

## **From Nuremburg to Kano, Eurocentrism to Afrocentrism**

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### **Abstract**

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*Scholarly discussions have long been gathering steam on the topic of cultural diversity in global bioethics. This essay joins forces with the momentum aimed at forging an appropriate rubric for practice particularly regarding Africa. It argues for a careful adoption and adaptation of Eurocentric bioethics principles, and indigenizing them in the Africa context using 'Afrocentrism'. Here, the placeholder test case is the 1996 Trovan experimentation in Kano Nigeria by Pfizer, Inc., which fallouts have continued to fester. Pfizer aimed to try out a drug for meningitis amid an outbreak. It was an attempt that was blamed for the death of 11 children, etc.; and for flouting local and international mores. As efforts have been converging on the specifics of retooling core bioethics principles and values to reflect the local color in various cultural climes, events such as the Pfizer-Nigeria crisis (with 20-year old ongoing effects) seem to have turned the clock backwards. Nevertheless, it unwittingly serves to stress the burning need to smith out some sort of blueprint for bioethics practices which recognize multiplicity of cultures worldwide.*

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**Key words:** Afrocentrism, cultural diversity, ethical pluralism/relativism, Eurocentrism, Westcentrism, Euro-Americanism, Trovan trial, Pfizer, Inc.

### **Introduction**

Bioethics is still young. It is in its 40s, having emerged in the 1970s in the US<sup>1</sup> but with roots in watershed antecedents such as the Nuremburg Code, the Declaration of Helsinki (DoH) and the Council for International Organizations of Medical Sciences (CIOMS). Being so young and with penetrating outreach, it was only a matter of time before its formative ideology would encounter challenging scenarios at socio-cultural milieus outside of its birth place. As bioethics continues to berth at many new places across the globe an inescapable challenge remains how to adopt and adapt its principles. Question: what counts as an appropriate protocol for framing the implementation and institutionalization process to embed research ethics principles into the various social and cultural contexts of the world? It is here proposed that with respect to the African context, the principle of Afrocentricism, a.k.a. Africology, may hold the answer.

For a start, it is acknowledged that the phenomenon of culture clash is always inevitable. That reality has been with mankind from the cradle of history. However, the concern has been that the pace of the new form of culture collision – globalization – is breathtaking. The practice of bioethics is not exempt and posers have been raised as to what should be an appropriate urgent response (Ryan, 2004; Zwart, 2008; Levitt and Zwart, 2009). Besides the speed, globalizing influences are also characterized by the assumed superiority of one culture over the other(s) – the West over the rest, or in this case, over Africa. Godfrey Tangwa, (1996) traces the root of this perceived dominance to technological advancement aided by intrusion in the form of imperialism, colonialism and neo-colonialism, of the Western world in non-Western worlds. “The scientific-cum-technological success of the Western world has, furthermore, made it to consider itself and to be generally accepted as an infallible oracle on all other spheres and all other matters. The Western point of view and Western philosophies and practices are everywhere loudly propagated and widely disseminated with continuing arrogance” (p. 185). Further still, the fanfare of biotechnology’s potential is tempered by fear that the consolidation of scientific knowledge and expansion of biotech markets will indeed create new opportunities for marginalization and exploitation (Ryan, 2004, p. 167).

The challenge of containing the intrusive force of Western<sup>ii</sup> practices in the deeply controversial issues of ethics of international research is perhaps well illustrated by the 1996 experimentation of Trovan drug on a large number of pediatric patients in Kano, a northern Nigerian city, which fallouts continue to fester up till today. The method by Pfizer, Inc., seem to belong to a class rarely found since the atrocities of 1946-1949 in Nuremberg, Germany. As multicultural efforts gather steam to retool core bioethical principles and values to reflect the local color in various cultures, the Pfizer-Nigeria fiasco and others like it, seem to set the debate several years backwards, literally throwing the wrench in the works. The fact that this incident took place in the mid-90s is not an indication that lessons from it have been learnt; just as we do not regard the half century-old Nuremberg episode irrelevant today. Also, the citing of the Pfizer example does not just serve to illustrate the imposition of Eurocentric bioethics principles on Africa. As a matter of fact, even the minimum requirement by the international research ethics principles was virtually unmet in that experiment. Crucially, it also points to the arrogant, ruthless expansion, and exploitation of scientific knowledge and biotech markets. Unwittingly though, this has served to emphasize the burning need to smith out some sort of blueprint for bioethical practices that recognizes multiplicity of cultures worldwide.

### **Recast of Trovan test case**

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

A Nigerian government investigative report later blamed the drug trial for the death of 11 children; scores more still suffer (till this day) permanent disabilities such as brain damage, paralysis, muteness/ slurred speech, and blindness. A series of law suits by the victims and the Nigerian government, filed under the US Alien Tort Claims Act, commenced in 2001, but aborted in the US Supreme Court in the fall of 2010. Pfizer had struck a \$75-million out-of-court settlement for claims related to the experiment. In late 2010, Pfizer also offered to build a \$25-million hospital in the city, a gesture aimed to further appease the people.

All this may have stymied the chance to validate (or disprove) a laundry list of allegations which include that:

- Pfizer took advantage of the chaos from the medical crises as an opportunity to quickly conduct the study (a potentially dangerous treatment) on young children, something it had been unable to obtain permission to do elsewhere.
- Pfizer obtained no assent from any of the children participating in the trial (or informed consent from their parents).
- Pfizer provided no explanation to the children or their parents that the treatment was experimental and that they were free to refuse it in favor of the known effective treatment available at the same hospital free of charge.
- Pfizer never received the necessary approvals (either from the Nigerian government or the hospital administration) to conduct the research, but when the FDA began to conduct an audit of Pfizer's Trovan records, suddenly a letter dated March 1996 surfaced stating that the hospital's ethics committee had approved the Trovan study.<sup>iv</sup>

Trovan was primed to be Pfizer's next major profit gusher, estimated to net \$1 billion in yearly sales if approved by the FDA. But pursuit of profits might just be only one reason clinical trials are globalizing at a fast pace (Petryna, 2009).

While science cannot advance without experimentation, pursuit of narrow scientific goals and populist economic motives have sometimes led to troubling behaviors by scientists which undermine international research ethical guidelines and principles. And as Western research arena continues to tighten regulatory noose, researchers are compelled to seek out 'soft targets' elsewhere, including Africa.

Victims of the Trovan experiment have continued to suffer and to die terrible deaths; a reality that has refocused attention not only on some of the troubling ethics of biomedical research that involve patient-subjects. It further raises the urgency to relate general norms or policies, to particular needs and contexts. Such urgency appeals to me and is the motivating factor for this essay.

Before returning to the task in hand, let me address some troubling *prima facie* issues with this drug trial that have either received insufficient or no attention at all.

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

To act with epistemic interest assumes the intrinsic value of persons. To do otherwise constitutes what Naomi Scheman (2009) has labelled an “ethical and epistemic threat to our moral community” – a fact that after all these years, vestiges of immoral and unethical practices which (if we must be reminded for the umpteenth time) catalyzed the formulation of guidelines to protect human subjects, are inexorably rearing their heads. The Pfizer-Nigeria case happened more than a dozen years ago, but its consequences are just as fresh. For instance, the scar of suspicion and erosion of trust are two prime factors that explain the failure of vaccination efforts in that part of the world. As such this Moslem-dominated area has harbored and witnessed the recurrence of preventable diseases like polio that have long been wiped out in other parts of the world.

I urge for a confluence of epistemology and research ethics. It is in this confluence that moral epistemology is whole and complete. It brings to the forefront the contexts in which objects and subjects of knowledge exist in both the laboratory and in clinical practice. To do otherwise will not only vitiate mankind’s epistemic baseline, it also goes against liberal egalitarian morality that all human beings are one another’s moral equals. This point is encased as well in the ethical guidelines for human subject research: *all humans* (emphasis intended) have equal basic moral status; “they possess the same fundamental rights, and comparable interests of each person should count the same in calculations that determine social policy and neither supposed racial differences, skin color, gender, intelligence, etc., negate their equal worth and dignity” (Arneson, 1999, p. 23).

Two, relics of the stereotypical mindset which regard Africans as unsophisticated or primitive may be at play too as was the case with ethnographic and social research of old. Pfizer is not on record for using any of such descriptives, but they are clearly implied in their actions. Actions, they say, speak louder than words. This mindset stems from the assumption that Africans are both unlikely to have equivalent word or phrase that translates to for instance, “informed consent,” and as such lack the conceptual resources, hence, “epistemically inferior,” to understand its philosophical import. Other writers have already offered arguments against the assumption that “informed consent will not be valued by such a culture as it is by ours” (e.g., Tollefson 2008, p. 39). The moral wrongness of dishonoring another is made worse by acting in a manner that shows that they can be dispensed with. It is intriguing that Pfizer (whose clout easily surpasses that of many individual countries) would apply trickery, deceptive, and hoodwinking tactics to recruit pediatric patient-subjects for the experimental drug test. It is insulting that it finds it suitable to do in an African country something it couldn’t do in the U.S. or anywhere in the West.

Three, this is reminiscent of the same argument that was made for the infamous AIDS experimental drug AZT in Thailand and parts of Africa (Tollefson, p. 42). As was apparent in the case of Trovan, it was urged that informed consent be bypassed as was in the case of AZT because of the urgent nature of the situation. That is wrong. Because disease outbreaks in Africa predominantly affect mostly uneducated and poverty-stricken populations, subject-patients must not be duped to think that they are undergoing a treatment aimed to make them better.

The gut-wrenching fact remains that while some were getting placebos others were receiving a potent concoction that was yet unapproved for children. To think that all this was decided and rammed through with no input from the patient-subjects (and their parents; including the local system) elevates the moral wrongness even higher. It is wrong enough to use the instrument of informed consent to manipulate patient-subjects, how much more (as it appears) to circumvent virtually all international ethical guidelines in the course of this experiment. It is a betrayal and exploitation of children by those who are *required* to care for them at a time of desperate clinical need.

Four, I'd like to highlight the element of responsibility here; the type that as a moral and socio-psychological construct fuses with a relationship between one individual and another, between one social unit and another, and between a small social unit and global societal structures (made inevitable by globalization). Of the many ways responsibility can be conceived, I am here arguing for the responsibility that is embedded in ethical values and caring. It is that which is bestowed on a person (including a 'legal person', Pfizer) or that which a person feels as well as knows that he/she will be held up to or responsible for. It is therefore a moral and ethical duty for which one is liable and accountable.

This is critical because if we merely live it up to the research ethics guidelines alone (and they largely lack legal bite), sufficient brakes won't be applied to stem the unacceptable behavior in which some scientists might engage. This behavior (as we have seen) pervades despite the guidelines and the long-accepted standards that research involving human subjects is much tightly regulated by such gate keepers as the US Food and Drug Administration and the National Institutes of Health.

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

The six-step "community permission" model by Diallo et al. (2005) – which seeks for *permission* and *approval* from the local authorities before biomedical studies are conducted – seems to present a more practical and ethically appropriate approach. Among its many advantages, by engaging the local leaders and traditional healers (who can legitimately speak on behalf of the community), disruption of traditional social structure and customs is reduced to a minimum.

A 2014 WHO public health publication bears this sentiment out. The design of this public health intervention tool – a genetically modified mosquito study, GMM – seriously recommends that targets be set primarily against improving human health; and that the overarching ethical goal should be to respond to obligations to individuals being asked to participate as human research subjects and/or to communities being asked to host trials; while maintaining transparent and respectful channel of communication throughout and long after the trial period. All in all, it marks a shift from considering ethics of research within the bare bones of principlism to considering the ethics of research in a much broader sense.

The GMM model for biosafety and ethics of engagement, reveals the need to improve the links between research and health care delivery and to promote the environmental, cultural, socio-political and economic processes that are involved so we can begin to widen our understanding of the vicissitudes of the impacts of public health research (or any other research for that matter). After reviewing and analyzing 14 case studies and articles, Dianne Quigley (2006) came to somewhat similar conclusions. Her work focused on research ethics issues in the conduct of environmental and public health research with Native American and other indigenous populations. She illustrates "how community-based participatory research practices can provide working guidelines that can overcome past research harms" (p. 147).

The GMM's special attention to ethics and public engagement in public health research is particularly remarkable in the way it provides for respectful manner of approach, the role of effective education and communication of goals and methods, and the provision of opportunities for follow-up discussions. Community engagement approach takes on a concentric relational web: from the core, or traditional human research subjects, to their, families, friends, neighbors, and so on. The outer spectrum recognizes individuals who do not typically fall within the definition of human subjects but who might be affected by the conduct of research in some way.

### **Revisiting principlism**

The principlist bioethical notion and its many revisions even in Western research ethical practice, clearly point to some embedded deficiencies, including its application in multicultural settings. For instance, Ryan (2004) has noted that, principlism – the application of autonomy, non-maleficence, beneficence, and justice to particular cases of medical decision-making or policy formation – has been subjected to serious scrutiny and undergone equally significant revisions through the years as a testimony to the scale of influence and the extent of criticism brought to bear on the method since its inception.

This is evident in the many philosophical reversals of the touchstone publication, *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress. Given its relative short life, that monumental publication is now in its seventh edition; yet still evolving. That, in and of itself, buoys the argument for an Afrocentric approach that is being proposed here.

On the converging discussion about global bioethics, Andre (2010) in “Fusion Bioethics,” encourages the growth and gelling of bioethics principles and concepts in a manner that both reflect the unity as well as the multiplicity of the cultural milieus around the globe.

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

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

Andre’s view seems to add a twist to a study by De Vries, R. et al. (2010) which argues that when bioethical principles are transported abroad, for instance to Nigeria, some of the features (say, autonomy), tend to face fresh challenges in the new environment due to their cultural bearing. This is as true of bioethics principles as it is of the frequent face-off between universalist and relativist theories: universalists believe in a universal ethical standard, relativists hold that ethical concepts can only be judged in terms of the society in which they appear. Principles that express universalism—autonomy, beneficence, non-maleficence, and justice – are unlike those in much of the rest of the world which mostly sees the person not as an isolated individual, but embedded in kinship, group and community (De Vries, R. et al. p. 170). Other analyst have long stressed likewise that while bioethics is traditionally practiced in the West within the four-corner stone principles of autonomy, non-maleficence, beneficence, and justice. But in other parts of the world, incongruities with these principles tend to emerge at the local level when their West-centric biases are subjected to closer examination (Akabayashi, A. & Slingsby, B. 2003; and Diniz, D., 2000). But, “Fusion Bioethics” is apparently not an either-or-approach; it retains universalism and principlism where they are most suited but urges relativism in its varied forms—multiculturalism, care ethics, narrative ethics, and so on — to give a local color to particular circumstances. In other words, it urges for the adoption and adaptation of Western ethical concepts and principles where they seem fit while pushing for other frameworks to sprout and blossom.

Pointing to the inadequacy of Western bioethical principles in the East (Asia), Legaspi (2001) in *Beyond a Western bioethics*, argues that “the secular humanist bioethics that is predominant in the West, which attempts to address complex bioethical issues in a pluralistic society, presents difficulties in a health care setting immersed in a culture deeply rooted in a long religious tradition.” It further suggests that “these transcultural confrontations within the bioethics movement are fueled by the growing acceptance of the political tenets of liberal democracy. “The enduring transcultural dialogue within bioethics, promises to be one of the major challenges to the field’s future identity and influence” (p. vii).

A more forceful argument is underlined by the fact that global bioethics will succeed *only* to the extent that it is local. Recommending a “matrix of relationships in dynamic equilibrium of the cosmos”, Chattopadhyay and DeVries (2008, p. 109) insist that to find the common ground of morality across different cultures that acknowledges and respects other faith, philosophical and moral traditions, bioethics must expand its vision. Indeed, “attentiveness to the concept of culture can illuminate how patients, family members, and healthcare providers interpret illness, healing, and moral obligations” (Turner, 2005, p. 310).

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

Having made the case, I propose a framework with Africanized basis for bioethics – an Afrocentric perspective – to complement and guide the resolution of issues that often require a specific perspective.

## Afrocentric boost

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

As a factual matter, Afrocentricity predates and transcends the ‘Eurocentric materialist’ thinking and the ‘Asiocentric spiritualist’ thinking. Afrocentricity “holds that all modalities and realities are united and move in one grand manner, there can be no separation between material and spiritual, profane and sacred, form and substance” (Owusu-Frempong, 376).

Afrocentricity’s methodological approach centers on the idea that African persons (human agents) are engaged in their destinies within the context of their own historical experiences (Asante, 1993). In other words, it directs their attention to “language, folktales, root rituals and the symbolic boundaries and iconic signposts not only for locating a text but also for generating substantive discourses and debates that would guide the knowledge about self as African people and transmit the knowledge to future generations” (Owusu-Frempong, p. 731).

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

One can hardly be faulted for asserting one’s identify and demanding that it be recognized as such. After all, it is neither a novel nor an exceptional move to do so. However, it points to the frequent suggestion that the African world view is subordinate to everyone else’s -- particularly the Euro-American one (Hamlet, 1998). Afrocentrism is the insistence that Africans should exist on their own terms not on borrowed Euro-American ones. It enables us to break free from the “unconscious adoption of the Western worldview and perspective and their attendant conceptual frameworks” (Mazama, 2001: 387). In the event of this, we would be able to think, orient and direct the rudder of our life toward a meaningful, positive and constructive manner.

Afrocentricity can be summed up as a principle that balances on a tripod: “philosophical ideal versus contextual determinism, scientific authority versus socio-political power, and scientific objectivity versus cultural subjectivity.” As such, there is the urge in the African thought to analyze African experience from a perspective that institutionalizes the themes of contextual determination and cultural subjectivity (Mudimbe, 1985, p. 205).

To use the concept of personhood as an example; the function of staging substantive discourses about the self as an African ‘self’ (person) is unique given the way it is delineated from the essentials of African culture, philosophy and customs. This is crucial given that the concept of personhood in bioethics is the fulcrum around which the vortex of activities swirl. A horde of established literature has drawn a sharp contrast between the African and Euro-American perceptions of a person (Mbiti, 1970; De Craemer, 1983; Menkiti, 1984, 2004; Riesman, 1986; Onyewuenyi, 1991; Owomoyela, 1991; Kaphagawani, 2004; Kelbessa, 2005; and Ikuenobe, 2006.). But, as Tangwa (2000) curiously notes, the Western conception of a person is appropriate only for the ascription of moral responsibility rather than for the ascription of moral worth. Conversely, the African perception of a person is drawn from the African worldview which incorporates “all the categories, stages, and modalities of a human being” and intimately belonging to an eco-bio-communitarian moral community made up of moral agents (p. 42).

The Euro-American ethical theory, according to Tangwa, seems to concentrate on the *object* of morality, the patient, to the neglect of the *subject*, the agent. This further conjures up the attribute in the Western culture of the principle of might is right which characterizes Western imperialism, colonialism, domination, exploitation and monopoly commerce. “By concentrating on the patient rather than the agent, Western ethical theory successfully shifts critical ethical attention from themselves and their actions onto their victims” (Tangwa, p. 40). This, he concludes, is a value judgment that seems to be dictated by economic, scientific, and technological considerations.

Ideally, the fusion of the efficiency of Western science and technology with the moral sensibilities of traditional Africa would be desirable. Thus, “Western culture could empower African culture while African culture humanizes Western culture”. (p. 42).

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

The Nuremburg atrocities led to the Nuremburg Code, the DoH, the CIOMS, and may be others. But while the Pfizer drug experimentation pales in importance nonetheless, it could easily have been Nigeria’s Tuskegee or indeed Nuremburg experience given that mankind has failed to learn from the lessons of history. It should at least add fillip to, a) the persistent ethical problems with research involving patient-subjects, and, b) the growing recognition that bioethics principles should not be seen as a one-size-fits-all approach. The Pfizer-Nigeria case – a biomedical blot which must not be overlooked – provides a formidable thrust to refocus on the task at hand, namely, the promotion of multiculturalism in global bioethics.

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

Tangwa (Ibid: 64) suggests a set of cogent models, summarized thus:

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

In the interest of clarity, Afrocentric application of bioethical principles that is suggested here applies to *all* medical decision-making, policy formulations and practices particularly on the African frontier. The following computer science lingos may help its further discernment: when West-centric bioethics principles are exported to be “installed” into a “system” or a “network” (such as a cultural milieu within Africa), it ought to have “plug-ins,” “snap-ins,” “extensions,” and “themes” – these are a set of software components that add specific abilities to the larger software application. In other words, it is like forging universal principles with a provision for relative or specific application. In the case of Africa, Afrocentricity enables the customizing functioning (plug-ins, snap-ins, etc.) of that application in locally appropriate ways. Note that add-ons are meant to target end-users not the “software developers” and they come in handy for playing videos, scanning for viruses, and displaying new file types. Similarly, well-crafted Afro-centered principles will conform to the language, folklore, root rituals and symbolic boundaries of the African ways of life. Think of it as a framework that enables Africans to structure their experiences and interests, and reconstruct their institutions to reflect their character.

While bioethics practice in Africa is generally the same as elsewhere, it must however be specifically shaped by the histories, mythologies, motifs, and ethos of the people who constitute the African cultural affinity. I submit that the Afrocentric tool can weigh its internal dynamics against external constraints and strive for a creative synthesis and response to achieve a balance in bioethical application within the African milieu.

For those who lament the lack of “human, institutional, infrastructural capacities and a real African authenticity in bioethics” (Andoh, 2011), I urge you to take up this gauntlet for the task ahead. It is up to us to highlight and sufficiently develop the African theoretical bases upon which bioethics must be hoisted. For if African intellectual arrow-heads do not confront the challenge of projecting their own conceptions to show case authentic African identities, specificities and approaches, we could be at the mercy of the enveloping force of Eurocentricism. That would mean succumbing to a globalized view that is not at all global; which would be unfortunate.

## Conclusion

I have argued that bioethics practice, like many of mankind’s endeavors, is (or rather, ought to be) culture-bound. And if we accept the essence of cultural relativity theory, we must accept the conclusion that all cultures have some valid contribution. Thus, we must actively begin to move away from the prevailing perception that modern bioethics is valid only if it is Westernized. With roots in West-centric philosophical tradition, but an emerging desire to take on a worldwide appeal, I suggest that bioethics application in other parts of the world (e.g., Africa) must reflect the attributes of local emersion in the given environment. It has been remarked that since the Nuremburg Code (with a few exceptions like the revised DoH and CIOMS), what has passed as “international” ethical guidelines to universalize and globalize bioethics practice has been to further advance the Western paradigm. I urge for other voices, perspectives and cultures to be encouraged and enhanced. Afrocentrism or Africology readily provides that voice on discourses about bioethics in Africa.

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<sup>i</sup> Bioethics, an intellectual and cultural phenomenon, rose from the ashes of some medical scandals in the U.S. and elsewhere that seemed to culminate in the 1970s. It was a turning point decade marked by other landmark movements such as the anti-Viet Nam war movement and the environmental movement.

<sup>ii</sup> “Eurocentrism”, “West-centrism” and “Euro-Americanism” are applied somewhat synonymously in this paper and the reason may be obvious: while bioethics as a field took off in the U.S., clearly that it’s philosophical principles are Eurocentric (for instance, the deontological theories of Kant and Mill-Bentham utilitarian principles).

<sup>iii</sup> The study took place at the same hospital where a team of *Médicins Sans Frontières* was already providing free treatment with Ceftriaxone, a gold standard antibiotic medication internationally recommended for treating meningitis.

<sup>iv</sup> The investigation established that at the time the trial took place, the hospital neither had an ethics committee nor the letterhead on which the (Pfizer’s) letter appeared.