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Final Paper: Applying Targeted Universalism to Bioethics

Most models of traditional bioethics rely on the view that it is possible to identify objective truths and morals that can be applied to any scenario or cultural context. Though this dominant narrative has structured much of modern Western medicine (Light and McGee 1998), newer models of bioethics have allowed for the acknowledgement that many of these traditional theories fail to account for the needs of many people. In fact, some of the traditional framings of bioethics lead to distinctly unethical and, sometimes, explicitly violent behavior towards marginalized communities. This can be seen in disproportionate health outcomes for poor and working-class people, for people of color (especially in the United States), and for women and gender-non-conforming people, among others. By applying john a. powell's (2008) theory of targeted universalism to more traditionally valued ethical models, it is possible to redraw the ways that people are treated in the healthcare setting, improving ethical outcomes for all.

Classic views of bioethics, though varied in their specific beliefs, often revolve around the assumption that it is possible to identify a set of ethical guidelines to be used to govern medical decisions and behaviors. Bennett-Woods (2005) provides a helpful overview of these theories, from moral objectivism, which holds that "at least some moral principles and rules are objectively knowable" to veracity, the "principle of truth telling" to common principles of justice about factors that influence how to decide what is just in a given situation. Though many of these ideas are critical to building an effective bioethical theory, they fail to account for wider cultural differences between people from different backgrounds. Indeed, it is arguable that because these

ethical frameworks are all built out of a Western knowledge tradition, they are largely unusable outside of that context.

Further, since Western medicine is built out of imperialist and colonialist visions of the world, one could make the argument that these theories could never be used as intended since the person implementing them is almost certainly flawed in their beliefs about who is valuable or not valuable. Petrena and Kleinman (2006) offer a helpful critique of how ethics are applied in the medical setting, arguing that because our moral economy is becoming more and more based on our political economy, “violence is perpetrated when populations and communities are treated in drastically different ways” (3). Even if some of the more classic bioethical theories were accessing an objective truth about what is just or fair, they will fail to be useful if some populations and communities are treated differently by the medical establishment. Petrena and Kleinman (2006) point specifically to the ways that pharmaceutical companies follow different procedures depending on the financial viability of a particular drug, and ask, “Whose illness is worth treating? Whose life is worth saving?” (6). The medical establishment has been operating in violent, dangerous ways towards many populations under the guise of using ethical frameworks. In other words, because it is impossible to separate bioethical theories from their cultural contexts, it is also impossible for medical providers to utilize an ethical theory that is not influenced by individual and societal beliefs about “whose life is worth saving.”

One traditional model that offers a helpful lens in figuring out how to build a bioethical model that results in equitable outcomes is Rawlsian ethics. Bennett-Woods (2005) explains the Rawlsian ethics liberty principle, which proposes the idea that there is an equal “right to as many basic liberties as possible [while] still allow[ing] a similar system of liberty for all.” Further,

Bennett-Woods (2005) describe Rawls' proposal that "social and economic inequalities be arranged so that they benefit those who are least advantaged." Rawlsian ethics centers the needs of "those who are least advantaged" without sacrificing the "system of liberty for all." This is a critical part of any bioethical model: that while all people are allowed freedoms and access to care, that those who are most marginalized are given support to actually obtain that equal access.

john a. powell's legal scholarship, which centers primarily on legality and ethics in the housing field, offers an extension of Rawlsian ethics that can be used to build a more sustainable, just bioethical model. powell (2008) argues that we should adopt a "targeted universal strategy," which is "inclusive of the needs of both the dominant and the marginal groups" but "pays particular attention to the situation of the marginal group" (802-803). In powell's model of targeted universalism, no intervention can be successful unless it places at the center the "situation of the marginal group." While the marginal group might vary based on geography and other cultural differences, powell's articulation of this framework goes against many traditional models, which do not place significant value on the ways that a person or group of people might be marginalized by wider cultural oppression. In "The Biotechnical Embrace," Good (2001) supports this argument by describing how "local meanings and social arrangements are overlaid by global standards and technologies in nearly all aspects of local biomedicine" (395). By using powell's theory of targeted universalism, it becomes easier to be explicit about how these global structures interact and influence "local meanings and social arrangements." In other words, rather than approaching each medical decision in a bubble, it becomes critical to make decisions based on wider trends of disenfranchisement and oppression; further, larger medical policies and

practices should be built on a consistent attention to the needs of marginalized communities and peoples to reduce inequities across the medical field.

If powell's theory is applied to modern Western medicine, it becomes clear that there are a number of marginalized groups whose needs should be addressed more fairly by the medical field. Jeanne Guillemin (1998) provides a poignant critique of the ways that the "inherent conservatism" (60) of modern bioethics has led to a "degradation of patient care and commercialization of medicine" (63). Guillemin's point complicates the application of powell's theory to bioethics: if much of modern medicine is governed by commercial and political interests, what incentive is there for these groups to change the outcomes for marginalized communities?

Klaus Hoeyer offers one vision for a potential way to convince companies and politicians (as well as people in the bioethical field) to become more engaged in alternative modes of ethical decision making. Hoeyer (2006) argues that "Through acceptance of the fact that other traditions work with different criteria, research questions, and modes of reasoning, and that no form of reasoning will ever be able to embrace all questions or generate all answers, it is possible to engage more productively with other knowledge traditions and see if they can alert one to blind spots in one's own research practice" (219). Rather than the traditional assumption that one "form of reasoning" can address all possible ethical dilemmas, Hoeyer challenges medical practitioners and other interested parties to consider the heightened productivity that would come from more interdisciplinary forms of thinking.

One of john a. powell's (2008) central arguments is that by adopting a targeted universalist approach, *both* the needs of the marginalized group *and* the needs or desires of the

group in power will be met more fully. In the case of the medical field, this would mean that through centering the ethical treatment of people in marginalized groups, both medical practitioners *and* pharmaceutical companies *and* political interests (etc.) would end up with improved results.

For example, much has been documented regarding the inequitable health outcomes for people of color in the United States. Under traditional models of bioethics, this disparity is neglected and ignored because it can be viewed as either: a) not the problem of the medical field to fix or b) too costly to address in any significant way by companies and political interests. Yet if, using powell's targeted universalist strategy, the health care needs of people of color in the United States were placed at the center of the bioethical conversation, perhaps much wider healthcare reform might be passed that would inevitably: allow people of color to receive ethical, productive treatment as well as redrawing some of the standards and practices that yielded inequitable treatment in the first place.

Another useful example could come from addressing the needs of individuals experiencing homelessness in the United States. People who are experiencing homelessness cost the government millions (if not billions) of dollars each year in temporary housing costs as well as government-funded healthcare needs. If the needs of this marginalized group were placed at the center of bioethical decisions, it is possible that a greater number of people would be able to find permanent housing and thus contribute more fully to the United States economy, leading to greater economic results rather than draining taxpayer funds.

While no bioethical theory should ever be lauded as the panacea to the many problems plaguing the biomedical industry either globally or nationally, the current American healthcare

tradition is founded in explicitly and implicitly violent, racist, classist, sexist practices that should be addressed. By applying john a. powell's theory of targeted universalism to dominant bioethical models, it might be possible to begin making some changes to reduce the rampant inequities facing marginalized communities both in our country and in others.

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