits the context. As Miller claims, a community is a result of long years of experimentation in which people living together explore its possibilities via full participation, publicity, and institutionalization. Dewey also believes that social experimentation uses collective intelligence to advance collective efficacies and enhance individuals' capacities.[156] Dewey also believes that social experimentation uses collective intelligence to advance collective efficacies and enhance individuals' capacity.[157]

Experimenting with suggested solutions in light of the cultural context, religious beliefs, and value system is critical during ethical deliberation in order to find the best solution that can be implemented in society. Different cultures have different views regarding procreation, family, and parenthood thought systems. This thought system affects ethical decisions and judgments concerning gestational surrogacy. For example, studies indicate that in West Africa, especially in the Yoruba community's culture in Nigeria, their ontological belief about life, motherhood, and personhood does not permit gestational surrogacy. Concerning parenthood, birth, and a relationship with a child in Yoruba, it is understood in terms of the blood and womb. For example, contrary to a society where parenthood is established based on genetics, in Yoruba, the child's ownership and parental rights born through surrogacy go to the surrogate mother, not

[156] Miller, A Pragmatic Health Care Policy, 48.
[157] Dewey, Reconstruction in Philosophy, 209.

the commissioning families. People in Yoruba communities don not like the idea of gestational surrogacy because of the childbirth and naming ceremonies and other blood-smearing ceremonies that go along with those events.[158] Likewise, the Catholic Church opposes gestational surrogacy, claiming that it contradicts the biblical rules about birth, marriage, and life. However, in Judaism, procreation is highly valued, and so long as it does not contradict the biblical commandments, surrogacy is allowed. In this regard, Methods of ARTs including in vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI)) are considered acceptable.[159]

As Dewey remarks, the community is always evolving, and the culture is always subject to change and dynamism. Emerging science and technologies challenge the accepted standards and norms, and each generation may ask different questions to which the age-old culture might not effectively answer. In this case, following the context-sensitive approach of ethical deliberation and addressing the emerging problem in-view-of society's growth as an end is vital for the continuance of a community or a nation. As Dewey claims, social frameworks and social policy options are guided by the projection of end of a society. The end, as he argues, arises in the function of actions. Ends are not inert or something that exists outside of actions; rather, they are the result of long-term experimentation activities.[160] Likewise, the moral judgement regarding gestational surrogacy is subject to context and situation, which is based on the calculation of consequences of choices.

When making moral judgments, when there is no experience to quantify the consequence, an imaginative calculation of the likely consequence is useful to decide the best option among alternatives. During moral judgments, when there is no experience to quantify the consequence, imaginative calculation of the likely consequence is useful to decide the best option among alternatives. At the fifth step of pragmatic ethical inquiry, we, therefore, look for alternatives by creatively rethinking the situation and publicizing it. Then we give cash-value for the values and views of different stakeholders and agents.

[158] Akande Michael Aina, "An African Perspective on Surrogacy and the Justification of Motherhood," *Bangladish Journal of Bioethics* 8, no. 3 (2017), 18-25.
[159] Zivotofsky and Loike, Cultural Influences, 44-5.
[160] Dewey, The Public and Its Problems, 206-11.

Different alternatives other than formerly announced alternatives would be entertained, and individual values and choices considered. Their value is measured in terms of means to achieve and the ends to gain.[161]

As Dewey claims, no social policy comes into existence as fully formed; instead, it is a result of evolution. In a democratic society, social policies result from social inquiry by face-to-face dialogue in the local community forums.[162] Thus, in a pragmatic ethical inquiry, different views and values are put on the table; their similarity and differences are highlighted, and the best solution will be sought through intersubjective understanding and acknowledgment of all participants. This step takes us to the final step of pragmatic ethical inquiry, in which the agreed solution or conclusion is put into action. To reach a conclusion or solution and make it practical, as Dewey claims, the role of education, democracy, and institutions is paramount. Of course, pragmatic inquiry as moral valuation or as an ethical-scientific problem-solving approach functions best in a system where education, democracy, and institutions are integrated and installed. In this respect, bridging ethics, law, and politics amidst education, democracy, and trusted institutions is significant for figuring out the best solutions workable in a society.

3.4 Conclusion

Based on the previous discussion concerning the ethical inquiry method and the example of gestational surrogacy, I stress that education, deliberative democracy, and institutions are significant for seeking solutions to ethical problems, which are social policy challenges. Dewey claims that education as experience is essential for the future since it emancipates individuals from social dependence. He argues that growth and the continuance of reconstruction of experience are the only ends of education. Acquisition of skills, possession of knowledge, and attainment of culture are not the ends of education; instead, they are marks of growth and means to its continuance. Education, Dewey claims, guarantees collective efficacy through liberation and the use of the diversity of individuals' capacities, initiative, planning, foresight, vigor, and endurance. Education enhances both individual and collective capacities.

[161] Inguaggiato et al., A Pragmatist Approach, 433.
[162] Dewey, the Public and Its Problems, 152.

The education of personality to develop this collective efficacy fixes democracy. Moral development is connected with education and democracy in the sense of building the personality of collective efficacy. As Dewey claims, moral development and education are connected with democracy.[163] Miller and his colleagues claim that democracy for Dewey is more than the instruments of the government. Instead, it is a way of life in which we adapt to a social environment by forming relationships and establishing institutions. As an ideal of social life, democracy invokes traditional ideals of fraternity, liberty, and equality,[164] but for Dewey, it also has a moral meaning and connotation. He argues, "Democracy has many meanings, but if it has a moral meaning, it is found in resolving that the supreme test of all political institutions and industrial arrangements shall be the contribution they make to the all-around growth of every member of society."[165]

Dewey's approach to democracy is connected to building democratic institutions. While it is true that Dewey emphasizes deliberative democracy, institutional building is also a primary thing in Dewey's idea. Institutions make democracy practical and realize the all-round growth of society. As Richard Rorty emphasized, democratic institutions are vital to creating democrats, and in a system where institutions are built, deliberative democracy as a process and practical functioning is used to realize the collective end of society and individual capacity. Similarly, Dewey contends that "organization as a means to an end would reinforce individuality and enable it to be securely self-sufficient by endowing it with resources beyond its unaided reach."[166] As I discussed earlier in the case of ethical challenges of gestational surrogacy, social intelligence and collective deliberation are essential during the moral deliberation process to judge particular surrogacy cases' moral appropriateness or set out a social policy solution. In the pragmatic ethical inquiry, it is important to entertain various viewpoints and suggestions from individuals, agents, stakeholders, and the general public in order to conduct social experiments on the proposed solutions and eventually arrive at the agreed-upon best solution. This is how Dewey sees it: through education,

[163] Dewey, Reconstruction in Philosophy, 183-186.
[164] Miller, Fins, and Bacchetta, Clinical Pragmatism, 42.
[165] Dewey, Reconstruction in Philosophy, 186.
[166] Dewey, The Public and Its Problems, 216.

democracy, and established institutions, all of these ethical inquiry processes are made real and become useful.

Chapter Four

Healthcare, Healthcare Resource Allocation, and Rationing: Pragmatist Reflections

4.1 Introduction

In the mainstream ethics and theories of health, healthcare is broadly conceived in terms of different conceptual categories, such as healthcare as public work, civic practice, commodity, private benefit, and professional service. In specific ethical terms, healthcare is also conceived in terms of human rights, social good, private-individual good, the individual, or social responsibility.[167] These divergent views of healthcare are rooted within our conceptions of health and disease. In modern Western medicine, disease, illness, and sickness are conceptualized in a triadic way – an approach wherein these three concepts are understood differently.[168] Based on this triadic approach, disease refers to physiological malefaction and is understood in terms of pathology – reasons for and causes of disease is objectively treated in biomedical science. Moreover, illness refers to a patients' undesirable state of health, connected to their subjective experiences. However, sickness represents poor health as defined by a given society and is perceived as a sociological concept distinct from disease and illness.[169]

Nonetheless, our idea of disease in modern medicine is based on the conviction that we ought to identify a set of symptoms as syndromes. We usually make sense of a disease category through assortments and classify diseases into groups, essentially using symptoms. Hence, unlike the triadic model, disease cannot be conceived purely biologically, nor can it be dissociated from illness and sickness. As Wright argues, disease is a "radial category"[170] which we know indirectly through the underlying experiences of symptoms as experienced by patients. In this spirit, disease is a biological concept, but it is also a sociological concept, which one can know through social constructions of the manifold symptoms and

[167] Charlene Galarneau, *Communities of Health Care Justice* (New Brunswick, New Jersey, and London: Rutgers University Press, 2016), 7.
[168] Andrew Twaddle, "Disease, illness, sickness and health: A response to Nordenfelt." *Disease, illness, and sickness: Three central concepts in the theory of health* (1994), 37-39.
[169] Bjorn Hofmann, "On the Triad Disease, Illness and Sickness," *The Journal of Medicine and Philosophy* 27, no. 6 (2002), 652-53; see also Seidlein, Anna-Henrikje, and Sabine Salloch. "Illness and disease: an empirical-ethical viewpoint," *BMC medical ethics* 20, no. 1 (2019),10.
[170] Hollis G Wright, *Means, Ends and Medical Care*. Vol. 92. (Springer Science & Business Media, 2007), 41.

their categorizations. Thus, symptoms provide an experiential, cross-cultural foundation for disease. Equally, health is a sociological concept that can be conceived in a specific social context. in other words, health is a relational concept, which is metaphorically understood as the absence of negatives or disease.[171] Hence, the concepts of health and disease are plural and metaphorical, and as such they have different culturally and societally embedded conceptions and meanings subject to different societies.

In fact, modern medicine's epistemic and normative challenges are rooted within the triadic conceptions of disease, illness, and sickness. Apparently, if disease is a purely biological concept, then health as the absence of disease becomes a private matter, and the caring relationship of health or healthcare would become a matter of civic practice, a commodity, or a private benefit individuals pursue based on their biological and physiological condition and medical preferences. However, disease is a sociological concept, and it cannot be conceptualized in a purely biological manner in terms of only pathologies.[172] In fact, from the grounds of the epistemology of modern medicine, we usually made disease assortments into different categories, and identify the underlying treatments to disease based on symptoms patients experience[173] Besides, environmental and social structures shape the distribution of disease across a population and determine societal and individual responses to suffering,[174] making disease more of a sociological concept than a purely biological category as represented in Western medicine. This epistemic grounding of disease and health determines our views of the allocation of medical resources.

In a healthcare system, the allocation of medical resources requires a consideration of the nature of disease and the societal understanding of disease and health. Different societies have multiple and culturally variant conceptions of disease and health, affecting allocation and rationing decisions both at macro and micro levels. For example, the African conception of health, disease, and treatment for disease

[171]Ibid, 41-54.
[172] Galarneau, Communities of Healthcare, 11; see also Azétsop and Rennie, Principlism, Medical Individualism, 7&8.
[173] Wright, Means and Ends, 54-70.
[174] Azétsop and Rennie, Principlism, Medical Individualism, 7.

is essentially different from the Western one.[175] In Africa, the ideas of disease and health are closely knitted to African conceptions of humanity, especially as they pertain to the rules of punishment for a deviation from the spirit of ancestors, ancestral harmony, and appeasement, instead of the biomedical sense of disease, health, and treatment in the West.[176] More precisely, disease in African culture is conceived in terms of some evil spirit disturbing the body, connected to their cultural environment and ancestral ties. From this, one can easily understand that healthcare resource allocation requires that we consider society's view regarding disease, health, and the treatment for disease. For instance, it is estimated that 70% of African people prefer traditional medicine to modern medicine. In the absence of universal healthcare, it is assumed that traditional medicine is much more affordable and cost-effective for Africans[177], which is decisive in the allocation of healthcare resources.

As Fleck argues, healthcare is a relational concept, which shows the caring relationship between members of society – representing societal solidarity between people of a given society or community. He argues "solidarity is supposed to be about taking responsibility for all. It must be about reciprocal responsibility; this is what builds the bonds of solidarity. Thus, if the need for health care rationing is inescapable, then it must not be the case that only the medically least well off bear the risks and burdens of rationing."[178] The effect of disease is not limited only to the individual being affected by a specific pathology. Since most pathogens transmit from person to person, the impact of disease is public, and health is primarily a matter of public health. Moreover, disease affects a patient, the whole family, the community, and society at large. Hence, healthcare is a social good rather than an individual good or personal benefit, since it is a service one shares within society. As a societal good shared by individuals or a society, health needs and demands are unlimited, whereas health resources are generally limited. Accordingly, either in the normal condition or during pandemics, allocating scarce resources is a persistent public moral challenge to any

[175] Alexander Butchart, "The 'Bantu Clinic': A Genealogy of the African Patient," *Culture, Medicine and Psychiatry* 21, no. 4 (1997), 405-47.
[176] Peter F. Omonzejele, "African Concepts of Health, Disease, and Treatment: An Ethical Inquiry," *Explore: The Journal of Science and Healing* 4, no. 2 (2008), 120-21.
[177] Ibid, 125.
[178] Leonard M. Fleck, "Just Solidarity: The Key to Fair Health Care Rationing," *Diametros* 43 (2015), 53.

country's healthcare system.[179] The allocation of healthcare is very challenging, especially in the resource-poor countries in the global south with people of greatest need for healthcare.[180] In these regions, people have a high demand for healthcare, but health resources are not available or limited due to socio-cultural, economic, and political factors.

The moral dilemma of healthcare allocation arises whenever we allocate limited resources and rationing is a necessary option for distribution. Indeed, allocation and rationing are intricate and complex tasks beset with philosophical, ethical, and practical difficulties.[181] The moral dilemma of allocating healthcare concerns justice or equitable distribution of limited medical supplies under competing needs for the available resources. In a broader sense of a just healthcare system, allocation issues also concern access to primary healthcare, especially for poor communities. However, in a more specific sense, the fair allocation of healthcare is a response to the increasing demand for scarce services under limited healthcare resource supplies. In this sense, rationing always entails denying service to someone for the benefit of others, which makes decisions concerning rationing healthcare morally controversial.

Unlike other goods and services, healthcare is special compared with other goods and opportunities[182] which should not be left to the demand and supply rules of market forces. Hart argues, "the market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."[183] Neither allocation based on medical need nor on the science of medicine is adequate enough to distribute healthcare. Allocation and rationing always entail denying potentially beneficial treatment to some individuals[184] in order to save healthcare resources for later use or to benefit the worst-off, or entail the use of any other values, principles and rules that go beyond mere equality of benefits. Hence, as Daniels claims, rationing always "raises morally

[179] Persad, et al, Principles for Allocation, 137; see also Ezekiel J. Emanuel et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine* 382, no. 21 (2020): 2049-51.
[180] Stefanini, Ethics in Health Care Priority, 709.
[181] David J Hunter, "Rationing: the case for "muddling through elegantly"." *BMJ* 311, no. 7008 (1995), 811.
[182] Norman Daniels, "Justice, Health, and Healthcare," *American Journal of Bioethics* 1, no. 2 (2001), 3.
[183] Julian Tudor Hart, "The Inverse Care Law," *The Lancet* 297, no. 7696 (1971), 405.
[184] Scheunemann and White, The Ethics and Reality, 1625-26.

troublesome questions about fairness."[185] In other words, under competing needs and insufficient healthcare resources, fair allocation is always a persistent moral quandary of just healthcare distribution

Owing to the morally problematic nature of rationing, it is hard to reach a consensus regarding a principled solution or theory of justice in healthcare, which is significant for solving moral controversies arising in rationing.[186] For that matter, as Dewey claims, the moral good, in general, cannot be understood as a separate good or a single end in a universal manner, as it is depicted in moral philosophy traditions. Likewise, health is understood in multiple dimensions and has several ends and means to achieve the good of health. As Dewey claims, the good always changes with new experiences and a new situation results in a unique problem.[187] Likewise, the good of healthcare is subject to a situation or context besieged by the plurality of conceptions of health; and values of health evolve with new cultures and experiences.

Similarly, moral decisions in healthcare are transient, dynamic, and context-dependent, sought through collective intelligence and deliberation. Specifically, context– a relatively stable background of interest, belief and knowledge which provides the physical, cultural, and historical locus of activity and moral concern[188] – is substantial in the decision-making regarding allocation of healthcare with the observance of justice. As a result, as Daniels argues, in the absence of an agreed-upon principle for rationing medical resources, relying on a fair process is essential in healthcare rationing. In other words, a fair process based on a deliberative democratic course of arriving at solutions is essential for allocating healthcare resources fairly. This reorientation to the democratic process of deliberation is helpful when addressing justice and legitimacy in healthcare through "accountability for reasonableness,"[189] which implies what Dewey terms deliberative democracy.

[185] Daniels, Rationing Fairly, 224.
[186] Persad, et al, Principles for Allocation, 423-429; see also Daniels, Justice, and Healthcare, 2.
[187] Dewey, Reconstruction in Philosophy, 163-169.
[188] Wright, Means and Ends, 89.
[189] Daniels, Justice, and Healthcare, 9.

In this chapter, I focus on scrutinizing the ethical dilemma of healthcare allocation and rationing from pragmatist ethical perspectives, taking insights from Dewey and Daniels. Against principle-based approaches, I argue that moral challenges of healthcare rationing ought not to be addressed through the appeal to principles, but rather through deliberation. Mainly, allocation and ratioing decisions and judgments require a more pragmatic and democratic approach to negotiation based on open dialogue. However, this does not mean that moral principles and values are insignificant in healthcare allocation. Instead, depending on the moral problematic situation and context, principles serve as a hypothesis or a presumptive guide for discovering moral solutions through deliberation and scientific investigation.

4.2 Health, Disease, and Healthcare Theories

Disease and health are interrelated concepts. In modern medicine and popular culture, the idea of disease has been established based on the conviction of identifying and categorize a set of symptoms as syndromes. These assortments and categorization in the form of diseases are made in groups, essentially using the criterion of symptoms experienced by patients and medically identified pathologies. For instance, in the wide category of disease we understand disease in terms of sub-categories of disease, such as "acute infectious disease," "chronic disease," "injury," "cancer disease," "vascular disease," "occult disease," "congenital conditions," "mental illness", and "deficiency diseases".[190] Each category contains further specific types of diseases with unique symptoms. Symptoms, as Wright contends, are experienced by patients, but diseases are constructs that attempt to relate and explain symptoms. Thus, as Wright argues, disease is a radial category that we know indirectly through the underlying experiences of symptoms. In this sense, disease is not a purely biological concept, but is also a social construction formed using the experience of symptoms thereof.[191]

In modern Western medicine and popular culture, Wright claims that disease is explained metaphorically as: (1) a mechanical breakdown; (2) abnormal; (3) the disintegration of a whole body; (4) disorder; (5) an imbalance; (6) loss of vital fluid; and (7) being under attack. Contrary to disease, health is a relational

[190] Wright, Means and Ends, 59-70 .
[191] Wright.

concept understood metaphorically as the absence of negatives, or in a literal sense, as the absence of disease. In a more specific sense, health is defined metaphorically as opposed to disease as: (1) a well-running machine; (2) normality; (3) wholeness; (4) order; (5) balance; (6) being full of vital fluid; and (7) victory or immunity to attack.[192] Despite these multiple latent categorizations and metaphors, disease and health are elusive concepts. We cannot clearly define them in the pure biological form in which they have been pictured in modern medicine, but we make sense of them as represented multiple, plural, and metaphorical culturally and societally embedded meanings.

As Wright argues, disease is a radial category in which its underlying sense is dynamic and context dependent. Disease is not value-free and cannot be conceived without taking into consideration of the non-medical societal issues and values.[193] Instead, it is a sociological concept, and it cannot be conceptualized in a purely biological manner alone. Similarly, being healthy is a relative concept, and our understanding of health depends on the experience we develop in our societal context. Indeed, our approach concerning the allocation of medical resources requires consideration of the nature of disease, health, and healthcare. Healthcare is a relational concept which shows the caring relationship between the community or society.[194] In a moral and political sense, healthcare signifying a caring relationship is understood as the social good negotiated amongst other individuals. This societal and political nature of healthcare makes the ethical issue of healthcare, especially the issue of allocation, controversial, and it is conceptually muddled with different philosophical orientations and views. Indeed, healthcare is a good to be pursued collectively. Moreover, allocation is always a problem of ethics, health policy, and the law, which in one way or another takes us to the debate regarding justice.

Concerning healthcare theories of justice, in bioethical literature, one can find many philosophical approaches including, among others, utilitarian, moderate egalitarian, strict egalitarian, prioritizing libertarian, sufficientarian and fair equality of opportunity theories of healthcare. For the sake of

[192] Ibid, 41-58
[193] Ibid.
[194] Fleck, Just Solidarity, 53; see also Galarneau, Communities of Healtcare, 1 & 23-36.

simplicity, these theoretical approaches are broadly categorized into three groups: libertarian, egalitarian, and utilitarian theories of healthcare. One of the major differences between these theories of healthcare is the issue of allocation of healthcare. In generic terms, for egalitarians, healthcare is guided by the maxim "to each according to their need." However, libertarians focus on the maxim "to each according to what is honestly acquired in a free market." Finally, utilitarian theorists follow the classical principle of maximizing utility – "benefit for the highest number of people."[195]

The communitarian liberal theory of healthcare justice is another new version of healthcare theories that emphasize community healthcare justice. It goes against egalitarian theories of justice to a more community-based, alternate, multilayered, relational, and inclusive community healthcare justice. For this approach, allocation of healthcare is decided by the community's conception of health.[196] Briefly, egalitarian theories conceptualize healthcare justice as assigning resources to those with the greatest need in order to eliminate inequalities and achieve equality. However, the challenge is that there is no limit to healthcare needs. Thus, healthcare needs based on equality amid scarcity of medical resources is utopian. Differently, liberals understand justice in healthcare mainly in terms of protecting autonomy and economic freedom. In light of this philosophical view, the satisfaction of healthcare needs is left to free and flexible healthcare market forces. Utilitarian theorists follow the classic theory of maximizing happiness and answer allocation problems with the principle of maximizing benefit for the majority of people, yet with the most cost-minimized system.[197]

As presented earlier in the introductory part, unlike other goods and services, healthcare is a special good or opportunity [198] which should not be left to the traditional demand and supply rules of market force,[199] as suggested by the libertarian approach to justice. Neither allocation based on medical need nor based on the science of medicine alone under the principle of equality in the egalitarian approach is helpful enough,

[195] Stefanini, Ethics in HealthCare Priority, 709; see also Galarneau, Galarneau, Communities of Healthcare, 11.
[196] Galarneau, Communities of Healthcare, 11-15.
[197] Stefanini, Ethics in Healthcare Priority, 709.
[198] Daniels, Justice, and Healthcare, 3.
[199] Tudor Hart, The Inverse Care Law, 405.

since the criteria underlying allocation of medical resources is not value-free and scientific, and medical resources are scarce. For that matter, the utilitarian approach to healthcare also has ethical challenges, as in the endeavor to maximize utility for the majority, one may deny the autonomy and benefit of other individuals. Also, while it is true that healthcare is understood relationally as a community relationship,[200] healthcare allocation and delivery of the service goes beyond the narrow conception of health bounded by a particular community's conception of health in the liberal communitarian approach of healthcare. Nonetheless, healthcare is a societal good whose benefits are shared and distributed at the communal, regional, national, and global levels, depending on the circumstances. One can relate this to the current COVID-19 pandemic, in which the matter of healthcare and response to the pandemic has been a concern of every society, nation, and world.

4.3 Healthcare Allocation, Rationing, and Ethical Principles

As presented earlier, there is a broad range of philosophical differences between theories of healthcare justice and principles of healthcare rationing in bioethical literature. These theories and views can be understood in terms of three dominant healthcare theories: egalitarian, libertarian, and utilitarian healthcare theories. Each theory follows different kinds of ethical principles as a guideline to allocate scarce resources. For instance, the egalitarian approach uses the principle of equal treatment following the lottery and first-come, first-served rules of allocation. In comparison, the utilitarian approach uses the principle of cost-benefit analysis and priority setting, following the approach of the maximization of benefit for the greatest number of people as a mechanism to ration healthcare. Finally, liberals follow the principle of maximizing benefit to the worst-off to ration healthcare.

In fact, the relevance of principles is to reconcile the moral problems of justice in allocating and rationing healthcare resources, including all materials, personnel facilities, drugs, and funds, as well as other essential infrastructures. In whatever context, either in the resource-rich countries or resource-poor countries, healthcare resources are scarce, since the demands for healthcare are unlimited. Hence, in the

[200] Galarneau, Communities of Healthcare, 3.

allocation of healthcare, rationing is not a choice – it is a matter of necessity to every healthcare system. Allocation and rationing are conceptually different in that allocation refers to dividing funds among various categories, whereas rationing refers to restricted distribution of scarce resources in terms of availability. For instance, the budget distribution between health and education systems or between education and defense systems is a matter of allocation. Besides, in a specific healthcare sector itself, allocation signifies the distribution of already available resources to different health programs, regions, specific disease control programs, patients, building infrastructure, healthcare facilities, equipment, and treatments and therapies. On the other hand, rationing refers to a fixed amount and scarce resource distribution under competing service demands.[201] Thus, allocation refers to the apportioning of resources at different levels of allocation. Rationing implies restricting the use of the available resources due to scarcity and entails sharing such scarce resources under competing needs.

The two levels of allocation of healthcare are macro allocation and micro allocations. Accordingly, macro allocation includes distributing health resources at the highest state policy and organizational levels. Societies determine allocation strategies through legislation, health insurance plans, and government funding mandates at the country and policy levels. At the organizational level, allocation decisions are made using policies, clinical practice guidelines, and protocols in a given institution. On the other hand, micro allocation is made at a clinical level between a physician and patient.[202] Thus, at the micro level, the patient's interest, treatment options, and availability of medical treatment for an individual patient, as well as other issues, are points of allocation concerns for the physician, clinical committee, or triage committee. At either level, healthcare needs are unlimited, whereas healthcare resources are by nature limited.

As indicated elsewhere, unlike other goods and services, healthcare is a good which determines the human pursual of other goods. Moreover, healthcare directly affects humans' lives, and healthcare is an

[201] Nancy S. Jecker, "Should We Ration Health Care?," *The Journal of Medical Humanities* 10, no. 2 (1989), 78.
[202] Hellen Ransom and John M Olsson, "Allocation of Health Care Resources : Principles For," *Pediatrics in Review*, Vol. 38 No. 7 (2017), 321.

existential issue for everyone, rather than something secondary. Hence, healthcare allocation cannot be left to market forces or distribution based on medical need. Moreover, allocation, especially under poverty, is a serious task, where distributing the limited healthcare resources to many people exposed to disease burden is difficult. In this situation, ethical principles and rules are significant when allocating healthcare resources fairly, as they ease the task of healthcare workers and physicians when distributing the available resources. Nevertheless, the significance of principles is still controversial given the unsettled nature of allocation and rationing and the inconsistency between different principles forwarded in bioethics literature according to which healthcare resources ought to be allocated and rationed. To further expose these issues of principles of allocation and rationing, it is essential to include Persad et al.'s elaborated discussion of principles and rules of allocation of medical resources. For the sake of the argument of this chapter, these principles are not by themselves sufficient guidelines for fairly distributing healthcare resources, but they are useful as a presumptive guide to allocating resources through deliberation.

Persad et al. examined these allocation principles and categorized them into four general principles, each having its own further rules of allocation and rationing. These principles are suggested as being relevant, especially to allocate scarce medical resources in any context. These principles include treating people equally, favoring the worst-off, maximizing total benefit, and promoting and rewarding social usefulness. In the principle of treating people equally, the lottery and first-come, first-served principles are used to distribute healthcare resources. The second principle is favoring the worst-off or prioritarianism, which includes the two principles of sickest first and youngest first. Maximizing total benefit is another utilitarian-grounded principle guided by the rules of the number of lives and the number of life years saved. As Persad and colleagues claim, this principle is applicable especially during pandemics and disaster triage. Most of the time, medical prognosis and expected life years saved are used as guiding

principles. Promoting and rewarding social usefulness is the fourth principle and considers instrumental value and reciprocity principles as criteria for allocating medical resources.[203]

One can also consider other allocation strategies such as quality-adjusted life years (QALY), which includes criteria such as prognosis and quality of life, or disability-adjusted life years (DALY), which includes criteria such as prognoses and instrumental value, applicable in the allocation and rationing of healthcare resources.[204] QALY is calculated by multiplying the value of each health state by the respective length of time of each state, which provides a summary measure of total health improvement. It is a simple metric widely used to measure health benefits by assessing the number of quality-adjusted life years. Following QALY, rationing is undertaken based on the metrics or index. Indeed, DALY is a principle applicable based on other principles such as the level of prognosis, age, and instrumental value.[205]

When we look at applying these principles within healthcare policies in the world, DALY is especially common and applied by the WHO and other international organizations working in healthcare. Especially on the macro allocation of the health budget, a principle inspired by utilitarian philosophy and economics – cost-benefit analysis – is employed for the cost-effective allocation of healthcare. International organizations such as the WB, IMF, and WHO recommend the principle of cost-effectiveness on DALY in the allocation of healthcare in Africa. The WB and IMF analyze the quality index of health and devise a cost-effective mechanism to address regional healthcare issues. Following this principle, the rationing is done using rationing by exclusion or rationing by refusal.[206]. Yet, as it is noted in the next chapter of this study, the guidelines and principles adopted by the WB and IMF do not consider the sociology of disease and socio-cultural situations, which are decisive in healthcare allocation and intervention. In fact, as

[203] Persad, Wertheimer, and Emanuel, Principles for Allocation, 424.
[204] Ibid.427-28
[205] Ibid.
[206] Stefanini, Ethics in Healthaare priority, 710.

Hunter claimed, following ethical guidelines, rationing is often implemented using rationing by dilution, delay, and rescue principles.[207]

The moral problematics of rationing amid a shortage of healthcare resources is that while benefiting some group, we always make decisions that exclude or denies the service to others. Of course, using principles, we use different ways to exclude others from benefiting from health services. In bioethical literature and the practice of medicine, there are many techniques of rationing. The first technique is rationing by deterrence, according to which we exclude patients through obstacles to accessing the service. The second is rationing by dilution, a mechanism of denying access by declining service quality. The third is rationing by denial, which refers to an explicit refusal to give service by removing or restricting funding for certain treatments. The fourth is rationing by selection, according to which we allow treatment to a certain population group, either using age or sickness as a criterion. The final and common rationing exclusion is rationing by a deflection, which refers to denying the service by providing the service to other agents such as insurance companies or other sickness funding organizations.[208]

The means of rationing mentioned above represent the degrees of rationing healthcare, commonly called soft and hard rationing. Soft rationing is an unsystematic manner of rationing health resources. Most of the time, interest group pressures, market forces, and explicit or implicit manipulations of individuals decide who receives what benefit. On the other hand, hard rationing occurs when choices are openly specified, and an open decision is made to choose one possible health good rather than another.[209] These hard and soft rationing techniques are also described as explicit and implicit rationing or systematic and unsystematic rationing.[210]. The implicit method of rationing refers to the unrecognizable deterring of access to healthcare by using various barriers such as long wait lists and bureaucratic referral systems.

[207] D.J. Hunter, Rationing, 812.
[208] J. Maybin and R. Klein, "Thinking about Rationing," *The King's Fund*, (2012), 15-25.
[209] Jecker, Should We Ration, 79-80.
[210] K. Obermann and D. J. Buck, "The Health Care Rationing Debate: More Clarity by Separating the Issues?," *HEPAC Health Economics in Prevention and Care* 2, no. 3 (2001), 114.

Depending on the context, setting eligible criteria either through age, disease type, or prognosis level may be set out as an implicit rationing model. In fact, from the perspective of ethics, such rationing techniques are justified with vague concepts such as best interest, quality of life, and futility and frail state, though each of them may contradict each other. Explicit rationing is undertaken with the explicit exclusion of patients from the service. In a clinical setting, explicit rationing is common in the emergency department while classifying and excluding patients in terms of severity level and prioritization to offer or deny the service. Most of the time, this rationing mode is common during pandemic situations[211] However, rationing healthcare always follows soft rationing, and rationing decisions are always made in a hidden manner. Most of the time, patients are not allowed to engage in discussion of the decision making, or they are not aware of how the decision is made.[212]

4.4 Why Principles are not Sufficient Enough?

As highlighted previously, no single principle or combination of principles of allocation and rationing is sufficient enough to allocate scarce resources fairly. The main reason is that each principle has ethical flaws, and the moral dilemma of rationing is controversial as any solution found by following one principle, can be equally discounted as unethical from the perspective of another principle or principles. So, there is a substantial disagreement concerning the principles and mode of rationing in bioethics literature. Indeed, in a more descriptive sense, allocation problems in healthcare result from decisions based on personal biases or preferences in health delivery institutions.[213] However, the deep philosophical moral problem of allocation is highly connected to rationing of limited resources and the resulting moral dilemma of excluding some groups from the benefit of the service. This issue is critical, especially during the pandemic, where many people are affected, and it is difficult to provide the minimum healthcare service for all.

[211] Bhatia, Talk About Rationing, 733.
[212] Obermann and Buck, Rationing Debate, 116; see also Bhatia, Talk About Rationing, 731-35.
[213] Maybin and Klein, Thinking about Rationing, 1-14.

As Daniels states, the moral dilemma of allocation and rationing of medical resources at the clinical level is about the question of whether it is fair to ask people to give up their equal chance of receiving a scarce good in order to promote better outcomes of others by using this resource. For instance, a contradiction may arise when prioritizing the worst-off and maximizing the net benefit, while giving less attention to the better-off in terms of benefiting from the service.[214] However, allocation and rationing at the macro and national levels could also raise a different dimension of moral controversies, signifying the size of the budget we allocate to healthcare compared to the share of other components, goods, and services. Further, under a given healthcare investment, the distribution of healthcare with sensitivity to disease character, lifesaving principles, and other guiding laws breeds other moral dilemmas of allocation. Nevertheless, as Daniels also argues, the central moral issue concerning healthcare allocation and rationing is addressing competing healthcare needs fairly under reasonable resource constraints.[215] As presented elsewhere in this chapter, in allocating medical supplies where resources are insufficient, rationing is a matter of necessity for allocating healthcare resources. Rationing entails denying potentially beneficial treatments to some individuals in order to save healthcare resources or benefit the worst-off. As such, rationing always raises troubling questions about fairness.

Unlike rationing of other goods such as economic and social benefits, healthcare allocation and rationing decisions are unique and have distinctive features. Daniels provides the following three key features characterizing healthcare and healthcare allocation decision making. First, healthcare, like social goods such as legal services and educational benefits, are not divisible without loss of benefit. In other words, when we provide benefit to one group, we always deny the interest and benefit of others. Second, while rationing, we deny benefit to some individuals who can plausibly claim they are owed this in principle. For example, following the age-based priority principle, if we deny a particular health service to X patient to provide the service for Y, the decision can be discounted and X can justifiably claim the service with another principle such as the principle of equal opportunity, priority through the worst-off principle, or

[214] Norman Daniels, "Liberalism and Medical Ethics," *Hastings Center Report* 22, no. 6 (1992), 42.
[215] Daniels, Justice, and Healthcare, 2-16.

following the traditional principle of autonomy of the patient. Finally, general distributive principles appealed to by claimants, and rationers do not by themselves provide adequate reasons for choosing among claimants. In other words, there is marked disagreement concerning the principles and mode of rationing; it is not easy to justify a rationing decision with conclusive deductive reasoning, nor the application of these principles to particular cases.[216]

As presented elsewhere, we cannot fairly ration healthcare resources through the deductive application of principles due to the controversial nature of rationing and the inconsistency behind rationing principles. For instance, when resources are scarce, especially during pandemics, epidemics, and relating to expensive treatments, it is difficult to apply the principle of treating people equally inspired by the egalitarian approach to healthcare theories: to each according to their need. Specific rules, such as lottery and first-come, first-served, can be discounted as unethical or flawed on various grounds. The lottery system is a simple and obvious principle to apply; however, this approach is inadequate to allocate resources, for it ignores the level of patient prognosis, the expected number of lives saved, and the life years gained as a criterion to ration healthcare in time of scarcity.

Similarly, the rule of first-come, first-served is not a legitimate means to distribute lifesaving treatment. This rule does not treat all people equally, even though that is the intent of the principle. The principle ignores relevant differences between people, but in practice fails even to treat people equally.[217] Besides, the principle favors those who have access to information and live close to a hospital. Furthermore, this approach also does not maximize the benefits of available resources to the majority of patients, since those who come first will consume the resources, and those coming later, even with a good prognosis,

[216] Daniels, Rationing Fairly, 224.
[217] Persad, Wertheimer, and Emanuel, Principles for Allocation, 424.

may not benefit for instance, in the case of COVID-19.[218] Similarly, the lottery principle ignores other relevant principles and criteria, and treating people equally often fails to treat people as equals.[219]

Equally, the worst-off or prioritarianism principle, which includes the other two principles of sickest first and youngest first, is also criticized and rejected on various grounds in terms of fair rationing of resources. The sickest first principle can be criticized as a surreptitious use of prognosis; it ignores the needs of those who will become sick in future; it might falsely assume temporary scarcity; it leads to people receiving interventions only after prognosis deteriorates; and it ignores other relevant principles.[220] Compared to the sickest first principle, age-based allocation states that we ought to distribute healthcare resources among different age groups in society by limiting or excluding certain age groups from the service. For instance, Callahan Daniels argues that in the situation of scarcity, a person who has had a natural life span is not entitled to receive government-funded life-extending treatment. Besides, Callahan argues, once the life span has been reached, the government should pay only for medical care[221]. In fact, lifesaving treatment for elderly persons costs more and more money. In this case, to minimize the health cost, it may be necessary to cut back on the healthcare resources available to the elderly section of society, yet without breaking the right to minimum decent for healthcare.[222] Daniels also argues that age-based rationing is a prudent and morally proper strategy to tackle resource scarcity under certain circumstances, which entails his justification based on the principle of intergenerational equity, favoring the youngest.[223] Nevertheless, equity among age groups and birth cohorts is still a problem in rationing through prioritization. Besides, the criterion of prudential lifespan is not evident that the decision to ration

[218] Arthur Rawlings et al., "Ethical Considerations for Allocation of Scarce Resources and Alterations in Surgical Care during a Pandemic," *Surgical Endoscopy* 35, no. 5 (2020), 2219.
[219] Persad, Wertheimer, and Emanuel, Principles for Allocation, 424
[220] Ibid, 424-25; see also Rawlings et al., Ethical Considerations for Allocation, 2219.
[221] Callahan Daniels (1987) cited Forbes, W. F., and M. E. Thompson. "Callahan Daniel, Setting Limits: Medical Goals in An Aging Society, New York, Simon & Schuster, 1987. 256 pp. $18.95 (US)." *Canadian Journal on Aging* 8, no. 4 (1989), 384.
[222] Jecker, Should We Ration,
[223] Norman Daniels, "The Prudential Life-Span Account of Justice across Generations," in : *Justice and Justification* (Cambridege: Cambridge University Press, 1996), 257-88.

based on age is not determined in advance for every society. Besides, the determination of prudential lifespan depends on that society's particular economic and political situation.[224]

Moreover, age-based priority setting cannot be objectively set out as a principle, since the prioritization group should be decided in context. Concerning this, Kilner (1988) criticizes the age-based exclusion of the elderly when medical resources are limited, claiming that it is unacceptable from the perspective of Christian Scriptures. He claims that elderly people are represented in scriptures as wise and weak. As Kilner claims, the wisdom of the elderly calls for respect and the weakness of the elderly calls for protection, which demands equitable benefit from medical treatment for those with the same medical condition. Kilner further claims that this special value placed on the elderly is likely the same culturally relative value found among the Akamba tribe in Kenya. Furthermore, he states that such cultural beliefs call into question intuitive (Western) preferences for the young rather than simply serving as a trans-cultural normative guideline.[225]

Moreover, as Cordeiro-Rodrigues and Ewuoso argue, healthcare rationing undertaken according to the Afro-communitarian ontology gives priority to community harmony. Community harmony in African society is essentially based on the adult and elderly groups within the society. Hence, in allocating resources during scarcity or pandemics, priority is given to the person of higher moral value, having instrumental value to the harmony of the community. To this end, priority is given to adults and the elderly who have instrumental value to the community.[226] Similar claims against age-based rationing and its moral appropriateness might be raised, especially during pandemics. In the West, concerning rationing of healthcare resources, priority principles in terms of age favors the youngest and gives less regard to infants and the elderly. However, this principle is not objective and applicable in all circumstances since, depending on the type of disease and pandemic situation, a society's priority section varies according to

[224] S Brauer, "Age Rationing and Prudential Lifespan Account in Norman Daniels ' Just Health," *Journal of Medical Ethics*, 2009, 30.
[225] J. F. Kilner, "Age as a Basis for Allocating Lifesaving Medical Resources: An Ethical Analysis," *Journal of Health Politics, Policy and Law* 13, no. 3 (1988), 413.
[226] Luís Cordeiro-Rodrigues and Cornelius Ewuoso, "A Relational Approach to Rationing in a Time of Pandemic," *Journal of Value Inquiry*, no. October 2020 (2021),7-9.

time and context. For instance, in connection with the COVID-19 pandemic, older adults were the most severely affected population in Belgium, France, Italy, Spain, the United Kingdom, and many other countries.[227] In this regard, given the effect on the elderly, a non-discriminatory healthcare decision-making approach that does not discriminate the elderly has been suggested as significant in healthcare rationing during the pandemic.[228]

Nevertheless, while considering chronological age as a criterion, we should also consider other factors such as the patient's previous lifestyle, the level of progenesis, the kind of disease, life expectancy after treatment, quality of life after treatment, and other values and principles. Moreover, age is not the only criterion for priority setting as a principle. Priority to the worst-off or patients with a bad prognosis is another criterion in allocating and rationing medical supplies. However, this principle can also be equally discounted as ethically flawed from the perspective of other principles. Depending on the context and situation, priority to those who can recover with reasonable medical expense and the available resource may be suggested as fair. For instance, it is naïve to claim that a patient with cancer should be given a chance equal to another patient with pulmonary infectious disease. The treatment for the first is costly and would require colossal financing, while the latter can be treated with significantly lower financial expense. In this regard, the priority setting principle through the worst-off may be reformulated into a more cost-effective analysis and prioritization of patients and treatment options based on the available health budget.

Concerning priority based on cost-effectiveness, a more utilitarian principle, inspired by economics, called maximizing total benefit through the calls to save more lives and save the most life years possible, may be suggested as a fair principle for rationing healthcare, especially at the macro level. However, this

[227] Oriol Miralles et al., "Unmet Needs, Health Policies, and Actions during the COVID-19 Pandemic: A Report from Six European Countries," *European Geriatric Medicine* 12, no. 1 (2021), 203; Wei Li et al., "Clinical and CT Features of the COVID-19 Infection: Comparison among Four Different Age Groups," *European Geriatric Medicine* 11, no. 5 (2020), 843.
[228] Miralles et al., Unmet Needs, 203; David G. Kirchhoffer, "Dignity, Autonomy, and Allocation of Scarce Medical Resources During COVID-19," *Journal of Bioethical Inquiry*, 2020, 204.

principle is also criticized because it ignores other relevant principles.[229] For instance, maximizing total benefit can be criticized as flawed through principles such as QALY and DALY, which are often considered as effective instruments for allocating resources, particularly at the macro level. The save the most lives and save more lives years principles are ineffective unless the quality of life and disability condition is considered. However, from the point of view of ethics, QALY and DALY are also often criticized as ethically flawed, partly due to the methodological problems of evaluating the different states of health and the inherent heterogeneity of patients and their quality of life and disability conditions.

QALY is a metric, and a principle of allocation which is hugely contested, as it can be construed subjectively and objectively. In a pragmatic sense, life quality is up to patients' assessment of themselves, which might also contradict the objective categorization of patients and the general public in terms of absence of suffering, happiness, minimal cognitive capacity, full consciousness, and capacity to engage in meaningful human relationships in the QALY indexes. Besides, the criteria used for ranking based on QALY is relative to society's conception of health and disease.[230] Furthermore, measuring life years after treatment is vague, and the number of lives saved and the number of life years saved makes it controversial. For instance, in calculating the lives and number of years, giving twenty people one more year to live is equal giving four people another five years to live. Moreover, the decision making is controversial when people who have the same expected life years, but when they are in a different age group. For instance, the rationing of healthcare services to a 70-year-old patient with one year of quality life expected and a 20-year-old with the same one year of quality life expected is a contentious decision unless another principle called priority is considered.[231]

Equally, DALY, which is based on prognosis and instrumental value when measuring the quality of life, is criticized on various moral grounds. For instance, it is criticized as flawed in that the outcome of

[229] Persad, Wertheimer, and Emanuel, Principles for Allocation, 428.
[230]Julian Savulescu, Marco Vergano, Lucia Craxì, and Dominic Wilkinson. "An ethical algorithm for rationing life-sustaining treatment during the COVID-19 pandemic." BJA: *British Journal of Anaesthesia* 125, no. 3 (2020), 254-58.
[231] Rawlings et al., Ethical Considerations, 2218.

DALY measures disabled people. Furthermore, age is considered to modify the value of individual life years rather than distributive justice. In addition, the criterion of instrumental value is too focused on economic worth and could justify bias towards heads of households and other traditional social positions. Finally, DALY does not incorporate many relevant principles which must be considered.[232] Certainly, these and other issues and inconsistencies that could be raised against principles of healthcare resource allocation and rationing would push us to see allocation and rationing decisions as being beyond principles, and rather as decisions which ought to be made through deliberation and discussion.

Principles alone cannot adequately and legitimately address justice in healthcare rationing and allocation, since a decision concerning rationing can at the same time be discounted as illegitimate and unjust according to different principles. Hence, instead of the straightforward application of principles and rules, a focus on public dialogue that provides opportunities to test arguments against evidence and explore conflicts between different values or preferences is significant for the fair rationing of healthcare. This claim does not, however, entail those principles are futile for fair allocation and rationing of medical resources. As noted earlier based on Dewey's idea, ethical principles are useful and have the status of a working hypothesis, which aids our moral judgments. Ethical issues, in general, need concerted deliberation to come up with solutions workable for a given specific problematic situation under a given particular context, instead of the deductive and straightforward application of principles. Moreover, the moral dilemma of healthcare rationing is unique in that a decision reached while following one principle can be discounted as unfair from the point of view from another principle or principles. Hence, the moral solution for allocating and rationing medical resources requires a consideration of many alternative principles. In fact, this is possible by going beyond principles and looking for solutions through deliberation. In this case, considering the views of a specific society, the nature of the problem and the overall context is pertinent when seeking solutions.

[232] Persad, Wertheimer, and Emanuel, Principles for Allocation, 428-429.

Deliberation allows us to see principles as potential hypotheses without moral gradation of each principle and value. In this regard, I claim that Daniels' pragmatist shift from the principle-based procedural distribution to a more deliberative approach to healthcare rationing is a more ethical manner in which to ration healthcare. Daniels calls this approach to justice "accountability for reasonableness",[233] which takes us to what Dewey emphasizes as deliberative democracy and intelligent inquiry in moral judgments. Daniels believe that allocation and rationing of scarce medical resources require extra consideration through a turn to democratic deliberation.[234]

4.5 The Need for Deliberation

As previously said, moral concerns of just healthcare allocation and rationing should be addressed through a more practical and deliberative decision-making method rather than an appeal to ideals. A single principle is insufficient to resolve the issue of constrained healthcare allocation. Furthermore, even the top-down application of a set of rules is insufficient to answer the question of rationing's ethical legitimacy. Although theories and principles can aid ethical deliberation, they are insufficient to resolve moral issues that arise in rationing. Hence, in a period of scarcity, as Daniels argues, democratic debate is required for the distribution and rationing of scarce medical resources. This is true because healthcare allocation concerns, particularly at the macro level, are increasingly political matters that necessitate society's active participation in decision-making. The democratic process of ethical decision-making in general, and moral judgements in medicine in particular, is further justified by the nature of morality.

As Dewey claims, morality is not imported to nature from divine power or from the rational realm, something beyond the world of everydayness. Moral judgments can only come from within the world being acted on where human beings live their lives.[235] As Wright argues, moral values for Dewey emerge out of the continued needs and interests of humans. They are present in experience and are modified and created therein. More specifically, moral values are produced through actions, and they are a reflective

[233] Daniels, and Healthcare, 9.
[234] Ibid, 14.
[235] John Dewey, Experience and Knowledge 192.

evaluation of qualities of situations. So, in moral actions, there are always means and ends. Means should have value not simply derived from ultimate intended ends but also as materials and processes to be experienced on their account. Moreover, ends are means when they are plans or aims-in-view for the endeavors that produce them, and when they are not total cessations, but also jumping off points for other activities.[236] Likewise, the means and the ends in healthcare are not fixed categories. Sometimes the means to healthcare become ends, and vice-versa. It is a truism that health is something we seek as an end, but among the satisfactions of good health is that it is the means for all kinds of fulfilling activities and enjoyments beyond itself. For instance, it is a means for someone to work and earn a living or a means for someone to be happy.[237] As Daniels claims, healthcare, as a special good, determines other opportunities and capabilities.[238] Better health, for example, enjoyed for its intrinsic pleasures, also enables us to strengthen our families, serve our communities, enjoy exercise and recreation, keep working productively, and defend ourselves against aggression. In this respect, it is a starting point and a means, yet it is also an end in itself.[239]

In Dewey's sense, moral issues are problems which should be solved through an intelligent inquiry using experience as a mode of reflection. For Dewey, experience is a complex, interactional, and value-creating activity in which logic and rationality go beyond deduction, calculation, and rule application, to more situational rationality – rationality based on local circumstances. This local and particularized rationality grows out of thinkers and their intentions, special situations, and particular subjects, rather than imposing an outside rational canon on the concrete issue. So, the actual rational thinking considers the context. Experienced situations, not deductive logical rules, determine the truth of statements. Likewise, the logic of moral judgment depends on a reflective inquiry into the underlying situation. In the inquiry process, deliberation is required to solve the underlying problematic situation, which, in the case of bioethical

[236] Wright, Means and Ends, 74-84; see also 95-116.
[237] Ibid.
[238] Daniels, Justice and Healthcare, 3-4.
[239] Wright, Means and Ends,100-116.

problems, is a public issue. Deliberation helps consider choices in action and foreseeing the consequences of actions so that it is possible to select the best solutions from among the available choices.[240]

As presented elsewhere in this chapter, healthcare is a relational concept, which shows the caring relationship between community members or society. It signifies societal solidarity between people of a given society or community. Hence, as Emanual and Galarneau agree, healthcare has a political aspect in which community deliberation and involvement is significant for healthcare justice. Galarneau takes healthcare further into a philosophy of multiculturalism and conceives the community as meaning makers and decision makers of health and medicine. Concerning healthcare allocation, she also suggests the community-based distribution of medical care. Emanuel also agrees on healthcare's political aspect, by showing three levels of decision making: political, medical, and patient-centered. At the political level, healthcare decisions are made regarding how much of society's financial resources should be devoted to medicine. Moreover, at the medical level, decisions are made regarding which medical services a community health program should offer and should not offer in a certain medical center. On the other hand, at the patient-centered level, decisions are made regarding which individual patients will receive specific and often scarce services which are not available to all the patients who need the service.[241]

Emanual and Galarneau's appeal to politics can be taken as a pragmatic approach to address issues of justice in healthcare. However, their approach is also open to critique, since they ignore shared values of health at the national, regional, and global levels by reducing the meaning of health to the community – a position inspired by the philosophy of multiculturalism. Indeed, healthcare requires a centralized bureaucracy for managing the system at national levels instead of federating it to local communities. One can identify many reasons for this, but the major reason is that health is a collective matter and disease is a social issue, not bounded by a particular community's life alone. Moreover, when it comes to allocation, it is difficult for the community to be self-sufficient in terms of health resources, and most of the time

[240] Wright, Means and Ends, 85-96.
[241] Ezekial Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge, MA: Harvard University Press, 1991), 16.

national governments own healthcare resources, which would be expensive for the local community to own. Besides, in a single society, we may find many diverse communities based on multiple interests connected directly or indirectly with health. This diversity in interests makes the relegation of healthcare allocation to the community more utopian than practicable in addressing community justice of healthcare.

Nevertheless, Emanuel's above-mentioned levels of decision making in healthcare demonstrates how the allocation of medical resources has a political dimension and how community involvement in decision making is pertinent. Indeed, the political aspect of healthcare can also be connected to the funding system of healthcare finance. For instance, the decision concerning an important aspect of financing health services through general taxation and decisions over the use of this fund is filtered through political processes. Moreover, at the highest government level, the decision over how much of general government revenues should be dedicated to health services is a matter of political decision making, since it forces governments to weigh tradeoffs between health and roads, education, defense, and other public services.[242] Finally, different actors, including healthcare personnel, insurance companies, pharmaceutical companies, professional unions, political parties, civil society organizations, government and non-government organizations, and other personal and institutional agents, affect healthcare decisions. Hence, any ethical analysis and judgment concerning healthcare allocation and rationing must ineluctably supply a political analysis, since the practicality of ethics on social policy dilemmas such as healthcare justice and allocation is realized through the medium of ethics, politics, and institutional agents.

In connection to the politicization of health, one may claim that the Rawlsian approach to justice as equality of opportunity is enough to allocate and ration healthcare legitimately. Nevertheless, as presented above, healthcare is a special and primary good in moral terms, that determines other economic and social opportunities. Medical care directly affects human life and the general public's well-being. Besides, medical resources are scarce, and depending on situations, we may be forced to go beyond the principle of equality of opportunity for the fair allocation and rationing of the available medical resources. Hence, it

[242] World Health Organization. "Tax-based financing for health systems: options and experiences/by William Savedoff." In *Tax-based financing for health systems: options and experiences*/by William Savedoff, 2004, 7.

should not be left to the procedural aspect of justice based on the constitutional rules of equality of opportunity. As presented in an earlier section, we do not have agreed-upon principles for the fair allocation and distribution of medical resources in medical ethics and healthcare theories. Hence, in the absence of a consensus on distribution principles, it is imperative to shift to a fair deliberation process and negotiation to make decisions and judgments regarding allocating and rationing critical medical resources. Daniels calls this process accountability for reasonableness. In his approach, for judgments and decisions to be fair and legitimate, the processes of arriving at decisions and judgments should meet the conditions of publicity, reasonableness, revisability, enforcement, and legal appeal when the decision is found to be incompatible with scientific evidence.[243]

Indeed, Daniels' shift to the process or accountability for reasonableness can be illustrated with the tenets of deliberative democracy or an approach to bioethics called deliberative bioethics, as termed by Amy Gutmann and Dennis Thompson. Bioethical issues are controversial and difficult to address through theories or top-down institutional or constitutional procedures and rules. As a result, Guttmann and Thompson believe in the role of political theories of democracy and suggest deliberative democracy for solving bioethical issues and healthcare problems. In such a system, citizens and officials justify any demand for collective action by giving reasons that those bound by the action and the general public's values can accept. In this respect, as Gutmann and Thompson argue, deliberative democracy has four important social purposes for bioethics forums and debates. These are: promoting the legitimacy of collective decisions; encouraging public-spirited perspectives on public issues that are ethically controversial; helping to promote mutually respectful decision making; and assisting with the correction of mistakes that citizens, professionals, and officials inevitably make when they take collective action. [244]

The ethical issues of healthcare, such as the moral dilemma of allocation and rationing, arise as public policy dilemmas instead of being a specific moral problem related to the actions of an individual. The

[243] Daniels and Healthcare, 7.
[244] Amy Gutmann and Dennis Thompson, "Deliberating about Bioethics," *The Hastings Center Report* 27, no. 3 (1997), 38-41.

political sense of healthcare is also related to this public nature of the healthcare dilemma to be negotiated. Hence, the active involvement of members of a society or community concerning healthcare resource allocation and rationing is imperative for the observance of justice. In this regard, deliberative democracy as a process of decision making contributes to figuring out solutions for ethical problems of healthcare allocation through concerted debate and dialogue. Theoretically, deliberative democracy provides citizens and their accountable representatives with a chance to give one another mutually acceptable reasons to justify the laws and policies they adopt.[245] Likewise, healthcare is a social good, and the matters of allocation and rationing are public issues that need an approach which entails fair cooperation among key actors, agents, and people to reasonably accept certain healthcare approaches or deny them if they are found not useful. As discussed earlier, healthcare resources are limited; during scarcity, necessary tradeoff conditions are expected in any healthcare system. Hence, in scarcity, allocation and rationing need to be democratically deliberated, accepted, or denied with an intelligent social inquiry.

Notably, while deliberating ethically controversial issues, we will have the chance to examine the issue afresh with new scientific information and evidence considering the context. However, this does not mean that the deliberative approach to healthcare is flawless and practical for the fair distribution and rationing of healthcare. Deliberative democracy sometimes fails to work in healthcare when people are not treated equally during deliberation, or other extraneous factors such as wealth and race are included as criteria for reasoned dialogue. Besides, deliberative processes are likely to suffer when the government fails to provide equal opportunity in education for all, as well as other social benefits and economic inequalities. This claim sounds true, especially in Africa, where economic and social inequalities affect the level of citizens' participation in healthcare. The absence of a strong African agency in the African health system would also challenge the practicality of the deliberative approach to healthcare.

[245] Amy Gutmann and Dennis Thompson. "Just deliberation about health care." *Ethical dimensions of health policy* (2002), 77.

Besides, most deliberations concerning healthcare are influenced by agents' rhetoric force, which can have considerable bargaining power. Insurance companies, pharmaceutical companies, medical resource manufacturing industries, and private health institutions have immense negotiating power on decisions concerning healthcare. The case in the United States is also an example in which the policy option of universal healthcare, which has been put on the table many times before, has not been successful in the formal deliberative approach because of the forces of institutional and human agents. In this regard, a retreat from deliberation and the acceptance of healthcare as a duty may be considered a pragmatic approach and can be taken as acceptable for addressing the issue. [246] There are also circumstances in which non-deliberative means are useful. For example, less affluent American citizens cannot adequately insure themselves for decent healthcare or sufficiently influence the political process to overcome health inequity. Thus, if a non-deliberative process offers the only means to gain adequate healthcare coverage for these citizens, then deliberation may justifiably be limited for the sake of furthering fundamental opportunities and better deliberation in the future.[247]

4.6 Conclusion

As indicated in the previous chapter, the success of a deliberative democratic approach to solving ethical issues in a society, such as moral problems with assisted reproductive technologies or healthcare allocation and rationing, depends on the societal and political systems established based on the education of citizens and the democratic institutions. Dewey claims that education guarantees collective efficacy through liberation and the use of the diversity of individuals' capacity and knowledge. Through education, individual and collective efficacy can fix democracy. In this sense, democracy goes beyond the mere instrument of government, becoming a more humane way of life. In a democracy, we adapt ourselves to a social environment where we make relations, establish industrial arrangements, and build institutions to bring the overall growth to every member of the society. In a system where institutions are built, and

[246] Goldberg, Universal Health Care, 189-90.
[247] Gutmann and Thompson. Just deliberation, 79-80.

capacity and knowledge are shared through education, deliberative democracy serves as a means to actualize overall societal growth. In other words, democracy as a process and practical functioning is used to realize society's collective end by using individuals' capacities.

When we apply the earlier idea to the ethical issue of healthcare allocation and rationing, a deliberative approach to democracy is significant for making judgements and decisions using collective societal intelligence. Mainly, deliberative democracy is used to entertaining various viewpoints and suggestions from patients, health professionals, individuals, personal and institutional agents, stakeholders, politicians, policy planners, ethical experts and the public, hence coming up with justifiable and agreeable solutions. As noted earlier, the ethical problems of healthcare allocation and rationing are matters of a public policy dilemma. Hence, allocation and rationing should not be left to the conscience of physicians, nor can it be left to ethical principles, or constitutional procedures; instead, entertaining the plurality of values through open discussion in a democratic sphere involving the community and various actors in healthcare is a matter of necessity for the just and fair allocation and rationing of medical resources. Besides, the allocation of medical resources requires a consideration of the natures of disease and health and the societal understanding of disease and health. Different societies have multiple and culturally variant conceptions of disease and health, affecting allocation and rationing decisions both at macro and micro levels. Hence, a sensitivity to the values and attitudes of society towards disease, health, and treatments, considering the context where the morally problematic situation arises, is vital to figure out solutions for the underlying moral problems of allocation and rationing.

Chapter Five

The Context of Sub-Saharan African Healthcare Systems, Healthcare Allocation, and the Case of the COVID-19 Pandemic

5.1 Introduction

Africa is underdeveloped in terms of healthcare infrastructure.[248] In most countries in the region, healthcare is not prioritized as a matter of policy, and it is not given much attention considering the seriousness of health, compared to other social goods and services. Compared to other regions globally, sub-Saharan Africa has the lowest wellbeing ratings and the lowest satisfaction of healthcare service.[249] Historically, African healthcare policies and systems were influenced by previous colonizers, global organizations, donor countries, and emerging political and ideological waves coming from the Western world. For instance, the Declaration of Alma-Ata, from 6–12 September 1978, influenced African healthcare policies for a decade. The declaration was initiated by the WHO and UNICEF, emphasizing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the "health of all the world's people."[250]

The Alma-Ata Declaration primarily emphasized improving the health conditions of developing countries. The declaration affirms that health is not a state of complete physical, mental, and social wellbeing, and it is not merely the absence of disease or illness. Instead, it is a fundamental right, and every government should strive to attain and promote the health of all the people around the world. Hence, to achieve such a goal, emphasis was placed on affordable primary healthcare that considers a community's situation and provides promotive, preventive, curative, and rehabilitative services, especially

[248] Obinna O Oleribe, et al. , "Identifying Key Challenges Facing Healthcare Systems In Africa and Potential Solutions," *International Journal of General Medicine,* (2019), 395; see also D. M. Sanders, C. Todd, and M. Chopra, "Confronting Africa's Health Crisis: More of the Same Will Not Be Enough," *British Medical Journal* 331, no. 7519 (2005), 755–58.
[249] Angus S. Deaton and Robert Tortora, "People In Sub-Saharan Africa Rate Their Health And Health Care Among The Lowest In The World," *Health Affairs* 34, no. 3 (2015), 519.
[250] WHO, "Declaration of Alma-Ata" (1978), https://www.who.int/publications/almaata_declaration_en.pdf.

for developing countries.[251] However, when it comes to its practicality, it was challenging to implement the Alma-Ata Declaration of "health for all" in the developing world – mainly in Africa – due to the rising population growth, shrinking of government budgets, and the rise of the costs of health services and goods.[252] Mainly, the 1980s economic reform initiated by the WB and IMF, commonly called the Structural Adjustment Program, introduced a gap in the implementation of "health for all" by destroying social services and safety-nets,[253] leading to an indiscriminate reduction in access to care and also to poverty traps through privatization and the user fees method.[254] Other initiatives and declarations following Alma-Ata, initiated by global organizations such as the WHO and UNICEF, were designed to curb the health crisis in developing countries, and in Africa particularly.

The present healthcare crisis in Africa connected to COVID-19 is part of many years of problems emanating from the healthcare catastrophe in the region. The COVID-19 situation in Africa, and the world in general, is a challenge in many respects. As of February 12, 2021, around 108.4 million positive cases, 2.4 million deaths, and 80.4 million recovered individuals were reported globally due to the coronavirus disease.[255] The pandemic has resulted in increased healthcare demand, which has created the need to ration medical equipment and interventions.[256] For example, in the United States of America, diagnostic, therapeutic, and protective medical devices such as personal protective equipment, testing

[251] Ibid.
[252] Gilbert Dechambenoit, "Access to Health Care in Sub-Saharan Africa," *Surgical Neurology International* 7, no. 1 (2016), 11; see also Brunet-Jailly *Innovation in the health systems. Experiments of West Africa*. (Karthala, Paris; 1997).
[253] Agostino Paganini, "The Bamako Initiative Was Not about Money," *Health Policy and Development* 2, no. 1 (2004), 11.
[254] Margaret Whitehead, Göran Dahlgren, and Timothy Evans, "Equity and Health Sector Reforms: Can Low-Income Countries Escape the Medical Poverty Trap?," *Lancet* 358, no. 9284 (2001), 833; see also David H. Peters et al., "Poverty and Access to Health Care in Developing Countries," *Annals of the New York Academy of Sciences* 1136 (2008),161-71.
[255] Worldometer, "Coronavirus Update (Live): Cases and Deaths from COVID-19 Virus Pandemic," *Worldometers*, 2021, https://www.worldometers.info/coronavirus.
[256] Ezekiel J. Emanuel et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine* 382, no. 21 (2020), 2049.

supplies, equipment, and ventilation-related products are in high demand due to the COVID-19 public health emergency.[257]

During the virus outbreak, the WHO warned about the severe and mounting disruption to the global supply of personal protective equipment (PPE) and other medical equipment and drugs. While the main reason is the increase in the number of patients and rising demand worldwide, especially at the beginning of the outbreak, panic buying, hoarding, and misuse were also observed in many countries. In fact, to meet the rising global demand, the WHO estimated that the industry would have to increase manufacturing by 40%.[258] In Africa, a shortage of medical supplies, the absence of universal healthcare, and low GDP expenditure on healthcare, in addition to limited healthcare funds and insufficient coordination of healthcare infrastructure, have made healthcare allocation worse during COVID-19. Currently, vaccine allocation associated with financial risk will severely enlarge the issue, especially when considering the continent's past state. As the continent with the most vulnerable populations to infectious diseases, it is predicted to be significantly affected by the ongoing COVID-19 outbreak.[259]

This chapter aims to analyze the context of Sub-Saharan African healthcare systems, healthcare allocation, and the case of the COVID-19 pandemic. In the first part of this chapter, I explore the issues of healthcare scarcity and the dilemmas of medical resource allocation in Africa. In the second part of the chapter, I raise the worldwide health crisis resulting from the COVID-19 pandemic and examine the role of ethical principles of distribution and rationing of healthcare resources. In the final part, I reconsider the African healthcare situation during the pandemic and argue for the relevance of going beyond principles through an appeal to ethical deliberation and sensitivity to context in healthcare resource rationing and

[257] Government of USA (FDA), "Medical Device Shortages During the COVID-19 Public Health Emergency," 2020, https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-device-shortages-during-covid-19-public-health-emergency; see also Emanuel et al., Fair Allocation, 2049-2055.
[258] WHO, "Shortage of Personal Protective Equipment Endangering Health Workers Worldwide," *World Health Organization*, 2020, https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide%0A.
[259] Shabir Ahmad Lone and Aijaz Ahmad, "COVID-19 Pandemic–an African Perspective," *Emerging Microbes and Infections* 9, no. 1 (2020), 1302; see also Bibi Aisha Wadvalla, "How Africa Has Tackled Covid-19," *The BMJ* 370 (2020), 1-3.

distribution. However, this does not mean that principles are irrelevant in the allocation medical supplies in the normal condition or during the pandemic.

5.2 The Situation of Healthcare Scarcity and Allocation in Africa

As presented earlier, in the Alma-Ata Declaration, the implementation of primary healthcare services was proposed to achieve health for all. However, it was difficult to implement as promised, mainly due to the economic and financial crisis. As a result, in 1987, UNICEF and the WHO launched a new public health policy named the Bamako Initiative (BI). The initiative was aimed to improve access to healthcare by revitalizing primary healthcare, especially in developing countries.[260] The BI was introduced by James Grant, the then director of UNICEF, to respond to health crises due to the economic reform and the resulting financial crisis in African healthcare systems. As part of the initiative, in addition to donor and government support, community contributions to financing healthcare as well as an active role of the community in decision-making and ownership of Primary Health Centers (PHC) was emphasized.

Indeed, BI has three central pillars: community participation, self-financing mechanisms, and a regular supply of medication.[261] The initiative has the following objectives: promoting women and children's health through the funding and management of essential medicines at the community level; promoting the implementation of cost-recovery systems for the supply of essential drugs at the community level as a self-reliant means of supporting primary healthcare as a whole; and promoting the health of women and children in particular.[262] This scheme advocated direct resale of medication to users, with a small margin for generic medicines purchased at a low cost – a mechanism intended to ensure a regular supply of medicines and to help cover the operating costs of health centers.[263]

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[260] Valéry Ridde, "Is the Bamako Initiative Still Relevant for West African Health Systems?," *International Journal of Health Services* 41, no. 1 (2011), 175.
[261] Ibid; see also Paganini, The Bamako Initiative, 11-13.
[262] WHO, Bamacko Intiative (AFR/RC38/R18)" (1988), https://apps.who.int/iris/bitstream/handle/10665/101220/AFR_RC38_R18_eng.pdf?sequence=1&isAllowed=y; World Health Organization Regional Committee for Africa, "Review of the Implementation of the Bamako Initiative: Report of the Regional Director," 1999.
[263] Dechambenoit, Access to Health Care, 11.

After decades of implementing the BI, experiences from several countries such as Mali, Uganda, Burkina Faso, Ethiopia, and other countries in Sub-Saharan Africa showed that the policy did little to improve access to healthcare for the disadvantaged and excluded vulnerable population groups. In addition, studies identify that there were several problems with the initiative, such as discrimination against the poor, national healthcare being dependent on the sale of medication, and foreign currency requirements to import drugs versus an income in local currency.[264] Nonetheless, contrary to the initiative, African countries such as Senegal, Ghana, Gabon, Cote d'Ivoire, Kenya, and Benin, who adhere to universal healthcare through public funding, were able to improve the health conditions of their society.[265]

In fact, in Africa, the policy of healthcare financing followed by each country is the primary reason for the healthcare crisis in the region. On the whole, studies indicate that its dependence on assistance, privatization,[266] and the de-politicization of healthcare[267] is a bottleneck for African and developing countries' healthcare systems. More importantly, the de-politicization of healthcare initiated after the Bamako conference reoriented health services to the capitalist political economy of privatization. This neo-liberal thinking in healthcare failed to answer questions about how to reconcile the objectives of efficiency and equity in the financing, production, and distribution of healthcare, especially in addressing the demands of medical care by the low-income section of societies. In developing countries, most healthcare services are provided by the private sector. However, the private sector is thought to be controversial in developing countries' healthcare systems, since it has less regard for public expenditure. Besides, it is difficult to control the cost and quality of the health services provided by private health institutions.[268]

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[264] Chettly Anderson, "A Healthy Business?," in *World Health and the Pharmaceutical Industry*, 1990, 126.
[265] Dechambenoit, Access to Health Care, 11.
[266] Whitehead, Dahlgren, and Evans, Equity and Health, 833; see also Vasudeva N.R. Murthy and Albert A. Okunade, "The Core Determinants of Health Expenditure in the African Context: Some Econometric Evidence for Policy," *Health Policy* 91, no. 1 (2009), 61-62.
[267] Friedeger Stierle et al., "Indigence and Access to Health Care in Sub-Saharan Africa," *International Journal of Health Planning and Management* 14, no. 2 (1999), 81.
[268] Marc J. Epstein and Eric G. Bing, "Delivering Health Care to the Global Poor: Solving the Accessibility Problem," *Innovations: Technology, Governance, Globalization* 6, no. 2 (2011), 118..

Moreover, the pandemic and epidemic catastrophes such as malaria, HIV/AIDS, tuberculosis, and other infectious diseases, were also a challenge for the inefficacy of the promise of the BI in Sub-Saharan Africa. It has further led to revising the initiative with Millennium Development Goals (MDG) and the Abuja Declaration. In the Abuja Declaration, African governments have pledged to spend 15% of their annual budget on healthcare. However, since the resource base of African countries is weak, in the declaration, development assistance from developed and donor countries was emphasized.[269]

The recurrent healthcare crisis in Sub-Saharan Africa is related to the absence of consistent and homegrown healthcare policies on the government's side and the top-down and donor-led healthcare policies of each country. In the region, high child mortality rates and adult death due to diseases that can be treated with low-cost interventions mark low healthcare quality and low healthcare development. The weak resource base on the government's side, increasing healthcare demand, and rampant poverty have also rendered the quality, accessibility, and equity issues of healthcare questionable in the region. As Penchansky and Thomas claim, the healthcare problems in poor countries, mainly in Sub-Saharan Africa and South Asia, have been problems of accessibility, allocation problems, and under-utilization of healthcare services. Indeed, access to healthcare is broadly conceived based on the availability, accessibility, affordability, and acceptability of the healthcare service.[270] Based on those indicators, African healthcare is characterized by an insufficient economic and financial resource base: lack of adequate and just allocation mechanisms geographically and based on income disparities; inadequate or poor quality of healthcare services; and low accessibility for rural communities and the low-income sections of society.[271]

In developing countries, access to healthcare is affected both by demand-side factors and supply-sides factors. But considering the intervention to poor health status in developing countries, the demand-side

[269] Organisation of African Unity, "The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases," no. April (2001), 7.
[270] Roy Penchansky and J. William Thomas, "The Concept of Access: Definition and Relationship to Consumer Satisfaction," *Medical Care* 19, no. 2 (1981), 127-40.
[271] Owen O'Donnell, "Access to Health Care in Developing Countries: Breaking down Demand Side Barriers," *Cad. Saúde Pública* 23, no. 12 (2007), 2822-31.

factors of underutilization of healthcare did not receive attention, such as household income, education, and cultural background.[272] Lack of financial resources and flawed delivery systems of healthcare are the major factors for the low health status in developing countries and Sub-Saharan Africa. On the contrary, health service demand in the less affluent societies is high, since they are vulnerable to infectious and other chronic diseases. However, as studies indicate, healthcare allocation is biased; most of the time, the rich benefit more from the available services than the poor. As a result, the benefits of health services and coverage disparities between the poor and rich are huge in developing countries including Sub-Saharan Africa.[273] The reason could be related to the absence of universal healthcare policies and packages in the region, with the exception of Tunisia and Botswana.

For the low-income section of societies, the user fee is a large challenge for healthcare allocation, which is further connected to capitalist free-market policies rooted in the BI and the structural adjustment program of the WB and IMF. Moreover, as noted in the previous chapter, poverty and ill-health are related concepts – developing countries have worse health outcomes than better-off countries, and the poor have worse results than the better-off. As such, the distribution of the healthcare budget between the rich and the poor is highly unequal, and most users of the healthcare budget constitute the affluent sections of society.[274]

As discussed in the previous chapter, allocation of healthcare is a response to the increasing demand for health services under limited medical resources. Allocation, especially under the conditions of poverty, such as in Sub-Saharan Africa and parts of Asia, is a painful task in which the observance of ethical principles with sensitivity to context is necessary. Indeed, when we see most African healthcare systems' histories, countries follow a top-down approach as well as rules of allocation and rationing often imposed by, or copied from, donor countries, previous colonizers, and declarations, policies, and initiatives from international organizations. For instance, following the structural adjustment program, the WB and the

[272] Ibid.
[273] O'Donnell, Access to healthcare, 2822.
[274] Adam Wagstaff, "Poverty and Health Sector Inequalities," *Bulletin of the World Health Organization* 80, no. 2 (2002), 97-102.

IMF introduced the "quality index of health" metrics and devised cost-effectiveness as a mechanism to allocate healthcare resources in developing countries and Africa. To ration healthcare, "exclusion" and "rationing by refusal" have been used as a rule.[275] Recently, many countries also follow the WHO rationing and allocation guidelines, such as priority setting and cost-benefit analysis, as part of their strategy.

Nevertheless, the allocation and rationing guideline coming from these organizations to Africa is criticized, as it does not consider the context of the region. Besides, steps taken by the WB and IMF did not consider the sociology of disease and socio-cultural situations that matter for healthcare allocation and interventions. The political environment of allocation decision-making is authoritative, in the sense that governments of respective countries have no autonomous power to deliberate concerning healthcare policies, to say nothing of community involvement. The WB and IMF use their economic assistance as a protocol and impose policies without considering these countries' socio-cultural local situation. As Stefanini insists, the WB uses universal measures to address healthcare issues in the North and South with the same techniques and impose rationing allocation models without considering the context of the region and disregarding the democratic procedure.[276]

As claimed in the previous chapter, health and disease are relational and sociological concepts whose meaning is culturally variant and plural. Accordingly, in the healthcare system, we need to consider the contextual dynamics of illness and its treatment in the provision and allocation of healthcare. Besides, since health is affected by poverty, a focus on healthcare allocation justice should consider solving the root cause of poverty. In this regard, justice in African healthcare systems goes beyond a simple allocation of available medical supplies to address the existing economic and social inequalities and their effect on public health. In connection with this, the matter of justice in healthcare in Africa calls for regulated healthcare financing and a solid economic base for the health sector, since the current health crisis is hugely connected to these factors. Indeed, concerning healthcare funding, general taxation, social

[275] Stefanini, Ethics in Health Care, 710-11.
[276] Ibid, 711.

health insurance, community-based insurance, and out-of-pocket payments may be suggested as a sustainable financial source and be free from donors' influence. However, a survey of African countries' healthcare systems such as the case of Ghana, Tanzania, South Africa and others shows that all these systems are already found in Africa to various degrees.[277] Nevertheless, these financial sources are not regulated and monopolized by the central healthcare systems of respective countries. That is why it is rare to find countries with universal healthcare systems in Africa.

When we consider the allocation and rationing of healthcare in Africa, a pragmatic means which should be taken first, to address questions of justice in each country, is a move towards universal healthcare. Of course, universal healthcare has been a global plan for the last half a century. Still, many countries, especially in Africa, have failed to achieve a universal healthcare system – health for all. In the absence of universal healthcare or at least a regulated healthcare system that controls the public and private health institutions, it is difficult to reason out and endorse ethical principles such as the principle of equality, the principle of priority, the focus on maximizing benefits, or the principle of cost-effectiveness as a just value of, or principle for, allocating medical resource in the region. Yet, it should be emphasized that amid the situation on the continent, an openness for public deliberation is suggested as significant for addressing moral questions of allocation and fairness through the considerations of the views of the community, ethicists, clinicians, physicians, triage committees, government bodies, and institutional and personal agents and stakeholders. However, this does not mean that ethical values and principles are insignificant in the context of Africa. Instead, in addition to the mainstream values and principles of allocation and rationing known in bioethics, the values and principles that emerged out of the cultural values and belief systems of each community in the region should also be considered as a possible hypothesis and preemptive guide in ethical deliberations to make judgments and decisions.

5.3 The Case of COVID-19 Pandemic

[277] Anne Mills et al., "Equity in Financing and Use of Health Care in Ghana, South Africa, and Tanzania: Implications for Paths to Universal Coverage," *The Lancet* 380, no. 9837 (2012), 126-133.

As presented elsewhere in this chapter, the outbreak of the COVID-19 pandemic has resulted in increased healthcare demand, which has created the need to ration medical equipment and interventions. Such an increase in demand has been observed in the USA, one of the world's leading economies. In almost all countries in Europe, the need for medical equipment and other preventive utilities has increased since the outbreak of the virus. For example, in Italy, during the first wave of the COVID-19 explosion, the national healthcare service was almost close to collapse due to years of fragmentation and decades of finance cuts, privatization, and deprivation of human and technical resources.[278] Similar situations of shortages of preventive medical equipment and vaccines after its introduction have been observed even in European countries with universal healthcare systems and adequate healthcare funds. In general, Europe has experienced an increase in some medicines used for patients with COVID-19. These include anesthetics, antibiotics, and muscle relaxants, as well as some medications used off-label. This contributed to shortages of medical supplies.[279] Further, due to the pandemic, increased illegal activities focused chiefly on medical devices linked directly or indirectly to the pandemic have been observed.[280]

A study from China suggests that close to 80% of those infected by the virus are asymptomatic or have mild symptoms. Based on these findings, of all the total patients infected by the virus, 20% require advanced medical services. [281] It makes the allocation and rationing of medical supplies complex both at the national and clinical levels. Besides, identifying patients eligible for using some medical supplies and denying others amid shortages has been a challenge at the clinical level decision-making. The situation of other patients affected by other chronic diseases, and who were under treatment for a long time, is also

[278] Miralles et al., Unmet Needs, 4-5; see also Benedetta Armocida, Beatrice Formenti, Silvia Ussai, Francesca Palestra, and Eduardo Missoni. "The Italian health system and the COVID-19 challenge." *The Lancet Public Health* 5, no. 5 (2020), 253.
[279] European Medicines Agency, "Availability of Medicines during COVID-19 Pandemic | European Medicines Agency," 2020, https://www.ema.europa.eu/en/human-regulatory/overview/public-health-threats/coronavirus-disease-covid-19/availability-medicines-during-covid-19-pandemic.
[280] European Directorate for the Quality of Medicines, "Impact of COVID-19 Crisis – National Authorities in Europe Report Shortages of Medical Products and Increase in Illegal Activities," 2020, https://www.edqm.eu/en/news/impact-covid-19-crisis-national-authorities-europe-report-shortages-medical-products-and.
[281] Zunyou Wu and Jennifer M. McGoogan, "Characteristics of and Important Lessons from the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72314 Cases from the Chinese Center for Disease Control and Prevention," *JAMA - Journal of the American Medical Association* 323, no. 13 (2020), 1239.

another issue that has been a burden for many countries.[282] Such problems of shortages have been observed, especially in terms of ICU beds, ventilators, clinical expertise, personal protective equipment (PPE), COVID-19 testing kits, medications, and vaccines.[283]

At the global level, the virus has demanded each nation's unexpected budget allocation to prevent the spread of the virus and protect the healthcare system from collapse. During the pandemic, allocating limited medical supplies at the national level to regions and hospitals affected by the virus has been a challenge for all countries globally.[284] The disparity between poor and wealthy COVID-19 patients and medical care use is another allocation challenge which has been observed, especially in resource-poor countries with no universal healthcare system. For instance, in Bangladesh, several patients with COVID-19, especially in poor and middle-class areas, have been denied care, while elites are prioritized to receive such scarce resources.[285]

The COVID-19 situation in Africa is a challenge in many aspects. As of February 14, 2021, in Africa, the total cases of COVID-19 were almost 3.8 million, and the number of deaths was 98,310.[286] Shortage of medical supplies, absence of universal healthcare, and low GDP expenditure on healthcare, in addition to limited healthcare funds and insufficient coordination of healthcare infrastructure, have made healthcare allocation worse in the region.[287] The situation during COVID-19 pandemic is even more worse in the

[282] G.J. Melman, A.K. Parlikad, and E.A.B. Cameron. "Balancing Scarce Hospital Resources during the COVID-19 Pandemic Using Discrete-Event Simulation*." Health Care Management Science* 19 (2021), 1; Keymanthri Moodley et al., "Allocation of Scarce Resources in Africa during COVID-19: Utility and Justice for the Bottom of the Pyramid?" *Developing World Bioethics* 21, no. 1 (2021), 36-43; Rawlings et al., Ethical Consideration, 2217' see also Emanuel et al., Fair Allocation, 2054.

[283] Angus Dawson et al., "An Ethics Framework for Making Resource Allocation Decisions Within Clinical Care: Responding to COVID-19," *Journal of Bioethical Inquiry*, 2020,2.
[284] Jonathan Pugh et al., "Beyond Individual Triage: Regional Allocation of Life-Saving Resources Such as Ventilators in Public Health Emergencies," *Health Care Analysis*, no. 0123456789 (2021), 18.
[285] Md Sanwar Siraj, Rebecca Susan Dewey, and A. S.M.Firoz Ul Hassan, "The Infectious Diseases Act and Resource Allocation during the COVID-19 Pandemic in Bangladesh," *Asian Bioethics Review* 12, no. 4 (2020), 491.
[286] Worldometer, "Coronavirus Update (Live): Cases and Deaths from COVID-19 Virus Pandemic." 2021, https://www.worldometers.info/coronavirus/coronavirus-death-toll/?fbclid=IwAR2sarY1v353_rN-908423AZmyt9yIOdZGQ_Z5E_dEXa_p031wviPQMPUfo.
[287] Barbera, Williams, and Taylor-robinson, Key Challenges, 398.

region.[288] Vaccine allocation associated with financial risk is now also a big challenge in the region, as a result of the previous state of healthcare on the continent.

According to a WHO report, in April 2020, there were just 2,000 ventilators across 41 African countries and 5,000 intensive care beds across 43. According to a CDC Africa report, the lack of human personnel is another issue. The Sub-Saharan region has 0.2 doctors for every 1,000 people. As a result, the continent with the most vulnerable populations to infectious diseases is predicted to be significantly affected by the ongoing COVID-19 pandemic.[289] Respective governments in Africa have implemented various preventive and protective mechanisms, such as PPE and lockdowns to decrease physical contact of people. However, since the majority of the African population lives from hand to mouth, measures such as lockdowns, "stay at home" directives, and other international best practices did not and do not work in the region.[290]

Compared with the normal state of affairs, the allocation and rationing issues experienced in the COVID-19 context are very serious, in that rationing limited medical resources to many populations who are unwell is a challenge in many ways. As a result, the situation forces us to move away from applying ethical principles and guidelines of allocation to individuals, to a more general focus on caring for society as a whole. Different authors have proposed various principles and values relevant to the distribution of healthcare resources fairly and efficiently during a virus outbreak. Concerning ethical values, one of the comprehensive studies done during the first wave of the pandemic is by Emanual et al. in their study, they argue that instead of basing decisions on individual institutions' approaches or a physician and clinician's intuition, it is necessary to allocate based on ethical values and principles. This dependence on values and principles is indispensable to minimize physicians' stress on decision-making and fairly allocate scarce medical resources to patients. Regarding these values, Emanual et al. draw the following

[288] Bibi Aisha Wadvalla, "How Africa Has Tackled Covid-19," *The BMJ* 370 (2020), 1-3; see also Samuel Nkachukwu Uwaezuoke, "Strengthening Health Systems in Africa: The COVID-19 Pandemic Fallout" *Journal of the Pan African Thoracic Societ* 1, no. 1 (2020), 15.
[289] Bibi Aisha Wadvalla, How Africa Has Tackled, 1; see also David Nderitu and Eunice Kamaara, "Gambling with COVID-19 Makes More Sense: Ethical and Practical Challenges in COVID-19 Responses in Communalistic Resource-Limited Africa," *Journal of Bioethical Inquiry* 2020, no. March (2020), 1-5.
[290] Nderitu and Kamaara, Gambling with COVID19, no page given.

recommendations: maximize benefits; prioritize health workers; do not allocate on a first-come, first-served basis; be responsive to evidence; recognize research participation; and apply the same principles to all COVID-19 and non–COVID-19 patients.[291] Equally, Rawlings et al. also observed that principles such as maximizing benefits, treating people equally, rewarding instrumental value, and prioritizing the worst-off, in addition to other principles, are essential to allocate resources during the pandemic.[292]

Essentially, the above recommendations suggested by Emanual *et al.* relevant for the coronavirus pandemic, are modified versions of the four major principles which have been discussed earlier in Chapter Four, based on Pansad *et al*., which includes: treating people equally; maximizing the benefits produced by scarce resources; promoting and rewarding instrumental value; and giving priority to the worst-off. Emanual *et al*. agree that each of these values has strengths and limitations, and that trade-offs are necessary. In the study, the importance of maximizing benefits is emphasized as the most important in the context of the pandemic, which is further coupled with saving the most lives and saving more life-years gained after treatment. Mainly, in the current pandemic situation, they advise going beyond the egalitarian principle of equality and making decisions by prioritizing the benefits we bring to society. Nevertheless, the maximizing benefits principle is suggested as a principle which is not sufficient allocate healthcare resources; instead, considering the principle of rewarding instrumental value is also underlined as a relevant guideline and value. Regarding the direction of rewarding instrumental value, authors recommend priority to frontline healthcare workers and others who care for ill patients and keep critical infrastructure operating. Such instrumental value also applies to those who participate in research to prove the safety and effectiveness of vaccines and therapeutics.[293]

Emanual et al. underline the need to balance multiple principles instead of applying a single principle. In this regard, the priority principle is also emphasized as an essential value in the fair allocation of scarce medical resources. Concerning the priority principle, Emanual et al. agree on prioritizing older

[291]Emanuel et al., Fair Allocation, 2051.
[292] Rawlings et al., Ethical Considerations, 2218-2221.
[293] Emanuel et al., Fair Allocation, 2053.

individuals, since COVID-19 outcomes have been significantly worse in older persons. However, regarding the use of scarce resources such as ventilators and ICU beds, for a similar prognosis, following maximization of benefit through the number of life-years is desired as a significant value and principle.[294] Furthermore, Emanual et al. recommend that the principle of equal opportunity should also be observed, especially for patients with similar prognoses, patients with COVID-19, and those with other medical conditions. In this regard, specific rules such as the first-come, first-served or lottery system may be applied. However, during the pandemic, the two techniques are criticized as inefficient to rationing healthcare fairly. For instance, as discussed in the previous chapter, the first-come, first-served approach would unfairly benefit patients living nearer to health facilities. It may also result in over-crowding and even violence during a period when social distancing is paramount. Finally, following first-come, first-served may mean that those who get sick later would be excluded from treatment. To avoid problems of first-come, first-served, Emanuel *et al.* suggest a lottery system to ration medical resources for patients of equal prognosis.

As argued in the previous chapter, no single principle or value is enough to guide the fair and efficient allocation of healthcare resources at both the macro and micro levels. Emanual *et al.* also claim that balancing multiple ethical values by following the procedural approach eases the physicians' stress on allocating scarce resources. However, they also stress that institutions may employ triage officers, physicians in roles outside direct patient care, or committees of experienced physicians and ethicists to help apply guidelines to assist with rationing decisions.[295] As Bhatia claims, in the context of the COVID-19 pandemic, instead of straightforward application principles, following an approach to make a decision based on open deliberation is significant for allocating and rationing medical resources. Especially, decision-making through organizing a triage committee which includes ethicists and representatives of the

[294] Ibid, 2053.
[295] Ibid, 2054.

community is paramount for filling in the loopholes in principle-based and paternalist approaches of healthcare allocation and rationing.[296]

As noted in an earlier chapter, no single principle or a combination of principles of allocation and rationing is sufficient enough to allocate scarce resources fairly. The main reason for this is that each principle has ethical flaws, and the moral dilemma of rationing is controversial, meaning that a solution attained at the hand of one principle can be equally discounted as unfair at the hand of another principle or principles. More than this, the allocation and rationing problems experienced in the pandemics in general and the COVID-19 situation in particular are unique in that we are forced to ration limited medical resources in many populations which are unwell and need critical care medical resources. Hence, in such a situation, instead of depending solely on principles, negotiating the distribution of medical supplies publicly through a transparent and honest discussion is important for the allocation of healthcare resources fairly and efficiently, especially at the macro level. Indeed, such deliberation allows individuals to gain a better understanding of how public funds are allocated and distributed. Moreover, a discussion is helpful to address moral issues of fairness in allocation and rationing, which are the loopholes of a principle-based approach to healthcare.

In a more pragmatist sense, open public discussions and scrutiny forces health authorities and physicians to make audited decisions, prevents arbitrary decisions, and encourages democracy through more societal and patient involvement.[297] However, it should not be denied that at a clinical micro level decision-making, community discussions for decision-making on the allocation of medical supplies may not be significant, and practicality may be questionable. It is true, especially with the case of the COVID-19 pandemic, that physical distancing is advised in order to control the spread of the virus.[298] Still, especially at the macro level, ethical deliberation is significant for the setting of clinical guidelines for physicians or

[296] Bhatia, We Need to Talk, no pages given.
[297] Bill New, "The Rationing Agenda in the NHS," *British Medical Journal* 312, no. 7046 (1996),1593-1601,.
[298] Richard Norman et al., "Public Preferences for Allocating Ventilators in an Intensive Care Unit: A Discrete Choice Experiment," *The Patient - Patient-Centered Outcomes Research* 14, no. 3 (2021), 328.

health departments,[299] and to decide on available resources based on facts and evidence on the ground. Besides, ethical deliberation is thought significant for the consideration of the views of various agents, stakeholders, ethicists, and the general public. As Dawson et al. argue, decisions are more likely to be accepted by individuals, clinical teams, organizations, and the public if the public can see that the decision-making process is fair.[300] This appeal to the process signifies what Normans Daniels pleas for, namely accountability for reasonableness for allocating healthcare resources.[301]

As noted elsewhere, we do not have a clear and straightforwardly applicable principle useful for allocating healthcare resources in every context. As Moodley et al. claim, the issue of how to allocate scarce medical resources fairly and how to responsibly control a novel infectious disease are questions that have to be negotiated in specific epidemiological, social, and political contexts. Indeed, ethical judgments concerning allocation and rationing should be contextually sensitive. Similarly, the relevance of each principle during ethical decision-making should depend on context. Hence, when we come to the African context of COVID-19 and resource allocation and rationing, we should not straightforwardly apply principles proposed in a Western setting. Such principles are not always effective as guidelines to allocate scarce resources.[302]

Sometimes there are situations where these principles should be in line with the concrete condition and the value of the community. As Moodley et al. argue, for instance, in the case of the priority principle, maximization and priority through saving more lives and the saving more quality life years prioritization principle, which is endorsed by Emanuel *et al*., are questionable, either considering the different backgrounds of patients or the values of different communities in Africa. For instance, there are ethical reasons to consider local community views about the life course when making decisions about allocation. For instance, if the prudential life span conception of the life course is alien to how communities associate

[299] Dawson et al., Ethics Framework, no pages given; see also Norman et al., Public Preferences, 319.
[300] Ibid, no pages given.
[301] Daniels, Justice and Healthcare, 9.
[302] Tangwa and Munung,and Nchangwi Syntia Munung. "COVID-19: Africa's Relation with Epidemics and Some Imperative Ethics Considerations of the Moment." *Research Ethics* 16, no. 3–4 (2020), 8; Moodley et al., Allocation in Africa, 5; Nderitu and Kamaara, Gambling with COVID-19, no pages given.

age and value, then using the prudential life span principle as a tiebreaker may be a strange imposition of an alien construct and undermine community trust in the basis on which life and death decisions are being made.[303] For instance, in the Akamba tribe in Kenya, a special value is placed on the elderly, considering them the highest moral authorities of a community. Such cultural beliefs call into question Western preferences for the young as normative guidelines in allocating medical resources.[304]

Moreover, as Cordeiro-Rodrigues and Ewuoso argue, looking at healthcare rationing in light of the Afro-communitarian ontology, priority is given to community harmony. Community harmony in African societies is essentially based on the adult and elderly groups of the society. Hence, in allocating resources during scarcity or pandemics, priority is given to the persons of higher moral values, having instrumental value to the harmony of the community.[305] To this end, priority may be given to adults and the elderly who have instrumental value to the community. Hence, it is important to undertake societal experimentation of the underline value through democratic deliberation and publicity.

Furthermore, in the context of Africa, it is difficult to apply the equality of opportunity principle through a lottery system or first-come, first-served principle, since this system can be easily abused to favor some groups. Besides, in low- and middle-income countries in Africa, medical resources such as ICU beds and ventilators are already scarce and dividing the already limited resources into COVID-19, and non-COVID-19 patients is challenging, given the mounting number of COVID-19 cases. In this regard, some patients who might have gained access to critical care a few months ago could be tragically out of luck during the COVID-19 crisis. This requires a carefully considered allocation of scarce resources by priority setting across disciplines, regardless of COVID-19 status. It also requires quick upscaling of human resources and facility capacity and process optimization to assist with performing more fundamental and routine tasks efficiently and cost-effectively, while considering the context.[306] Moreover,

[303] Moodley et al., Allocation in Africa, 2.
[304] Kilner, Age as a Basis, 413.
[305] Cordeiro-Rodrigues and Ewuoso, A Relational Approach, no page given.
[306] A. Taylor et al., "How Should Health Resource Allocation Be Applied during the COVID-19 Pandemic in South Africa?," *South African Medical Journal* 110, no. 7 (2020), 399.

concerning healthcare workers, priority should be given to frontline workers directly involved with COVID-19. Still, the issue of other health workers who are not directly involved should ideally be a matter of public debate.[307] Clinical research during a pandemic is also pertinent, and priority should be given to those who voluntarily take part in clinical trials. However, often in medical research, people of low- and middle-income countries are exposed to coercion and exploitation to research-related medical experiments and trials. Hence, it is essential to publicize COVID-19 clinical research and give awareness to the general public. Additionally, in response to the COVID-19 pandemic, attention should be given to low-income sections of society, since many populations are economically and socially marginalized in Africa, and the highest burden of disease falls on them.

5.4 Conclusion

While ethical guidelines and values are essential, it should be emphasized that the process of taking patient care allocation decisions out of the hands of clinicians or individual health institutions and placing them in the hands of triage officers or committees of physicians, ethicists, and community members is identified as essential in the African context. Considering the history of African healthcare systems, such triage systems and active involvement of community members have been used to fight against Ebola, HIV, malaria, and other pandemic diseases. In addition, African countries have leveraged experiences from past epidemics to build resilience and response strategies through community engagement. [308] Hence, given the context of Africa, a deliberative approach built on intensive community engagement is recommended as significant for providing practical and ethical responses to the COVID-19 pandemic. However, for the long term, I propose that establishing an African agency that decides by itself the matters of healthcare through the active involvement of Africans is a pragmatic and sustainable manner of addressing the existing healthcare crisis in the region.

[307] Moodley et al., Allocation in Africa, 3-4.
[308] CésaireAhanhanzo, et al., "COVID-19 in West Africa: regional resource mobilisation and allocation in the first year of the pandemic." *BMJ Global Health* 6, no. 5 (2021), 1.

Chapter Six

Organ Trafficking and Africa: A Pragmatist Considerations

6.1 Introduction

Organ transplantation is a newly emerging medicinal science which has shown significant developments since the second half of the twentieth century. Advances in medical technologies such as mechanical ventilators, cardiac pacemakers, and drugs that maintain blood pressure have brought the threat of death under the physician, family, and patients' control. Such technological advances have opened up ways to harvest fresh organs for transplantations. Indeed, newly emerging human tissue banking[309] and organ freezing devices, as well as immuno-suppressive drugs have eased the task of tissue matching and further enhanced transplantation research.[310] As a result, solid organ transplantations from both deceased and live donors have saved the lives of those affected by terminal organ failures and improved patients' quality of life.

Nevertheless, in recent years, ethical and technical problems such as high organ demand and the resulting issues of allocating the available organs, donor autonomy and consent, the dead-donor rule, and related moral problems of retrieving organs from deceased and live donors challenge the development of transplantation medicine. Moreover, alternative recommendations such as legalizing organ selling, incentivizing donors and their families, and organ retrieving mechanisms from deceased donors through the flexibility of the dead-donor rule and reformulation of 'consent' have over-crowded the debates over organ transplantations. However, in recent years, organ trafficking—the recruitment, transport, transfer, harboring, or receipt of living or deceased persons or their organs[311]—has become a pressing issue in bioethics, in debates on transplantation, and in research on migration. Studies show that compared to other forms of illicit trafficking of humans, organ trafficking and its connection with migration is the least

[309] Louise Irving and John Harris, "Biobanking," in *The Oxford Handbook of Bioethics*, ed. Bonnie Steinbock (Oxford University Press, 2007), 240-46.
[310]Ronal Mulson, "organ transplantation," in *The Oxford Handbook of Bioethics*, ed. Bonnie Steinbock (Oxford University Press, 2007), 211.
[311] The American Society of Nephrology, "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism," 3 *Clinical Journal of the American Society of Nephrology* (2008), 2.

researched of all kinds of crimes.[312] Surprisingly, a 2017 report listed illegal organ trade as the fourth among the top 11 transnational crimes, with an estimated annual value ranging from $840 million to $1.7 billion.[313]

Studies indicate that worldwide approximately 100,000 patients undergo organ transplantation annually.[314] For example, according to the Global Observatory on Donation and Transplantation (GODT) report, in 2018, the overall number of transplantations was 146,840.[315] Nevertheless, the worldwide transplantation rate is, in general, still far from meeting global needs. Besides, organ transplantation's global distribution is highly unequal, showing a marked difference from region to region.[316] For instance, only a few countries in Africa have developed better systems of transplantation. A 2016 study shows that living-related-donor transplantation is limited to a few countries, such as South Africa, Egypt, Nigeria, Ghana, Kenya, Algeria, Sudan, Tunisia, Ethiopia, and Cameroon.[317] Between 2016 and 2018, seven countries (Algeria, Côte d'Ivoire, Ethiopia, Kenya, Namibia, Nigeria, and Uganda) had functional transplantation programs from living donors.[318] Moreover, in the region, deceased donation for organ transplantation is still only available in South Africa.[319] This situation seems surprising when the 2019 worldwide figures of deceased organ donations in different countries is considered. For instance, in 2018, countries such as Spain (48.9 per million population), the U.S.A. (36.88 per million population), Croatia (34.63 per million population), and Portugal (33.63 per million population) had the highest numbers of

[312] Sallie Yea, "Trafficking in Part(s): The Commercial Kidney Market in a Manila Slum, Philippines," *Global Social Policy* 10, no. 3 (2010): 358; Juan Gonzalez, Ignacio Garijo, and Alfonso Sanchez, "Organ Trafficking and Migration: A Bibliometric Analysis of an Untold Story," *International Journal of Environmental Research and Public Health* 17, no. 9 (2020, 1.
[313] Dave Kar and Joseph Spanjers. "Transnational crime and the developing world." *Global Financial Integrity. Washington* (2017), xi.
[314] Francis L. Delmonico et al., "A Call for Government Accountability to Achieve National Self-Sufficiency in Organ Donation and Transplantation," *The Lancet* 378, no. 9800 (2011), 1414.
[315] Global Observatory On Donation And Transplantation, "Summary Global Report 2018," 2020. http://www.transplant-observatory.org/data-charts-and-tables/.
[316] Josep M. Grinyó, "Why Is Organ Transplantation Clinically Important?," *Cold Spring Harbor Perspectives in Medicine* 3, no. 6 (2013), 1; see also Elmi Muller, "Transplantation in Africa - an Overview," *Clinical Nephrology* 86 (2016), 90-95.
[317] Muller, Transplantation in Africa, 90.
[318] André Loua et al., "A Review of Policies and Programmes for Human Organ and Tissue Donations and Transplantations, WHO African Region," *Bulletin of the World Health Organization*, 2020, 2.
[319] Muller, Transplantation in Africa, 90.

actual deceased organ donors. In 2016, South Africa had 1.29 per million population or 72 deceased donors,[320] while no other African countries have figures available for transplantations from deceased donors.

In countries with advanced transplantation facilities, an increasing number of qualified patients remain on the waitlist—for instance, the 2020 the U.S.A. Renal Data System shows the imbalance between the rising trend of organ demand and the increased average waitlist time of five years. Of course, thousands are removed from the waitlist due to death or as a result of becoming too sick for transplantation. Except in a few countries (such as Iran and Spain), the increasing number of patients who need organ transplantation has led to a critical shortage of organs. This organ shortage has fueled the development of the illicit organ trade and organ trafficking. Remarkably, the rising number of older people and their associated health complications, and the demand for organs in affluent nations, has become a challenge in terms of balancing the supply and demand of organs. In Europe and the U.S.A the number of available deceased and living donors seems insufficient to address the growing demand for organs.[321] For instance, in 2017, the total supply of kidneys in the U.S.A. was 20,000. This number covers only 25% of the estimated patients on the waitlist for transplantation in that year. The total number of transplantations conducted was 39,712, less than half of the total number of patients who desperately needed transplantations. As a result of organ shortage, approximately 10% of transplantation took place in black markets, with patients desperately searching for transplantation through illegal means.[322]

Due to the shortage of organs in their home countries, each year many patients from high-income countries travel to areas where organs are obtainable through commercial transactions. Commercial transaction opened up a new business called transplant tourism.[323] Most transplant tourists are from Europe, the U.S.A., Canada, the Republic of Korea, Japan, Israel, Malaysia, and the Middle Eastern

[320] Global observatory on donation and transplantation, 2016. http://www.transplant-observatory.org/summary/.
[321] Leo Roels and Axel Rahmel, "The European Experience," *Transplant International* 24, no. 4 (2011), 350-351.
[322] Bahar Bastani, "The Present and Future of Transplant Organ Shortage: Some Potential Remedies," *Journal of Nephrology* 33, no. 2 (2020), 286.
[323] I. Glenn Cohen, "Transplant Tourism: The Ethics and Regulation of International Markets for Organs," *Journal of Law, Medicine and Ethics* 41, no. 1 (2013), 269.

countries. Most of the time, these patients travel to low-income countries and purchase either organs from a paid donor or trafficked organs to undergo transplantation at a low price. Transplant tourism and the shortage of available organs, in addition to failures of managing organ transplantations worldwide, have contributed to illicit organ transplantations and trafficking. Studies indicate that, this business has made the less affluent sections of societies as well as migrants vulnerable to social, psychological, economic, and health problems. [324] The illegal organ trade backed by organ trafficking is fueled by the growing demand for organs and the fact that organ traffickers have networks in different parts of the world. The WHO based study estimated that annually over 10,000 kidneys are traded on the black market worldwide. The 2007 estimate indicates that up to 5-10% of transplants worldwide are done through illegal means with commercialized and trafficked organs.[325]

Global and regional organizations and several countries have formulated various laws, policies, resolutions, and guidance documents on transplantation in order to overcome organ shortage and control organ trafficking. The guiding principle adopted in 1991 by the World Health Assembly (WHA57.18) approved dead donors and genetically related donors as potential organ sources. The World Health Organization's (WHO) guiding principles on human cell, tissue, and organ transplantation also prohibits giving or receiving money for organs[326]. Similar principles, rules and values guiding transplantations and controlling organ commerce were also emphasized in the Istanbul Declaration (2008), which has been subsequently endorsed by more than 135 national and international medical societies and governmental bodies. Hence, worldwide, *altruistic organ donation* is considered as a *de facto* recognized principle and rule governing organ source in transplantations by almost all countries in the world. However, quite the opposite, studies indicate that altruism as a rule for organ procurement and the resulting worldwide organ shortage observed globally is considered a reason for organ trafficking. In fact, to battle organ trafficking,

[324] Ibid, 273-79; see also Yosuke Shimazono, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information," *Bulletin of the World Health Organization*, vol. 85, (2007), 960.
[325] Shimazono, International Orga Trade, 959.
[326] WHO, "World Health Organisation Guiding Principles on Human Cell, Tissue and Organ Transplantation," *Who Guidlein on Organ Trasplantation* § (2010).
https://www.who.int/transplantation/Guiding_PrinciplesTransplantation_WHA63.22en.pdf.

ethicists mainly from the aspect of utilitarian ethicists suggest regulated organ selling,[327] compensation donations,[328] and non-directed paid donations[329] as solutions, instead of *altruistic orthodoxy*.

In this chapter, I observe organ trafficking in the context of Africa from the aspect pragmatist ethics mainly, using basic methodological insights emphasized in previous chapters. I look at the moral situation in the context of the region by going beyond the mere moral dilemma of the principle of *altruism* and organ shortage. As indicated in the previous chapters, in pragmatist ethics and mainly in pragmatist bioethics, previous moral cases and associated judgments, pre-given moral principles and previous solutions cannot be used as universally binding and everlasting solutions to a given problem arising in a different situation, since a unique problem arising in a different context needs a unique solution. As noted previously, rules and principles in ethics are not decisive and final; instead, they have the logical status of a working hypothesis, and are essential in order to have a clear picture about the problem and to help guide us the search for solutions through moral experimentations. Mainly, in this chapter, I asses the problem of organ trafficking under the context of the region using Dewey's two steps of ethical inquiry: (i) identifying a felt difficulty; and (ii) location and definition of the problem) to raise facts and figures on the ground. Finally, using the third step of ethical inquiry ((iii) suggestion of possible solutions) and other methodological insights in pragmatist bioethics. Then, I reflect on solutions to it with the reconsideration of the context of transplantation, organ trade and trafficking in the region. However, in the chapter, it is also noted that further societal experiment is needed to measure and evaluate the consequences of these solutions and to make it practical by using an approach of bioethical deliberation.

6.2 The Context of Organ Trafficking and Africa's Situation

A shortage of organs and long waiting lists in resource-rich countries have pushed many desperate patients to travel to poorer countries where they can purchase organs from a paid donor and undergo

[327] Clay and Block, Free Market for Human Organs, 52; Friedlaender, The Right to Sell or Buy a Kidney, 973; Taylor, Autonomy Constraining, 155.
[328] Castro, Commodification and Exploitation, 142.
[329] Mor and Boas, Organ Trafficking, 299.

transplantation. For instance, the WHO estimated that 10% of all global kidney transplants in 2004 were for patients from developed countries who traveled to low-income countries to buy organs.[330] In 2005, around 66,000 kidneys were transplanted worldwide, and transplant tourism accounts for about 10% of total transplants.[331] The Global Financial Integrity report also showed that kidneys are the most trafficked organ, given that it is possible to live with only one kidney. The report indicated that approximately 7,000 kidneys are illegally harvested and trafficked each year, and that one-fifth of all global kidney transplantations involve trafficked kidneys. Patients from developing countries who have money but are unable to find transplantation facilities at home also travel to better-off countries for transplantation. For example, a 2019 study found that 90 living donor kidney transplants have been performed in Ethiopia since the first transplant in 2015. The country's total number of transplantations was 300, of which 210 were involved donors outside of the country, mainly from India and Thailand.[332]

Traveling for medical services may not be a problem from a patients' perspective. However, the challenge is that most transplants undertaken in this manner are linked to organ commercialism and organ trafficking. Various studies and reports indicate that illicit organ transplantation, trade, and trafficking are associated with transplantation tourism.[333]In transplant tourism, most transplantations are done illegally by using illegal organ vendors, trafficking in organs, or trafficking in humans for organ removal. For instance, in the case of Egypt, this medical tourism targets the poor, migrants, asylum seekers, and prisoners as potential organ transplantation sources.[334]

Except in Iran, organ selling is illegal worldwide. Nevertheless, organ selling through black markets remains a source of transplant tourism and illegal transplantations globally. Illegal transplantation and the

[330] Shimazono, International Organ Trade, 957.
[331] The Lancet, "Legal and Illegal Organ Donation," *Lancet* 369, no. 9577 (2007), 1901.
[332] Momina M. Ahmed et al., "Organ Transplantation in Ethiopia," *Transplantation* 103, no. 3 (2019), 449-51.
[333] Nancy Scheper-Hughes, "The Body of the Terrorist: Blood Libels, Bio-Piracy, and the Spoils of War at the Israeli Forensic Institute," *Social Research* 78, no. 3 (2011), 849-87; see also Cohen, Transplant Tourism, 269; Shimazono, International Organ Trade. 960.
[334] Sean Columb "Disqualified Bodies: A Sociolegal Analysis of the Organ Trade in Cairo, Egypt." Law and Society Review 51, no. 2 (2017), 282-312. See also Sean Columb, "Excavating the Organ Trade: An Empirical Study of Organ Trading Networks in Cairo, Egypt." *British Journal of Criminology* 57, no. 6 (2017),1301.

organ black market operate by exploiting the poor and uninformed of society. These people are recruited either in the area where the transplantation is done or trafficked from other countries for organ removal. The end-users of the commercialized and trafficked organ are most of the time from better-off countries. For instance, based on the case of *Milina* in Philippines, the rise in organ demand in more affluent countries has led to physicians and health workers, especially in low economic conditions in developing countries, becoming involved in the organ black market.[335]

While less data is available from Western countries side, people from the U.S.A., Australia, Canada, and European countries are reported to be the organ recipients in transplant tourism and organ trafficking.[336] The major organ-importing countries in East Asia include Japan, Taiwan, South Korea, Malaysia, Singapore, and Hong Kong. In the Middle Eastern corridor, Israel, Saudi Arabia, and Oman take the upper hand by receiving organs traded illicitly[337]. The situation in Africa is interconnected with the worldwide system. Indeed, Africa is underdeveloped in terms of transplantation medicine. This treatment is still inaccessible for most African populations who are considered medically suitable for transplantation. The region's overall transplant centers number no more than 70; only a few well-established transplantation centers in a few countries provide solid organ transplantations.[338] Indeed, domestic organ demand contributes to organ trafficking in the worldwide context, but when we view organ trafficking in the African context, it is highly interconnected with the global organ trade, migration, and transplant tourism. In this regard, in the region, the Northern and Southern African corridors are primary routes of organ trade and trafficking.

The Northern corridor of Africa is the primary site that combines kidnapping and murder of humans for organ harvesting, with Egypt and Libya named as major organ trafficking areas. In 2007, Egypt was

[335] Yea, Trafficking in Part(s), 358-376.
[336] Cohen, Transplant Tourism. 269-273; see also Scheper-Hughes, The Body of the Terrorist, 849; Yea, Trafficking in Part(s), 360-62.
[337] Nancy Scheper-Hughes "Prime numbers: organs without borders." *Foreign Policy* (2005), 29-31.
[338] Loua et al., Review of Policies, 470.

identified as the major organ-exporting country globally. [339] Organ trafficking syndicates in Egypt are further connected with brokers in Libya and Sudan. The network mainly targets immigrants from East African countries such as Sudan, Eretria, Ethiopia, and Somalia [340]. The trafficked organ's end-users in the Northern corridor include patients from Israel, Saudi Arabia, Kuwait, the U.S.A., and some European countries. Patients from Sudan, Libya, Jordan, and countries of the Persian Gulf are also the recipients of Egypt's trafficked organs.

In Africa, organ traffickers use mechanisms such as stealing organs from a patient being treated for a minor sickness, coercion using money and physical force, and cheating. Recent studies have reported that organ trafficking in the Sinai Desert, which is commonly called 'Sinai Trafficking' in academia, is unique regarding the use of violence, torture, and killing of migrants crossing to Israel. Particularly, migrants from Eritrea, Sudan, and Ethiopia are exposed to networked traffickers who work clandestinely from Egypt and Israel. Brokers who facilitate their travel to Israel via Sinai demand that migrants pay a ransom, and those who are unable to pay the ransom are forced to cover their travel expenses by giving up their organs.[341]

Brokers in Egypt and Sudan also use money to induce individuals to voluntarily sell their organs, especially targeting the poor, illiterate, rural-urban migrants, and other asylum seekers.[342] Studies show that people passing in this direction are usually cheated or end up with a much smaller payment than what they were promised, left to health deterioration other problems.[343] In this regard, various reports document the targeting of the poor and migrants. For instance, in 2016, nine Somali migrants had their organs

[339] Shimazono, International Organ Trade, 959.
[340] Columb, Excavating the Organ Trade, 1301-1321; See also Coalition for organ-Failure Solution. "Sudanese Victims of Organ Trafficking in Egypt," 2011, https://cofs.org/home/wp-content/uploads/2012/06/REPORT-Sud-Victims-of-OT-in-Egypt-NEW-COVER-16-Jan-20124.pdf..
[341] Mirjam van Reisen and Conny Rijken, "Sinai Trafficking: Origin and Definition of a New Form of Human Trafficking," *Social Inclusion* 3, no. 1 (2015), 113–24.
[342] Columb, Excavating the Organ Trade, 1301-1321.
[343] Ibid. see also Cohen, Transplant Tourism, 273-78; Shimazono, International Organ Trade, 960.

removed and their bodies were dumped in the sea near Alexandria, Egypt.[344] In 2015, in the northern Sinai Peninsula, Egyptian police found the bodies of 15 African migrants, most of them from Sudan. They appeared to have been shot, and some of their organs had been removed.[345] Similar reports of bodies with missing organs were found in Nigeria and the Lake Chad Basin.[346] The 2011 Coalition for Organ Failure Solutions (COFS) report indicates that 57 Sudanese refugees reported to be victims of organ trafficking. Most of them came from Darfur, through human traffickers.[347] The victims reported health deterioration and adverse social, economic, and psychological problems resulting from forced organ removal. The terrorist groups that call themselves ISIS (the Islamic State of Iraq and Syria) or ISIL (the Islamic State of Iraq and the Levant), who operate in the Middle East, are accused of selling their captives' organs for transplants.[348] Similarly, recent news reports in Libya also show that West and East African migrants are exposed to terrorist groups operating in the region.

The Southern part of Africa is the second hub of illegal transplantation, organ trade, and trafficking. In the Southern corridor, South Africa is mentioned as the second hub of organ trafficking. Illegal transplantation, organ trade, and trafficking in South Africa are connected to the boom in private sector engagement in transplantation which occurred between 2001 and 2003. The recent reports of organ trafficking in South Africa are connected to the police record of *Net Care's St. Augustine Hospital* in Durban, which conducted thousands of illegal kidney transplants between 2001 to 2003.[349] Transplant

[344] Small Voice Human Trafficking, "Nine Somalis Dumped in Egyptian Sea After Kidnapped and Organs Removed by Traffickers in Egypt ," 2021. https://www.humantrafficking.co.za/index.php/news/1041-nine-somalis-dumped-in-egyptian-sea-after-kidnapped-and-organs-removed-by-traffickers-in-egypt-6-april-2016-note-not-for-sensitive-viewers.
[345] BBC News, "Bodies of 15 Migrants Found in Egypt's Sinai Peninsula -," 2021. https://www.bbc.com/news/world-middle-east-34826469.
[346] FairPlanet, "Illegal Organ Trafficking in Africa _," n.d. https://www.fairplanet.org/story/a-penny-for-a-kidney-illegal-organ-trafficking-in-africa/.
[347] Coalition for organ-Failure. https://cofs.org/home/wp-content/uploads/2012/06/REPORT-Sud-Victims-of-OT-in-Egypt-NEW-COVER-16-Jan-20124.pdf.
[348] Nancy Scheper-Hughes, "Neo-Cannibalism and ISIS: Organs and Tissue Trafficking During Times of Political Conflict and War," *Ethical, Legal and Psychosocial. Aspects of Transplantation Global Challenges*, no. August (2017), 166-73.
[349] M. R. Moosa, "The State of Kidney Transplantation in South Africa," *South African Medical Journal* 109, no. 4 (2019), 235-40; Weimar W Ambagtsheer F, Gunnarson M, De Jong J, Lundin S, van Balen L, Orr Z, Byström I, "Trafficking in Human Beings for the Purpose of Organ Removal: A Case Study Report," *The HOTT Project* 91 (2014), 10-13.

tourists coming from Israel and Eastern Europe accounted for the highest number of recipients in the Southern corridor of Africa. South African citizens, as well as people trafficked from Brazil and Israel, were organ transplantation sources for transplant tourists in this country.

Today, reports of a new wave of organ trafficking of forced organ removals and organ theft targeting the poor and migrants are coming from East African countries, as well as from conflict-prone areas in Central and West Africa. However, for the last three decades, in the Northern and Southern African corridors, Egypt, Libya, South Africa, and other conflict-prone and migrant areas of the continent have been hot spots of organ trafficking. In such organ commercialism and trafficking, various human and legal-personal actors are involved, both from within the region and from outside. This regional and global dimension of organ trafficking in Africa makes the issue in the region grounded in a more systemic, structural, socio-economic, and political problems, related to the abuse of practice of transplantation, and connected to transplant tourism and migration. This root of organ trafficking further makes the moral dilemma more complex and controversial connected to advance transplantation therapy, the rules and method of organ procurement and the overall socio-economic and political conditions a society.

6.3 The Ethical Dilemma of Organ Trafficking: Being Pragmatic about Context of Africa

The debates on organ transplantation ethics in general rests on various moral principles, broadly categorized as utilitarian and deontological in their ethical-philosophical orientations. Regarding transplantation, both approaches agree that it is a significant achievement in terms of improving the life of patients. Nonetheless, there is a marked difference between them regarding organ procurement and solutions for organ trafficking. The moral controversy over organ trafficking is also viewed historically in relation to the ethical debates of transplantations and organ procurement. Indeed, organ trafficking itself is not debated in ethics as a controversial issue, since it is an inhuman act and a crime. Instead, the ethical controversy over organ trafficking rests on the method of organ procurement and illegal transplantation. Specifically, the ethical dimension of organ trafficking is viewed in light of the method of organ

procurement, organ selling and different modes compensations of donors- which further fuels organ trafficking.

In the moral philosophy tradition, the debate on organ trafficking rests on the above two ethical-moral philosophy standpoints. From the deontological standpoint, permitting organ selling by bypassing the rule of altruistic donation is considered a reason for organ trafficking. On the other hand, in the utilitarian perspective, the incapability of altruistic donation to satisfy the rising organ demand is mentioned as a reason for organ trafficking. For instance, in the deontological Kantian approach, Cohen argues that selling an integral human body part corrupts the very meaning of human dignity. Selling organs alienates human dignity because it implies considering human beings as mere commodities in terms of body parts. Such acts of organ selling disembodies human beings and denies dignity. However, for Cohen, human beings are embodied beings seen in terms of organic wholeness and the embodied integrity of humans is observed within the human body's wholeness.[350]

Moreover, in the Kantian approach, organ selling is viewed under the big umbrella of social justice and society's good. In this approach, organ selling by bypassing altruism is part of organ trafficking; and permitting organ selling is considered as opening the door for organ trafficking. From the aspect of social good, organ selling is exploitative and coercive, making the low-economic sections of societies as well as migrants vulnerable to physical, psychological, and socio-economic exploitation. Mainly on the seller's side, organ selling, and the resulting organ trafficking, bring associated social, economic, psychological, and physical health impacts both on the recipients and donors. Thus, the deontological approach appeals to altruistic donation and legal control of organ trafficking as a primary solution for organ trafficking, rather than compensation, paid organ donation, or organ selling.[351]

[350] Cynthia B. Cohen, "Selling Bits and Pieces of Humans to Make Babies: The Gift of the Magi Revisited," *Journal of Medicine and Philosophy* 24, no. 3 (1999), 288.
[351] Ibid, Cynthia B. Cohen, "Public Policy and the Sale of Human Organs," *Kennedy Institute of Ethics Journal* 12, no. 1 (2002) 47; see also , Cohen, Transplant Tourism, 276.

Unlike the deontological-Kantian approach, in the utilitarian approach, organ transplantation is seen as a more libertarian and consumer-oriented principle. Similarly, the issues of organ procurement and organ shortage are seen in a more utilitarian sense, viewed in light of a more libertarian and consumer-oriented principles. For instance, regarding organ selling, those who are able to broker or buy a human organ should not be prevented from doing so. Likewise, the principles of autonomy, beneficence, non-maleficence, and justice are construed in light of an individual's freedom of decision making, preferring the seller's right to sell and the patient's right to purchase an organ in a free market system. In this approach, organ selling is considered a win-win situation for both.[352] In light of this, in the utilitarian approach, organ trafficking is seen in connection with organ shortage, which is further connected to the incapability of altruism as rule of organ procurement. Hence, increasing organ supply through a flexibility of rules for organ procurement is suggested as a lasting solution to the problem of organ trafficking.

As indicated earlier in the introductory section, studies under the utilitarian moral approach recommend compensation, a non-directed paid donation, and regulated organ selling as options to increase organ supply so that to control organ trafficking. For instance, Clay and Block claim that the legalization of the sale of body parts in legitimate free market activity decreases human body parts' price and discourages human organs' theft, which the present laws cannot control. Furthermore, in a free enterprise system, the original owner of the organ (or his/her estate) will receive the profit from the sale, and the recipient also benefits from the free transaction of organs.[353] Friedlaender also supports legislation governing regulated kidney sales, since the shortage of organs and organ trafficking are getting worse. He further claims that patients' welfare is neglected and left them to unregulated market transactions by failing to consider legal alternatives of paid donations. Moreover, considering the prevailing practice, patients, donors, and commercial go-betweens are already trading organs through black markets. Thus, Friedlaender suggests

[352] J.S. Taylor, Autonomy, Constraining, 143-260; Clay and Block, A Free Market for Human Organs, 49-51.
[353] Clay and Block, A Free Market for Human Organs, 49.

that regulated organ trading is a morally acceptable option for the patient's welfare, the sustainability of transplantation medicine, and control of the organ black market.[354]

Standing from the pragmatist bioethics, the earlier two approaches on organ trafficking can be taken as possible hypothesis. The incapability of altruistic transplant orthodoxy to serve as an applicable foundation for a public policy may be the reason for organ shortage and organ trafficking. Moreover, since organ trafficking is connected to the global organ shortage, more utilitarian solutions such as organ selling, compensated donations, and non-directed paid donations may be suggested as practical alternatives to battle organ trafficking especially, in economically advanced countries in the West. Alternatively, in a context where there is no universal healthcare system and the majority of people are poor, permitting organ selling and introducing compensated donation may open up further avenues for organ trafficking instead of controlling it. Thus, sticking to altruistic donation with strict legal control of organ trafficking may be suggested as a second alternative. As I discussed in the previous chapters, bioethical issues are context embedded, and the ethical inquiry of the problem and solution depends on the situation and context where the problem arises as a challenge for the existing structural order of the society. Likewise, when we view the context of organ trafficking in Africa, the issue goes beyond the mere moral dilemma of altruism and organ shortage.

As noted earlier, Africa is under-developed in terms of organ transplantation. There are shortages of medical facilities, physicians, and nurses in the region. In fact, only a few countries have standardized medical facilities for transplantation. Based on a 2016–2018 report, 62 transplantation centers are found in Africa, and transplantation from deceased donation is only provided in South Africa. In most countries, donation and transplantation of organs and tissue is not consolidated enough and national transplantation programs lack effective coordination and referral systems. In fact, only 15 countries (Egypt, South Africa, Algeria, Burkina Faso, the Comoros, Côte d'Ivoire, Ethiopia, Kenya, Mauritius, Namibia, Nigeria, Rwanda, Senegal, Uganda, and Zimbabwe) have legal requirements governing organ donation and

[354] Friedlaender, The Right to Sell or Buy, 971-73.

transplantation.[355] Hence, considering the inaccessibility of transplantation medicine and low transplantation rates in Africa, organ trafficking in the region is related to domestic organ shortage to a lesser extent. Indeed, as discussed earlier, when we look at records in Egypt, Libya, and South Africa in the context of the region, organ trafficking is connected to transplant tourism and organ theft targeting migrants, the poor, and asylum seekers, connected to countries outside Africa. Thus, in the region, organ trafficking is rooted in more systemic, structural, socio-economic, and political problems, grounded in the practice's abuse, and connected to transplant tourism and migration instead of inefficacy of altruism and organ shortage.

6.1 Toward Pragmatist Solutions

As I discussed in the previous chapters, in pragmatist bioethics, previous moral cases and associated judgments and pre-given moral principles cannot be used as an ever-lasting solution to a given problem arising in a different situation and context. In this regard the context where the moral problem arises determines the solution. Moreover, as noted in the earlier chapters, rules and principles in ethics are not decisive and final; instead, they have the logical status of a working hypothesis, and are necessary in order to have a clear picture of the problem and help guide us in the search for solutions. Besides, depending on the type of bioethical issue under investigation, a consideration of a particular society's rules, practices, customs, and habits regarding the problem is essential as a background to provide moral judgment or suggest solution to the problem. Besides as noted in chapter two, the behavior of key actors and stakeholders involved, the rules and responsibilities related to agents, the maxim developed from agents' previous moral judgments, and agents' habits are also important during ethical deliberation to seek solutions. Equally, the moral dilemmas of organ trafficking cannot be comprehended universally in terms of the inefficacy of the rule of altruism and organ shortage neither a universal solution can be offered to the problem in absence of consideration to context. For instance, in a more economically and institutionally advanced countries in the West, the problem may be connected to the incapability of

[355] Loua et al., A Review of Policies, 422.

altruism, and compensated donation or organ selling in a free market may be suggested as solutions. However, under the context of Africa, the problem has a different appearance; and solutions based on the real context of the continent and passed over societal experiments will be suggested as effective instead of universal solutions.

As presented in the earlier sections, organ trafficking in Africa is rooted in more systemic, structural, socio-economic, and political problems, grounded in the abuse of transplantation practice, and connected to transplant tourism and migration. Thus, instead of mainstream pathways such as organ selling and paid donations, we can argue that pragmatist multimodal solutions formulated with the consideration of the nature and progress of organ transplantation on the continent, cultural values of the societies, and key actors involved in organ trafficking is paramount to control organ trafficking in Africa. In this regard, on the systemic and socio-economic side increasing the supply of organs by controlling and policing illegal transplants; establishing a central regional transplant registry system; and seeking sustainable economic solutions focusing on migrant areas are essential to control organ trafficking both in the short and long term. On the side of the abuse of the practice transplantation, revising professional codes of conduct that addresses organ and tissue transplantation is imperative to control illegal transplant, organ trade, and organ trafficking in the region. However, for the practicality and effectiveness of such solutions, a continued experimentation in a society is required following the approach of public deliberation.

6.1.1 Increasing Organ Supply by Controlling Transplant Tourism

Organ trafficking in Africa is connected with transplant tourism and cross-border organ commerce targeting migrants and low-income societies. The problem in the region has a global dimension, which goes beyond the increasing local demands for new organs. Hence, controlling transplant tourism and addressing the increasing organ demand nationally, regionally, and worldwide is essential to control organ trafficking. Transplant tourism can be controlled through the official banning of transplantations for foreigners and employing legal remedies or imposing fines on those engaged in such activities. However, multimodal technical, ethical, and legal solutions, as well as innovative models that encourage more

donations, are essential to increase organ supply and control illegal transplant, trade, and trafficking. Moreover, especially in Africa increasing resources for transplant medicine and optimizing resource use in Africa is one of the technical mechanisms helpful for increasing the supply of organs in the region.[356] In in the continent, a few patients have access to transplantation, and it is inaccessible to rural communities. Besides, there is a shortage of medical facilities, physicians, and nurses. Only a few countries have standardized medical facilities for solid organ transplantation, and deceased donation is limited to South Africa.[357]

Indeed, depending on the culture, religion, and technical facilities available in a specific region, living-related donations, unrelated living donations, deceased donations after brain death (DBD), extended criteria donations, or donations after cardiac death (DCD) may be used to increase organ supply. However, since organ trafficking targets live-donors, a shift towards deceased donation with education and awareness is suggested as essential to increases organ supply and controls organ commerce. This strategy is significant, especially for Africa, to increase organ supply without permitting organ selling, paid donation or compensated donation- (which difficult to implement in increasing live-donations in absence of universal healthcare, absence of insurance packages, and other risk pooling systems on the side of governments in the continent). For instance, one can mention the case of high traffic accident rate in Africa is high;[358] and if medical, clinical, and technical facilities are well established, the traffic accident may easily cover the local demands of organs.[359] However, it should also be noted that religious and cultural factors play a significant role in the rate deceased organ donation. Moreover, the scarcity of organs may prompt a modification of the dead-donor rule, which needs continuous cultural experimentations. For instance, South Africa ranks first in Africa in terms of transplantation; however, compared to countries in Europe, the donation rate is insufficient. A study on Zulu communities shows

[356] Muller, Transplantation in Africa, 92; see also Moosa, The State of Kidney Transplantation, 238.
[357] Muller, Transplantation in Africa, 390-93 see also Moosa, The State of Kidney Transplantation, 239; Loua et al., A Review of Policies, 421-22.
[358] World Health Organization. *Global status report on road safety 2015*. World Health Organization, 2015.
[359] Moosa, Kidney Transplantation in South Africa, 237 & 38.

the Zulu family structure and spiritual belief's influence on organ donation. The study shows that people in the community preferred live-related donation instead of cadaver organ donation. The Zulu communities' attitude to death and the spiritual union they establish with their ancestors makes them reluctant to donate.[360] Similarly, in Egypt, cultural and religious factors limit transplantation from deceased donors.[361] However, the low rate and less preference to cadaveric donation in Africa is highly connected to lack of awareness and education, and low level of medical infrastructure in the region. As compared to live donations, deceased donations require a different infrastructure than living donations. Hence, investing in the technical, nursing, and logistical dimensions of transplantation and transplant theatres to harvest organs from deceased donors is essential to increase organ supply without resorting to organ trafficking. Hand in hand with the technical and human resource investment, education and awareness campaigns in the community and healthcare professionals are also recommended to increase the number of deceased-donors.

Indeed, increasing organ supply from deceased donors requires flexible rules regarding consent, modification of the criteria of death, and technologization of organ harvesting theatres. More importantly, it needs a strategy to bypass the dead-donor rule. The standard approach which is frequently mentioned in connection to the bypassing of the dead-donor rule is to expand the donor criteria to encompass donation after cardiac death (DCD), in addition to donation after brain death criteria (DBD).[362] In fact, in collaboration with multi-regional working groups, transplant societies, and governments, in 2010 the WHO developed a new approach called the "critical pathway" to increase organ harvesting from deceased donors. The pathway's objective is to give a systematic approach for a deceased organ donation by considering both DBD and DCD. In the critical pathway, patients with a devastating brain injury or lesion, patients hospitalized in an intensive care unit and sustained with a mechanical ventilator, and

[360] B. R. Bhengu and H. H. Uys, "Organ Donation and Transplantation within the Zulu Culture.," *Curationis* 27, no. 3 (2004), 30.
[361]Sherine Hamdy. "The organ transplant debate in Egypt: a social anthropological analysis.," *Droit et cultures. Revue internationale interdisciplinaire* 59 (2010), 357-365.
[362] John A. Robertson, "The Dead Donor Rule," *The Hastings Center Report* 29, no. 6 (1999), 6-13; see also Roels and Rahmel, The European Experience, 362.

patients with circulatory failure arriving at a hospital in the emergency ward are identified as medically suitable organ donors.[363] There has been a similar initiative in China to implement a Chinese critical pathway, based on a pilot study in 2010 and 2012 on the Chinese culture and their attitude to DCD. In addition to the two critical pathways, the Chinese pathway combines DBD and DCD and introduced the third option called organ donation after brain death (DBCD), followed by circulatory death as a third critical pathway.[364] Such pathways can also be suggested as solution for experimentation in Africa, and if the value of consequence is high, it can be practical and implemented as rule.

In connection with deceased-donation, reforming the consent system from an "opt-in" to an "opt-out" system and reforming the technical, medical, legal, and ethical modalities of the dead-donor rule is one of the most effective strategies to increase potential organ donors. For instance, compared to countries with an opt-in system, there is a higher procurement rate for organs in countries with presumed consent laws.[365] Therefore, adopting presumed consent would reduce the number of organs obtained through the black market. In fact, in Africa, cultural and religious factors play a significant role in consent and organ donation. For instance, in the Zulu community, consent for organ donation depends on the extended family, especially males.[366] A recent studies in South Africa and Ghana shows that only a small percentage of people show a willingness to donate organs, partly related to lack of knowledge.[367] Thus, to increase the consent rate, discussions and public awareness initiatives need to be sensitive to observed religious and cultural reservations about organ donation.[368] Besides, proper donor pool system which

[363] Beatriz Domínguez-Gil et al., "The Critical Pathway for Deceased Donation: Reportable Uniformity in the Approach to Deceased Donation," *Transplant International* 24, no. 4 (2011), 373-78.
[364] Jiefu Huang et al., "The National Program for Deceased Organ Donation in China," *Transplantation* 96, no. 1 (2013), 5-9.
[365] The Lancet, Legal and Illegal Organ Donation, 1901.
[366] Bhengu and Uys, the Zulu Culture, 30.
[367] Moosa, Kidney Transplantation in South Africa, 238-39; V. Boima et al., "Knowledge and Willingness to Donate Kidneys for Transplantation in Ghana: A Cross-Sectional Survey," *Transplantation Proceedings* 52, no. 10 (2020), 2883-89.
[368] H. Bookholane et al., "Factors Influencing Consent Rates of Deceased Organ Donation in Western Cape Province, South Africa," *South African Medical Journal* 110, no. 3 (2020), 204-9; see also Moosa, Kidney Transplantation in South Africa, 238; V. Boima et al Knowledge and Willingness to Donate, 2888.

protects donors and their families is imperative to increase organ supply.[369] In this regard, the government's role is also critical in terms of formulating a national policy for general public education and expanding organ donation and transplant services.

6.1.2 Control and Policing of Illegal Organ Transplant, Trade, and Trafficking

Fighting organ trafficking must combine uncompromised law enforcement with heavy penalties for brokers and physicians involved, with a radical revision of the living donations procurement methods.[370] Unlike other forms of crime, illegal transplants connected to commercialized or trafficked organs are easily detectable, since transplantation happens with identifiable hospitals. In Africa, transplant centers are limited in number and are easily identifiable by the public and governments. As this is the case, organ trafficking can be controlled through effective legal control and policing of illegal transplants, transplant tourism, and organ selling. In this regard, establishing a centralized patient and donor registry at the national, regional, and continental level plays a paramount role in monitoring transplant and tracing the legality of donated organs and tissue.

In Africa, health facilities are limited, and only a few clinics and hospitals, close to 70 in number, provide transplantation services. Thus, the respective countries' national governments can easily control the domestic illegal organ transplantation through the registry of hospitals, patients, donors, and the available organs. Hand in hand with the central registry, denying access to medical services for patients who undertook transplantation abroad or in a country outside organ transplantation centers registered in the central organ transplant unit effectively controls transplant tourism, trade, and trafficking in organs. Home country measures through insurance and extraterritorial criminalization of persons receiving organs from other countries or engaging in such kind of trade is another strategy to control transplant tourism. Home countries can discourage their citizens from engaging in transplant tourism by making these patients ineligible for insurance coverage relating to an illegal transplant. Since transplant tourists have to take

[369] Tazeen H. Jafar, "Organ Trafficking: Global Solutions for a Global Problem," *American Journal of Kidney Diseases* 54, no. 6 (2009), 1145.
[370] Mor and Boas, Organ Trafficking, 294-299.

immunosuppressive drugs and require other post-transplant treatments, doctors and pharmacists can monitor and report patients who have engaged in illegal transplantation. [371] Further, the criminalization of organ vendors, patients, health care workers, and institutions, together with heavy fines, is a significant manner in which to control illicit transplant, trade, and trafficking. In this regard, it is essential to integrate the criminalization and control system of transplant, trade, and trafficking on the continent with international organizations and security departments, local, national, and regional security agencies, and authorities considering it a criminal act. In addition, as Glaser claims, strengthening laws against this crime and removing any loopholes that encourage corruption is important to control illegal organ transplant, trade, and trafficking.[372]

Organ trafficking and trafficking in persons affects all regions of the world. Thus, organ trafficking as a problem calls for a robust and coordinated response from the international community. International cooperation in criminal matters is crucial to prosecuting organized criminal groups engaged in organ and human trafficking.[373] In this regard, increasing extra-legal measures, international cooperation, and a focus on the causes and victims of organ trafficking, rather than criminal law alone, are essential to control organ trafficking and trafficking in humans for organ removal. For instance, domestic, regional, and international legal and semi-legal instruments are powerful legal tools to deal with organ trafficking. [374] In fact, several non-binding international instruments have been designed to control organ trafficking. The most crucial multilateral convention for the prosecution of both traffickers in human beings for organ removal and organ traffickers is the United Nations Convention Against Transnational Organized Crime (UNTOC). There are also regional legal instruments against organ trafficking. For instance, the 2008

[371] Beatriz Domínguez-Gil et al., "The Key Role of Health Professionals in Preventing and Combating Transplant-Related Crimes," *Kidney International* 92, no. 6 (2017),1299-1302; see also Asif Efrat, "Professional Socialization and International Norms: Physicians against Organ Trafficking," *European Journal of International Relations* 21, no. 3 (2015), 647-71; Cohen, Transplant Tourism, 279-82; Efrat, Combating the Kidney Commerce, 780.
[372] Sheri Glaser, Glaser, Sheri R. "Formula to stop the illegal organ trade: presumed consent laws and mandatory reporting requirements for doctors," *Human Rights Brief* 12, no. 2 (2005), 22.
[373] Luigi Kalb and Stefania Negri, "The Criminal Justice Response to Organ Trafficking and Trafficking in Human Beings for Organ Removal," *Journal of Trafficking and Human Exploitation* 1, no. 2 (2018), 184.
[374] Alexis A. Aronowitz and Elif Isitman, "Trafficking of Human Beings for the Purpose of Organ Removal: Are (International) Legal Instruments Effective Measures to Eradicate the Practice?," *Groningen Journal of International Law* 1, no. 2 (2013), 73.

Council of Europe (CoE) Convention on Action Against Trafficking in Human Beings is a legal instrument useful to manage organ trafficking, especially in European member states. The 1997 CoE Convention on Human Rights and Biomedicine, with its supplementary protocol dating from 2002, is another legal instrument regarding transplantation and associated abuses.[375]

However, when it comes to Africa, other than international laws, declarations and resolutions on organ and tissue transplantation by the WHO, and regional laws concerning human trafficking and children's rights, there is no clearly stated convention or regulation addressing the issue of illegal transplantation, organ trade, and organ trafficking. Even in countries where there are international, regional, and domestic laws governing transplant tourism, the lack of strong political will from the government is the main reason for the existing illegal transplantations, organ trade, and trafficking. Thus, strong government willingness to formulate laws addressing transplantation and criminalization, and the substant fining of those who engage in such illegal transplant and organ trade are imperative to control organ trafficking.

6.1.3 Towards a Pan-African Transplant Registry

The long-term mechanism to handle illicit organ transplant, trade, and trafficking in Africa may be establishing a pan-African transplant registry system. Considering Africa's situation, most countries do not have central organ registry systems. In fact, the establishment of a continental Africa Renal Registry has recently taken off. In March 2015, the African Renal Association of Nephrologists (AFRAN) organized a workshop for African nephrologists and decided to establish an African Renal Registry for the first time.[376] Broadening this insight and establishing a pan-African transplant registry is important to control organ trafficking. This system can be designed through a record of transplant centers, patients, donors, available organs, and transplantations in the continent.

A pan-African transplant registry system can help organize a task force and regional units, especially in the migrant areas, to control transnational illegal organ trade and trafficking. Today, integrating Africa

[375] Ibid, 83-87.
[376] M. Razeen Davids et al., "A Renal Registry for Africa: First Steps," *Clinical Kidney Journal* 9, no. 1 (2016),162-67.

through trade and investment is a top priority of the continent. Regional economic integration and attempts to unite African countries economically are underway in West and East Africa. However, integrating the use of available medical resources, health professionals, and technical knowledge has not yet been placed on the agenda of the African Union (AU) or other regional organizations. Some countries (such as South Africa, Tunisia, and Algeria) have advanced medical resources to offer transplantation options for patients from other countries. However, most patients who need transplantation in the region either die without having a transplant or go to Asia, the Middle East, or European countries to receive treatment. In addition to the absence of a cooperative use of the region's medical resources, there is no common security front and legal control against trafficking in organs on the continent.

Establishing a pan-African organ registry system at the continent level is important in order to cooperatively use the available medical supplies, professionals, and organs in the region, as well as establishing a universal legal instrument. As Miller argues, a pan-African Transplant Registry can serve as institutionalized power for Africans to decide on the price of immunosuppressive drugs and develop a center of excellence on the continent.[377] The system can also help to initiate cooperation among nations on the continent to control migration and human trafficking. Studies indicate the existence of a gap regarding seeing illegal organ transplantation in connection with migration worldwide.[378] Looking at Africa's situation, illegal organ transplantation and organ trade are connected with trafficking in humans and migration. In this regard, establishing a pan-African organ transplantation center would help control organ trafficking by connecting it to migration and human trafficking.

6.1.4 Sustainable Economic Solutions Targeting the Poor and Migrants

In Africa, organ trafficking is rooted in a more systemic, structural, socio-economic, and political problems in the region. As indicated elsewhere in this chapter, organ trafficking in Africa is connected to migrant areas on the continent. Thus, devising strategies focusing on migrants and poor and vulnerable

[377] Muller, Transplantation in Africa, 94.
[378] Gonzalez, Garijo, and Sanchez, Organ Trafficking and Migration, 1.

sections of society in different parts of the continent is important to minimize the vulnerability of these sections of society to organ trafficking and trafficking in person for organ removal. Education and awareness targeting migrant source countries and human and organ trafficking hotspots are critical to bringing change in the long term.

Most migrants become vulnerable to such organ transactions and trafficking because of economic reasons in their home countries. Thus, to address the issue in the long term, devising a sustainable economic solution in those countries is essential. For example, in Egypt, criminalization alone cannot address the problem of illegal organ trade. Social exclusion and economic migration are the primary factors that push low-income individuals, asylum seekers, and migrants into the illegal organ trade. Thus, a solution that considers the cultural, social, and economic situations of these migrant areas is essential to control organ trade and trafficking.[379] In this regard, international and regional organizations' role in economic aspects, security, health, and education, as well as other areas, is important in order to improve migrant source countries' economic situations. On the emigrant side, a sustained global economic and social support and education awareness on the risks of illegal organ trade to East and West African countries can help minimize migration and migrants' exposure to organ piracy. In this regard, the European Union has to revise its policy towards security in North Africa regarding emigrant source countries' economic and social sustainability. Besides, it is essential to establish a regional security force and observatory group working on organ and human trafficking in the region. Especially, controlling medical facilities (such as mobile organ harvesting clinics and devices, brokers and professionals working in clandestine or in the registered legally functioning hospitals) is imperative to address illegal organ trade and trafficking hotspot areas in the North and South corridor of Africa.

[379] Seán Columb, "Disqualified bodies: A sociolegal analysis of the organ trade in Cairo, Egypt." Law & Society Review 51, no. 2 (2017), 308-309

6.1.5 Revising Health Care Professionals' Codes of Conduct

As presented earlier, organ trafficking in Africa is also rooted in the abuse of transplantation medicine and connected to transplant tourism and migration. The practice's abuse is connected to the misconduct of health professionals, physicians, nephrologists, and others working in the health sector. Organ trafficking is undertaken clandestinely with a network of brokers, health professionals, and health care institutions from different parts of the world. Indeed, compared to other criminal activities, the distinctive feature of transplant-related crimes is the necessary involvement of health professionals.[380] In fact, it is obvious that the driving force for physicians and brokers to engage in organ selling and trafficking in organs is financial gain.

On the contrary, health professionals are crucial sources of information to understand organ trafficking networks. They are significant information sources, especially in the information phase, the pretransplant phase, and the posttransplant phase.[381] However, the paradox is that most health care professionals do not take seriously legal and ethical responsibilities to report organ trafficking or illegal transplants. For example, in a recent study in the Netherlands, most health professionals are silent regarding the reporting of transplants done with unknown organs or organs from abroad.[382] Thus, revising the medical codes of conduct and devising ethical, legal, and criminal control, as well as fining health professionals, is a matter of urgency regarding the control of illegal transplantation. Health professionals should not turn a blind eye or passively facilitate transplant-related crimes. Instead, they are responsible for educating patients about risks related to transplant tourism and transplantation with purchased organs.[383]

As Glaser emphasizes, to control organ trafficking, countries should also impose mandatory reporting requirements on doctors who suspect that a patient has obtained an organ from a trafficked person or has

[380] Beatriz Domínguez-Gil, Marta López-Fraga, Elmi Muller, and John S. Gill. "The key role of health professionals in preventing and combating transplant-related crimes." *Kidney international* 92, no. 6 (2017), 1299.
[381] Timothy Caulfield et al., "Trafficking in Human Beings for the Purpose of Organ Removal and the Ethical and Legal Obligations of Healthcare Providers," *Transplantation Direct* 2, no. 2 (2016), 1.
[382] Frederike Ambagtsheer, Linde J. Van Balen, W. L. J. M. Duijst-Heesters, Emma K. Massey, and Willem Weimar. Reporting organ trafficking networks: a survey-based plea to breach the secrecy oath." *American Journal of Transplantation* 15, no. 7 (2015), 1759.
[383] Domínguez-Gil et al., The Key Role of Health Professionals, 1299-1302.

obtained a trafficked organ.[384] Physicians and surgeons have a responsibility in terms of the safety and legal condition of transplants. Hence, physicians' and surgeons' awareness and responsibility from the perspective of ethics and law help to control organ trafficking.[385] Besides, activists, civil society, and physicians play a significant role in eliminating or combating illegal organ trade in Africa. For example, studies indicate that health-related civil societies in Israel and Pakistan have improved the control of organ trade and organ trafficking.[386] In Egypt's case, a revision of fines for professionals engaged in illegal transplantation has brought change after the 2010 introduction of new legislation. However, many African countries do not have rules and regulations addressing organ transplantation and related crimes. For instance, in South Africa, even though the health care system has the expertise and facilities to provide solid organ transplantation, there is a marked lack of legislation and regulatory guidelines from national to hospital level.[387] Thus, an emphasis on revising health professionals' codes of conduct, setting out national regulations governing transplantations, and integrating it with the country's criminal codes helps to address organ trafficking. Besides, developing policies regarding health care professionals' and health institutions' economic ground is significant, since it is the main reason health professionals and institutions engage in illegal transplant and organ trafficking. In this regard, formulating universalized ethical norms addressing health care institutions and health care professionals at the national and regional level is pertinent for the future progress of transplantation medicine in the region.

6.2 Conclusion

Worldwide illegal transplant, organ trade, and trafficking are connected with transplant tourism and organized networks of organ and human traffickers. The situation in Africa is highly interconnected with global organ trade, migration, and medical visits. These days, in Africa, reports of forced organ removal, inducement, and theft, focusing on the poor and migrants, are coming from East African countries and

[384] Glaser, Formula to Stop, 22.
[385] Jafar, Organ Trafficking, 1145.
[386] Efrat, Combating the Kidney Commerce, 764.
[387] June Fabian and Kim Crymble, "End-of-Life Care and Organ Donation in South Africa – It's Time for National Policy to Lead the Way," *South African Medical Journal* 107, no. 7 (2017), 545.

conflict-prone areas in Central and West Africa in a new wave of organ trade. However, in the Northern African corridor, Egypt and Libya, and South Africa in the Southern corridor, have been hotspot for three decades. In such illicit transplantations and commercialism, various natural and legal-personal actors are involved. Thus, organ trafficking in Africa is caused by more systemic, structural, and socio-economic problems grounded in migration and transplant tourism than the mere moral dilemma of altruism's inefficacy. Hence, on the systemic and socio-economic side, increasing the supply of organs by controlling transplant tourism, controlling and policing illegal transplants, the organ trade, and trafficking, as well as establishing a central regional transplant registry system, and seeking sustainable economic solutions focusing on migrant areas, is essential to control organ trafficking both in the short and long term. Organ trafficking is also grounded in the abuse of the practice, mainly by health professionals. In this regard, revising professional codes of conduct addressing organ and tissue transplantation is imperative to control illegal transplant, organ trade, and organ trafficking in the region. However, for such suggested solutions to be practical and effective, it needs continues experimentations within the societies and institutions in Africa following the approach of deliberative bioethics.

Chapter Seven

Summary and Conclusions

In this dissertation, I have looked at the nature and dimensions of bioethics, emphasizing topical issues in the field. Primarily, I have examined the methodological controversies of bioethics and reflected on some of the practical problems in bioethics. On the methodological dimension I have focused on exploring the methods and goals of bioethics, mainly from the aspect of pragmatist bioethics following the line of Dewey's ethics; on the practical dimension I have investigated specific issues or problematic situations in bioethics, specifically the moral problems of gestational surrogacy, healthcare allocation and rationing, and the issues of organ trade and trafficking. The aim of inquiring into specific problems is to illuminate further the method of pragmatic bioethics by reflecting on those problematic situations and their solutions.

Indeed, as discussed earlier, the controversy over the methods and goals of bioethics is related to the different interpretations of the logic and epistemology of morality and ethics in general. Historically, this contention can be further associated with the academic delving of ethics into the aspects of the tradition of moral philosophy and the morality of everyday life. On the one hand, one could relate, for instance, the tradition of bioethics based on applied ethics and the recent principlism approach in ethics to the moral philosophy tradition. On the other hand, bioethics that appeals to the methods of the social sciences and empirical ethics can be seen in the morality of everyday life.

The current contention over the methods and goals of bioethics and the objection against the dominant approach of bioethics called principlism is undeniably connected with the critique of the logic and epistemology of morality and bioethical issues, judgments, and decision-making. This objection stems from the consideration of the context in ethics – a relatively stable social background that shapes humans' moral behavior and determines the appearance of specific moral problems and their solutions. This context is further connected with the pragmatic nature of morality and ethics in general. For instance, taking the 1970s principlism approach as a point of contention in today's bioethics, the critique against

this approach essentially sprang from the objection to the abstract nature of applied ethics meant to comprehend the specificity, particularity, complexity, and contingency of the real moral issues of bioethics. This is further connected to the debate over the logic and epistemology of morality and moral judgments. From the grounds of context-based ethics, moral judgments and decision-making are essentially based on non-formal logic itself based on intelligent inquiry and experience, which is connected to the position of a more practical, empirical-pragmatist ethics.

Indeed, bioethics is a practical and empirical philosophical science grounded in human experience and oriented towards action and outcomes. Hence, the epistemic foundation of bioethics, the rationality of moral judgment, is grounded in the contextual embeddedness of a particular moral problem, judgment, and solution to it. From the aspect of logic, I argue that bioethical judgment, reasoning, and decision-making always goes against the commonly accepted deductive reasoning, towards a non-formal reason based on observation, creative construction, formal and informal reasoning methods, and systematic critical assessment of the situation and context where the problem arises. This is further philosophically connected to pragmatism, an approach that addresses the controversy over the methods and goals of bioethics by going beyond philosophical and theoretical perspectivism by serving as a method.

Justifications, deliberations, and moral actions are, in general, contingent, dynamic, and context-sensitive, because judgments and decisions concerning specific moral problems are socio-culturally embedded and institutional. This aspect of the nature of morality represents how the epistemology of morality is essentially pragmatist. In pragmatist ethics, mainly following Dewey, actions are always specific, concrete, unique, and individualized; similarly, judgments must be distinct. The morality and evaluation of actions are connected with the exegesis of practices – representing the method of intelligent inquiry. Moral values are present in experience and are modified and created therein, by humans' sustained needs and interests. More specifically, moral values are produced through actions undertaken using experiences and the habit formed, and these values reflect the qualities of situations in view of the good. So, in moral actions, there are always means which we use and ends to achieve. Means should have value not simply

derived from ultimate intended ends but also as materials and processes to be experienced on their own account. As Dewey claims, means and ends are not fixed compartments. Depending on the type of moral action, a means can sometimes be an end and vice versa. For instance, we seek health as an end, but among the satisfactions of good health is that it is the means for all kinds of fulfilling activities and enjoyments beyond itself. In fact, there is nothing more than the field of bioethics that edifies such a nature of the logic and epistemology of morality, moral judgment, and actions.

Bioethical issues are essentially public problems arising as a challenge to the existing social order or already accepted *ethos* of a society. Most of these problems occur due to advances in science, technology, and biomedicine, whenever the advance becomes a threat to human life or it goes against the already accepted social and public order. As a result, the need for ethical inquiry arises whenever there is a problematic situation faced by people in a certain context and where seeking a solution through intelligent inquiry using experience as a mode of reflection is an issue for the public. As presented elsewhere in this dissertation, for Dewey, a moral judgment based on experience is a complex, interactional, and value-creating activity. Its logic and rationality go beyond deduction, calculation, and rule application to more situational rationality – rationality based on local circumstances. This local and particularized rationality grows out of moral agents and their intentions, special situations, and particular subjects. Thus, moral valuations are not based on fixed laws and principles or on a single good, since such rules and principles do not exist or change with human experience and context. Bioethics' rules and principles have an epistemological function serving as a hypothesis or presumptive guide in moral judgments instead of serving as a binding rule deductively applied to a situation. Indeed, regarding the contemporary debate over bioethics, this transfer of moral life's burden from the fixed rules and absolute ends to the detection of moral situations and contexts, eliminates controversies over moral theory and principles.

The earlier pragmatist-empirical turn in bioethics through context sensitiveness is relevant in the theoretical-conceptual study of bioethics and decision-making concerning specific bioethical dilemmas. In this regard, Dewey's approach to ethics is remarked as a promising approach in the study of bioethics.

As I presented mainly in Chapters Two and Three, Dewey's approach illuminates both the epistemology and logic of morality and ethics by allying with the social sciences and philosophy. He reconstructed the tradition of ethics based on moral philosophy with a more scientific approach to morality, morality based on humans' everydayness. That is why Dewey emphasizes the important role of situation and context in the assessments and reflections on moral problems. In fact, Dewey's pragmatist view of ethics is connected to his comprehensive analysis of scientific, social, and political issues. Following a more scientific and philosophical approach, Dewey has provided steps for the ethical inquiry method, which is significant in bioethics to comprehend the problem and figure out solutions workable in a particular morally problematic situation. As highlighted in Chapter Three, this method includes the following steps: (i) a felt difficulty; (ii) its location and definition; (iii) suggestion of possible solutions; (iv) development by the reasoning of the bearings of the suggestion; and (v) further observation and experiment leading to its acceptance or rejection. In other words, these methodological steps refer to the observation of the detailed makeup of the problematic situation; analysis of the problem into its diverse factors; clarification of what is obscure; coming up with possible solutions and discounting of the most insistent and vivid traits; considering various modes of actions and solutions as a tentative hypothesis and tracing their consequence through imaginative calculations and experimentation; and a further experiment in society until the supposed consequence squares with the actual consequence. So, in the process of inquiry, deliberation helps consider choices in action and foreseeing the consequences of actions so that it is possible to select the best solutions for a problem from among the available choices.

Dewey’s inquiry method is a practical, instrumental approach to find moral solutions to a problematic situation through scientific experimentation. In the approach, context determines the overall steps of the inquiry process, that is, in the identification and clarification of a given problem, suggesting solutions, and experimenting with the acceptance and rejection of a solution. Context, in this case, refers to the relatively stable societal background that includes the cultural and institutional environment and the nature of the relations between the different actors and these actors' own beliefs and values. Hence, given

the context of the problematic situations, a moral solution is figured out through deliberation with the view of societal growth and improvement as the end.

The relevance of Dewey's approach and the recent pragmatist bioethics, in general, is illuminated particularly in the case of the moral dilemma of gestational surrogacy (i.e., the problem related to advances in reproductive technologies); the case of healthcare allocation and rationing; and organ transplantation and the abuses of the practice – the cases which have been investigated in this dissertation. For instance, the recent advances in assisted reproductive technologies (ARTs) have enabled an infertile couple to conceive through numerous medication techniques and the avenues of third-party reproduction agreements. However, the moral problems mainly stemming from third-party arrangement is always a challenge of the medication. As stated earlier, in Chapter Three, most ARTs use the avenues of third-party arrangement techniques such as the use of sperm donors, egg donors, embryo donation and transfer, and surrogacy arrangements. Patients make third-party agreements using one or two arrangement techniques depending on the kind of disease or the infertility condition. Thus, the moral problem of gestational surrogacy is connected to ARTs, and as such, it is not straightforwardly a single problem since, depending on a particular case, the underlying moral problems of ARTs also breed other moral problems.

These days, in connection with medical tourism, gestational surrogacy's ethical issue is becoming an issue for every society worldwide, as a new public policy dilemma or a specific case-based moral problem where gestational surrogacy is already enshrined as legal. Yet, established social orders may not always be feasible to answer emerging problems related to medical options of the time. That is why surrogacy cases are arising in different countries and are challenging the established order of reproduction. Thus, revising the social order, devising a new form of social policy against the accepted order may be at the front door of every country. In both situations, Dewey's pragmatist inquiry method and recent pragmatic bioethics methods are vital to understand the problem and develop solutions effectively. As I discussed in Chapter Three, for instance, following the steps of the inquiry process, in the first step, the felt difficulty

and the problem of gestational surrogacy can be identified as a moral problem that challenges the existing clinical practice or social policy in a particular societal context. Once we identify gestational surrogacy as a moral challenge, the next step is to locate and define the felt problem by presenting facts or experiences without sticking to abstractions, theories, and principles, essentially using empirical sciences. In this regard, facts and experiences in a certain context regarding gestation surrogacy and the medication process, its use, the effect on the commissioning parents and on the surrogate mother in a situation where gestational surrogacy arose as being challenged would be illuminated for further investigation.

Using these experiences and facts on the problem, opportunities and benefits of gestational surrogacy as well as ethical and legal problems would be identified, which is important to situate the issue into either category A or B choices. Amid the process, ethical issues connected with surrogacy such as the following would become topical issues to locate and define the problem and to suggest solutions in the third step: the moral status of the surrogate mother; the interest and parenthood of the child; the societal culture and public interests; the natural desire of the infertile couple (or a single mother or father) to have a baby and enjoy the happiness of procreation; and the ethical appropriateness of the ARTs. The arguments in defense of surrogacy and those standing against it will be clarified here. After clarifying and defining the problem, we then suggest possible solutions to the problem. For instance, surrogacy arrangements can be considered beneficial, and one of the options may be its permeation with clearly stated codes of ethics, laws, and public policy. Although surrogacy seems beneficial to all parties or one party in the arrangement, there are also complex social, ethical, moral, and legal problems. Thus, in a pragmatist ethical inquiry, a social policy option that prohibits surrogacy with a strict moral and legal control of infertility medications, infertility clinics, brokers, and surrogacy tourists may be presented as the second alternative for ethical deliberation.

As I stated in Chapter Three, once we come up with the suggested solutions, in the fourth step of the inquiry process, we publicize those solutions and debate them in order to reach an agreement or consider alternative solutions coming from the public. Regarding gestational surrogacy, the suggestions from

various stakeholders, agents, patients, fertility clinics, physicians, cultural and religious groups, lawyers, ethical experts, and policymakers, as well as the general public, will be consulted. At these steps, suggested solutions will be experimented with by publicizing them, and other alternative solutions coming from stakeholders, agents, professionals, experts, and the general public will be considered. In the final step, we experiment on its acceptance and rejection by measuring the consequences of solutions in view of the ends of society – societal growth. Here, the social experiment makes pragmatist bioethics drawn from Dewey's line of thought essentially based on science. Such aspects of the method avoid ethical and philosophical perspectivism, for which other methods such as the method of applied ethics, principlism, casuistry and the feminist approach in bioethics are often criticized.

Nevertheless, as emphasized in previous chapters, such a pragmatist approach of bioethical inquiry taken from Dewey's insight would become practical and serve as a problem-solving approach only in a system where education, democracy, and institutions are integrated. In the system where ethics, law, and politics are bridged amidst education, democracy, and institutions based on democratic values of accountability for reasonableness, bioethical problems arising in a certain context can be addressed through social intelligence – collective deliberation involving the participation of individuals, agents, stakeholders, professionals, bioethical experts, community and religious leaders, and the general public. The promise of this approach is also clearly illuminated, especially for addressing the moral dilemmas of healthcare allocation and rationing.

Indeed, as discussed in Chapter Four, the moral dilemma of healthcare allocation arises whenever we allocate limited resources, and rationing is necessary for distributing the available resources. As such, allocation and rationing are intricate and complex tasks beset with philosophical, ethical, and practical difficulties, since allocation always entails rationing, which implies denying service to some for the benefit of others. Allocation issues also entail access to primary healthcare, especially for low-income sections of communities. Moreover, as presented in Chapter Four, based on Daniels' argument, healthcare is not divisible without someone losing the benefit, like social goods such as legal services and

educational benefits. Moreover, from the ethics perspective, when benefiting someone while rationing, the one who is denied the service may be owed the service at the hand of another ethical principle or principles. Besides, it is not easy to choose principle(s) agreeable to both service claimants and distributors.

In fact, in a more philosophical and pragmatist sense, such complications in today's debate regarding healthcare resource distribution and associated moral problems are connected to the epistemic and normative challenges of concepts of health, disease, and healthcare. This problem is further rooted within the triadic representation of disease, illness, and sickness in modern Western medicine. As presented in Chapter Four, disease is conceived of as a purely biological concept in the triadic approach. This conception further leads to the conceptualization of health as the absence of disease and as a private matter; in the end, healthcare would become a matter of civic practice, a commodity, or private benefit which individuals pursue based on their biological and physiological condition and medical preferences in a free-market, rather than signifying a caring relationship between members of communities.

Indeed, as discussed in Chapters Four and Five, disease and health are elusive concepts. We cannot clearly define them in the pure biological form as pictured in modern medicine, but we make sense of them as represented in multiple, plural, and metaphorical culturally and societally embedded meanings. In a pragmatist sense, disease is a sociological concept which, even in modern Western medicine, we usually classify into different categories, and we get to know a specific disease based on symptoms patients experience. Similarly, being healthy is a relative concept, and our understanding of health depends on the experience we develop in our societal context. Moreover, different societies have multiple and culturally variant conceptions of disease and health. Besides, environmental and social structures shape the distribution of disease across a population and determine societal and individual responses to suffering. Hence, given the societal nature of disease and health, healthcare becomes a relational concept that shows the caring relationship between members of a community or a society. As such, the matter of healthcare is also a political issue; the societal and political nature of healthcare makes the ethical issues of allocation

and rationing controversial by being a problem of ethics, health policy, and the law, which in one way or another brings us to the debate regarding justice.

Concerning healthcare theories of justice, in bioethical literature one can find many philosophical approaches, including, among others, libertarian, egalitarian, and utilitarian theories of healthcare. These approaches follow a principle-based approach to answer allocation and rationing issues in healthcare. For instance, the egalitarian approach uses the principle of equal treatment following the lottery and first-come, first-served rules of allocation. In comparison, the utilitarian approach uses the principle of cost-benefit analysis and priority setting, following the maximization of benefit for the greatest number of people as a mechanism with which to ration healthcare. Finally, liberals follow the principle of maximizing benefit to the worst-off to ration healthcare. However, as I argued mainly in Chapter Four, healthcare is a special good, unlike other goods and services. As such, the distributions of health resources should not be left to the market forces' traditional demand and supply rules, as suggested by the libertarian approach to justice. Neither allocation based on medical need nor the science of medicine under the principle of equality in the egalitarian approach is helpful, since the criteria underlying allocation of medical resources is not value-free and scientific, and medical resources are scarce. For that matter, the utilitarian approach to healthcare also has ethical challenges, as in the endeavor to maximize utility for the majority, one may deny the autonomy and benefit of other individual patients.

Healthcare signifying a caring relationship between community members shows solidarity. As a result, the distribution of healthcare is also a political matter that demands the community's active participation, as well as that of various professionals and political agents and stakeholders. Besides, healthcare is a special and primary good in moral terms, determining other economic and social opportunities. Medical care directly affects human life and the general public's well-being. Moreover, medical resources are scarce, and depending on specific situations, we may be forced to go beyond the principle of equality of opportunity for the fair allocation and rationing of the available medical resources. Hence, healthcare allocation and rationing should not be left to the procedural aspect of justice based on the constitutional

rules of equality of opportunity; neither should it be left to ethical principles, since we do not have an agreed-upon principle applicable in all circumstances. As I argued in Chapter Four, each principle has ethical flaws. The moral dilemma of rationing is controversial, as any solution found at the hand of one principle can be equally discounted as unethical at the hand of another principle or principles. Thus, moral questions of just healthcare allocation and rationing ought not to be addressed through the appeal to principles, but rather using a more pragmatic and deliberative decision-making approach.

The importance of a deliberative approach in the allocation and rationing of healthcare rings true, essentially because allocation issues, especially at the macro level, are more political issues where the active participation of members of the community, stakeholders, professionals, ethical experts, policy planners, and other personal and non-personal agents are required. Indeed, the nature of morality in bioethics also further justifies this turn to the deliberative democratic process of ethical decision-making in the allocation and rationing of healthcare. Deliberation helps us to consider choices in allocation and to foresee the consequences of choices, and finally to select the best solutions from among the available choices through reflective inquiry into the underlying situation with a sensitivity to context. In this situation, principles can serve as hypotheses to seek solutions or as presumptive guides during deliberation. Nevertheless, this does not mean that the deliberative approach to healthcare is flawless and practical for the fair distribution and rationing of healthcare. As I argued earlier, the success of a deliberative democratic approach to solving bioethical issues in a society depends on the societal and political systems established based on the education of citizens and the democratic institutions.

The role of the move towards democratic deliberation and active participation of the community, professionals, ethical experts, and other personal and institutional agents and stakeholders on the matter of healthcare allocation and rationing can also be vividly illuminated with the problematic situation of healthcare allocation and rationing in the context of the healthcare systems of Sub-Saharan Africa and with the situation of the COVID-19 pandemic. In the region, the moral dilemma of healthcare scarcity and sacrifices is rampant where access to primary healthcare, especially for poor communities, is the largest

concern regarding the issues of allocation and rationing. Indeed, historically, African healthcare policies and systems were influenced by previous colonizers, global organizations, donor countries, and emerging political and ideological waves from the Western world.

As stated in Chapter Five, the recurrent healthcare crisis in Sub-Saharan Africa is related to the absence of consistent and homegrown healthcare policies on the side of the government and the top-down and donor-led healthcare policies of each country. Equally, most countries in the region follow a top-down approach, as well as employ principles and rules of allocation and rationing which are often imposed by, or copied from, donor countries, previous colonizers, and declarations, policies, and initiatives from international organizations such as the IMF, WB, WHO, and UNICEF. However, such allocation and rationing guidelines and rules are often criticized, as they are drawn for Africa without considering the region's broader healthcare and other socio-economic and political context. Undeniably, the sociology of disease and health, socio-cultural, political, and economic situations hugely influence healthcare policy and medical interventions, which is decisive in resource allocation and rationing. However, donor countries, the WB, the IMF, and other organizations use their economic assistance as a protocol and impose a policy and allocation strategy practiced in the Western world on the region without considering countries' socio-cultural local situations.

Indeed, past experiences of healthcare crises, past pandemic and epidemic catastrophes in Sub-Saharan Africa, and the present global COVID-19 pandemic show how deeply intricate the problem of healthcare allocation and rationing is in the region. Seeing the issues paradigmatically, health and disease are relational and sociological concepts whose meaning is culturally variant and plural, affecting healthcare distribution regionally. Accordingly, in the healthcare system, we need to consider the contextual dynamics of illness and its treatment in the provision and allocation of healthcare. Besides, since health is affected by poverty, a focus on healthcare allocation justice should consider solving the root cause of poverty. In this regard, I argue that justice in African healthcare systems goes beyond a simple allocation of available medical supplies to addressing the existing economic and social inequalities and their effect

on public health. In connection with this, I maintain that the matter of justice in healthcare in Africa calls for regulated healthcare financing and a solid economic base for the health sector, since the current health crisis is hugely connected to these factors.

When we consider the allocation and rationing of healthcare in Africa, a pragmatic manner that should be employed to address questions of justice is a move towards universal healthcare. Almost all countries in Sub-Saharan Africa have failed to establish a universal healthcare system. As such, in the absence of universal healthcare, or at least a regulated healthcare system, it is difficult to reason out and endorse ethical principles such as the principle of equality, the principle of priority, the focus of maximizing benefits, or a principle of cost-effectiveness as a just value of or principle for allocating medical resource in the region. Yet, it should be emphasized that amid the situation of the continent, an openness for public deliberation is suggested as a pragmatic approach to address moral questions of allocation and fairness through the considerations of the views of the community, ethicists, clinicians, physicians, triage committees, government bodies, and institutional and personal agents and stakeholders. However, this does not mean that ethical values and principles are insignificant in the context of Africa. As I argued in Chapters Two and Five, in addition to the mainstream values and principles known in bioethics, the values and principles that can emerge out of the cultural values and belief systems of each community in the region should also be considered as possible hypotheses and preemptive guides in ethical deliberations to make judgments and decisions.

The implication of public deliberation in the allocation and rationing of scarce medical supplies can also be demonstrated by the current COVID-19 situation in the region. While ethical guidelines and values are essential, it should be emphasized that the process of taking patient care allocation decisions out of the hands of clinicians or individual health institutions and placing them into the hands of triage officers or committees of physicians, ethicists, and the community members is identified as essential in the African context. One can also relate the role of deliberation and active participation of the community and the involvement of other actors based on the past experiences during Ebola, HIV, malaria, and other

pandemic diseases in the region. Hence, given the context of Africa, intensive community engagement is suggested as significant for providing practical and ethical responses to the COVID-19 pandemic. However, for the long term, establishing an African agency which decides the matters of healthcare through the active involvement of Africans is sought as a pragmatic and sustainable way to address the current healthcare crisis in the region.

As I noted earlier, justifications, deliberations, and moral actions, including a solution for the underlying moral problem, are contingent, dynamic, and context-sensitive, since bioethical problems and their solutions are socio-culturally embedded and institutional. As such, context is relevant in investigating a particular moral problem and seeking a solution for it. As I showed in Chapter Six, one of the issues that would illuminate the relevance of context and the basic tenets of the method of pragmatist bioethics is the moral dilemma of organ trafficking in Africa. In fact, in mainstream utilitarian ethics, the broader ethical dilemma of organ trafficking is viewed within the moral contestation of altruism as a rule for organ procurement and the resulting worldwide organ shortage. The incapability of altruistic transplant orthodoxy to serve as an applicable foundation for a public policy is considered a reason for organ trafficking. In fact, to battle organ trafficking, utilitarian-inclined studies suggest organ selling, compensated donations, and non-directed paid donations as practical alternatives.

However, as I presented it in Chapter Six, when investigating organ trafficking in the context of Africa, the issue goes beyond the mere moral dilemma of altruism and organ shortage. Instead, the situation in Africa is highly interconnected with the global organ trade, migration, and medical tourism. Certainly, currently in Africa, reports of forced organ removal, inducement, and theft, focusing on the poor and migrants, are coming from East African countries and conflict-prone areas in Central and West Africa as a new wave of organ trade. However, Egypt and Libya in the Northern African corridor and South Africa in the Southern corridor have been a hotspot for three decades. In such illicit transplantations and commercialism, various natural and legal-personal actors are involved. Therefore, organ trafficking is

rooted in more systemic, structural, socio-economic, and political problems in the region, grounded in the abuse of transplantation and connected to transplant tourism and migration.

In light of the context of organ trafficking in the region, the nature of actors involved, the role of agents, and the experience regarding the problematic situation in the region, I suggest that a pragmatist approach that considers strategies combining ethical, legal, political, and economic measures is an important way in which to address the problem in the region. In this regard, on the systemic and socio-economic side, increasing the supply of organs by controlling transplant tourism, controlling and policing illegal transplants, the organ trade, and trafficking, as well as establishing a central regional transplant registry system and seeking sustainable economic solutions focusing on migrant areas, is suggested in this study as essential to controlling organ trafficking both in the short and long term. Organ trafficking is also mainly grounded in the abuse of the practice, predominantly by health professionals. In this regard, revising professional codes of conduct in general and ethical codes addressing organ and tissue transplantation are imperative to control illegal transplants, organ trade, and organ trafficking in the region. To make it practical and effective, however, I argue that it is important to go beyond the rules and principles of the mainstream and dominating ethics of transplantation and experiment with the practicality of the above-suggested solutions through an approach of bioethical deliberation.

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