Islam and Biomedical Ethics

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GLOBAL BIOETHICS: TRANSNATIONAL EXPERIENCES AND ISLAMIC BIOETHICS

by Henk ten Have

Abstract. In the 1970s "bioethics" emerged as a new interdisciplinary discourse on medicine, health care, and medical technologies, primarily in Western, developed countries. The main focus was on how individual patients could be empowered to cope with the challenges of science and technology. Since the 1990s, the main source of bioethical problems is the process of globalization, particularly neoliberal market ideology. Faced with new challenges such as poverty, inequality, environmental degradation, hunger, pandemics, and organ trafficking the bioethical discourse of empowering individuals is no longer sufficient. Global bioethics nowadays is concerned with applying and implementing a universal ethical framework. Islamic bioethics has contributed to creating such framework (exemplified in the UNESCO Universal Declaration on Bioethics and Human Rights) while at the same time it is continuously articulating and interpreting this framework in specific settings and contexts.

Keywords: bioethics; human rights; Islam; medicine

Medical Ethics

Medicine and ethics have been associated with each other from the beginning. In the West, Hippocrates (fourth to fifth century BCE) is known as "the father of medicine." He was a contemporary of the famous Greek

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philosophers Socrates and Plato. In his works he argued that medicine should be emancipated from mythical and magical thinking since medical interventions are based on experience and reasoning. He explains that one can no longer assume that diseases have a supernatural cause, but rather one should make accurate observations and experiments to identify what pathological processes are going on and how they can be remediated. For Hippocrates this scientific methodology of observation and analysis is not separated from religion and should be combined with an ethical approach. A good physician is not only competent but also responsible; he will follow certain ethical rules. These rules are formulated in the Hippocratic Oath (Carrick 1985, 60).

Greek medicine was not unique. Healing activities are as old as humankind. Ancient Mesopotamia was famous for its medicine. Hammurabi, king of Babylon in the eighteenth century BCE, promulgated one of the first law codes in history, written on clay tablets. In the ancient Indian medicine of Ayurveda the physician Charaka (third century BCE) produced a code of conduct emphasizing compassion as the basic ideal in medicine (Francis 1996). He built on an older tradition in which Hindu physicians took so-called Vaidya's Oath requesting them to give absolute priority to the care for their patients (Young 2009). This connection between ethics and medicine was certainly also true for the Islamic tradition regarding the physician as *hakim* (doctor as well as wise man) whose main task was to act as "moderator" between nature and illness, health and religion in order to cultivate both health and virtue (Farage 2008). It is well known how medieval Western medicine was influenced by Islamic examples, notably in education (following the scholastic centers in Bagdad, Cordoba, and Toledo), hospital care (with famous *bimarestans* in such major cities as Damascus, Cairo, and Bagdad) and public health (based on lifestyle, hygiene, and health policy in the culture of the *hammam*) (Schipperges 1976). This interaction and the works of well-known scholars such as Hunayn Ibn Ishaq, al-Razi (Razes), and Ibn Sina (Avicenna) reiterated the interconnection between medicine and ethics as Western medicine started to develop. For example, Avicenna's *Canon of Medicine* was used for teaching medicine at least until the seventeenth century, emphasizing a holistic approach to the human being, and considering ethics as integral part of medicine (UNESCO 2004).

Although in scholarly literature the term "medical ethics" was used for the first time in the nineteenth century, consideration of ethical questions in connection to health, disease, and health care is not new (Baker and McCullough 2009). But the focus of ethics has not been the same from era to era. For a long time the emphasis of medical ethics was on the person of the doctor, on conduct according to professional rules, or on professional duties. The importance of the virtuous conduct of physicians was transformed when, in the nineteenth century in Western countries, medical

associations emerged, and when social changes like health insurance and health-care systems developed. The rise of medicine as a profession made it clear that individual virtues were insufficient; professional rules and standards needed to be defined and exemplified as codes of conduct. What has remained consistent during these changes is that medical professionals themselves continued to determine the standards for good conduct as well as the criteria for the virtuous doctor. Other significant changes took place in the second half of the twentieth century. The growth of medical science and technology as well as social changes, such as the civil rights movement, necessitated two changes in medical ethics. First, the ethics discussion was no longer focused on the behavior of health-care professionals. Many ethical issues went beyond the usual orientation on good conduct, professional ethics, and professional virtues. New ethical problems have emerged related to death and dying, continuing or forgoing treatment, and allocation of scarce resources. The scope of medical ethics therefore has enlarged. Second, the ethical debate is no longer in the hands of medical professionals. The media, policymakers, and health administrators were originally involved, but increasingly all citizens became aware of the significance of ethical issues in the field of health, disease, and care. These changes became visible in different terminology: "medical ethics" was regarded as too narrow; "health-care ethics" and "bioethics" became more popular.

Bioethics

The first person to use and elaborate the term "bioethics" in print was the U.S. cancer researcher Van Rensselaer Potter (1911–2001) who became interested in ethical issues precisely because of his research. Cancer is a complex problem that requires interdisciplinary cooperation. A focus on individual and medical perspectives is insufficient since many cancers are related to lifestyle and individual behavior, such as smoking, but also to environmental pollution with carcinogenic substances. Medical research will bring some limited progress at the individual level, for example, with new chemotherapies that can alleviate suffering and prolong life expectancy, or with new surgical interventions. But much more progress can be accomplished at the level of populations with preventive programs educating people to live more healthily. His long years of cancer research convinced Potter that a broader approach beyond the individual medical perspective was necessary. At the same time he regretted that his long-term preoccupation with cancer had prevented him from addressing more important issues. Potter summarized these priority problems of our time as the six P's: population, peace, pollution, poverty, politics, and progress (Potter 1971, 150).

For Potter it is clear that an innovative approach in ethics is necessary. In order to be able to deal with the priority problems of humankind,

we need a new discipline that combines the science of living systems, or biological knowledge (*bio*) with the knowledge of human value systems and philosophy (*ethics*). This new discipline of "bioethics" will introduce a broader perspective than the usual medical ethics approach.

The first characteristic of bioethics is that it is orientated toward the future. This orientation is prominent in the title of Potter's first book: *Bioethics—Bridge to the Future* (Potter 1971). Bioethics should be a bridge between the present and the future because the survival of humankind requires a focus on long-term interests and goals. For Potter the overarching concern of bioethics is long-term global human survival. This goal can only be reached by forging compromises between individual interest and social good, and between quality of the environment and the "sanctity of the dollar" (Potter 2001, 20).

Second, bioethics is an interdisciplinary enterprise. It refers to the need to bridge science and philosophy. The basic problems of humankind are multidimensional. To address them it is necessary to combine all categories of knowledge, in particular biological knowledge and ethics. We cannot proceed with experts working only in their own specialties. What should be created, according to Potter, is "a new breed of scholars," persons who combine a knowledge of new science with old wisdom (Potter 1964, 1022). Also urgently needed are new methods and approaches. The fundamental problems of humankind can only be addressed with a mix of basic biology, social sciences, and the humanities. Interdisciplinary groups should be established that exchange new ideas and examine old ideas in the light of scientific knowledge. These innovative approaches can provide the wisdom that is fundamental for the overarching long-term goal of human survival. We do not merely need more technology, specialized knowledge, or philosophical reflection. What is required in the first place is "knowledge of how to use knowledge"; and this is what Potter called "wisdom" (Potter 1971, 1).

The third characteristic of bioethics is that it emphasizes that human beings are part of nature. We cannot continue to degrade and destroy the environment. Bioethics should widen its scope and focus on the question how to preserve, in Potter's words: "the fragile web of nonhuman life that sustains human society" (Potter 1970, 243). Ethics should be extended from individual and social issues to environmental concerns. Intrinsically, bioethics therefore has a wide scope.

Since it was introduced in the scholarly literature in 1970, the term "bioethics" became popular and widely used. One of the early centers in this field, the Kennedy Institute at Georgetown University in Washington DC, USA which was established in 1971, included "bioethics" in its original name. Already in 1978 more than 1,500 colleges in the United States offered courses in bioethics (Potter 1987). The new name was assumed to highlight the broadening of scope of medical ethics. But in the opinion of

Potter this was misleading. His new idea was misused since "bioethics" in practice continued to be focused on medical issues. It was simply an "outgrowth of medical ethics" (Potter 1988, 1). First, it is concerned with the perspective of the individual patient: how can individual lives be enhanced, maintained, and prolonged through the application of medical technologies? Second, it is exclusively interested in the short-term consequences of medical and technological interventions. Although Potter concedes that medical bioethics has a broader approach than traditional medical ethics, it is still too narrow to address what are, in his view, the basic and urgent ethical problems of humankind that are threatening the human survival. In order to adequately address these problems, according to Potter, a new science of survival is necessary. It was for this purpose he had proposed a new discipline called "bioethics." Because contemporary bioethics is not generating new perspectives and new syntheses, Potter wants to reemphasize the concern for the future of the human species by qualifying the terminology. What we currently have is medical bioethics. It needs to be combined with ecological bioethics. Both approaches in bioethics should be merged in a new synthetic approach called "*global* bioethics."

Global Bioethics

In Potter's vision (1988) global bioethics unites two meanings of the word "global." First, it is a system of ethics that is worldwide in scope. Second, it is unified and comprehensive.

The fact that bioethics nowadays is a worldwide ethics can again have two meanings: international or planetary. Bioethical issues and concerns transcend national boundaries. But global bioethics is more than international bioethics; it is not merely a matter of crossing borders, but it concerns the planet as a whole. Bioethics nowadays is relevant to all countries and takes into account the concerns of all human beings wherever they are and whatever their religious belief may be. While bioethics emerged in Western countries, it has expanded globally. There is now a new social space, not simply a collection of countries, regions, and continents, that engages bioethical discourse. This new space has emerged since ethical problems today are planetary. An important source of inspiration for Potter at this point was the work of Pierre Teilhard de Chardin (1881–1955), French philosopher, geologist, and Jesuit (ten Have 2013). Potter referred frequently to Teilhard. Writing in the 1940s and 1950s, Teilhard anticipated what we now call "globalization." Humanity will develop into a global community. Due to the processes of "planetary compression" (intensified communication, travel, exchanges through economic networks) and "psychic interpenetration" (increased interconnectedness and a growing sense of universal solidarity) humankind will be involved in an irresistible process of unification. Human beings are becoming increasingly aware of

their interdependency and their common destiny. The world population is growing while the surface of the earth remains the same; therefore, people are obliged to cooperate even more intensely: "We can progress only by uniting" (Teilhard de Chardin 2004, 66). According to Teilhard we are in a process of evolution that will lead to a moral community of citizens of the world. It is this process that he calls "planetization of Mankind" (Teilhard de Chardin 2004, 108).

Potter's second meaning of "global" refers to bioethics as more encompassing and comprehensive, combining traditional professional (medical and nursing) ethics with ecological concerns and the larger problems of society. For him, global bioethics is the mainstream into which medical and ecological bioethics eventually must merge. Taking global bioethics seriously will imply a further evolution of ethics: from a focus on relations between individuals, to relations between individuals and society, and ultimately to relations between human beings and their environment (see also Lang and Rayner 2012). The evolution of ethics in the context of health care reflects this pattern as it developed from medical ethics into health-care ethics and medical bioethics. Today we are witnessing the emergence of global bioethics.

Another way of defining the "global" in global bioethics is through issues and problems that are nowadays addressed. Of course, the "traditional" topics continue to be discussed, such as abortion, end-of-life care, reproductive technologies, transplantation medicine, and medical futility. But these concerns are primarily relevant for developed countries, while many developing countries cope with issues like access to medication, traditional medicine, and exploitation. New bioethical problems such as pandemics, organ trade, international clinical trials, climate change, obesity, malnutrition, food production, corruption, bioterrorism, and disasters are global in nature. Global bioethics is characterized by new issues that affect everyone everywhere.

The Impact of Globalization

In the 1990s drug research rapidly became a global enterprise. Clinical trials are increasingly outsourced, initially to Eastern Europe, now more often to developing countries, especially India and China. Forty percent of clinical trials were carried out in so-called emerging markets in 2005 (Petryna 2009). This expansion of clinical research into countries without a strong ethical infrastructure (limited regulation, often no legislation, not many ethics committees and ethics experts) has been associated with many ethical problematic cases. But it has also created new debates, for example, about the use of placebos because standard treatment is not available or too expensive in resource-poor countries (Macklin 2004) Health care itself has also increasingly been globalized because it is considered a global market.

This has created, for example, disconcerting brain drain. Health professionals such as nurses are educated in poor countries like The Philippines and then recruited to work in the United Kingdom. Medical tourism is another global phenomenon. For example, patients with chronic diseases such as Parkinson's disease are lured into so-called stem cell clinics in Russia where they pay for futile and unproven treatment. There is also the phenomenon of organ trafficking. People in resource-low countries such as Pakistan sell their kidneys to rich patients in the United States who resist being on a waiting list. Many bioethical problems today are no longer domestic problems. Health care requires global policies and approaches. The 2009 flu pandemic (swine flu) originated in Mexico but infected 11%–21% of the world population. The global response to this pandemic, including the ethical problems engendered, needed international coordination by the World Health Organization.

Contemporary bioethics is therefore characterized by global interconnectedness of medical research and health with resulting and often similar challenges and problems in various parts of the world. But it is also influenced by the increasing interest for the global context of health and disease itself. Broader perspectives in bioethics have been advocated since the 1980s with increasing interest in issues such as access to health care, right to health care, prioritizing limited resources, and social determinants of health. This macro focus of bioethical analysis easily leads into a global perspective (Brock 2000; Daniels 2006). Of particular relevance is the issue of global health. Global threats like pandemics and global warming demonstrate that individuals, communities, and the wider world are deeply connected. Globalizing the concerns of bioethics means that more attention is paid to issues relevant to developing countries, in particular global inequalities in health. Global concerns demonstrate the interdependence of people in the world. If an epidemic disease is breaking out in one country, it will have consequences for other countries. If rich patients want to buy organs, people in poor countries run the risk of being exploited.

Another relatively recent global concern relates to the environment. Since Potter introduced the notion of bioethics, environmental ethics has developed as a separate discipline in applied ethics. Merging the medical and environmental perspective was Potter's intention with proposing the new concept of "global bioethics." Both perspectives have different theoretical approaches: individual versus common good, concern for individual patients versus survival of humankind, short-term versus long-term interests, present versus future generations. Recently, it has been argued that a clear separation between bioethics and environmental ethics is no longer tenable (Dwyer 2009). What is more important is that in practice and policy medical and environmental issues have common causes and grounds. Environmental degradation and loss of biodiversity have serious impact on global health and health care (Mascia and Mariani 2010). Climate

change and global warming will change disease patterns and will create new health needs. Recent diseases and epidemics such as mad cow disease, salmonella, and swine flu have threatened human health, demonstrating the interconnections between food production, the way we treat animals, and the environment. The widespread use of antibiotics in animal farms contributes to multidrug resistance while at the same time production of animals for food creates an environmental disaster (as one major source of greenhouse gas emissions). These examples illustrate that concern for individuals is not incompatible with concerns for the biosphere.

Another effect of globalization is the increasing need in global bioethics for international policymaking. The interconnected nature of ethical problems today requires international cooperation and regulation. Regulation at the level of the nation-state is no longer sufficient. Now that clinical trials are taking place in many countries around the world, it is necessary to determine what the ethical principles and guidelines for the execution of trials will be in heterogeneous conditions and different social and cultural contexts. Practices such as organ trafficking are almost universally condemned, but in practice continue to take place. Eradication of this practice requires legislation and implementation policies, not only at the level of each country but also at the international level. Even if some countries legally prohibit it, the practice will move to other countries without a strong international legal framework. This is why professional organizations have taken action (Delmonico 2008, 2009). Transplantation of kidneys requires surgeons. Trafficking will be more difficult when the world transplant surgeons unite against illegal and commercialized transplant practices. Because of the need for international cooperation, many international organizations (WHO, UNESCO) are now active in the field of global bioethics.

Bioethics and Globalization

Nowadays, globalization is a major source of bioethical problems. While there are different interpretations of globalization, the common core of these interpretations has been identified as "the operation of a dominant market-driven logic" (Kirby 2006, 80), shifting policies away from maximization of public welfare to the promotion of enterprise, innovation, and profitability. This logic changed the nature of state regulation, "prioritizing the well-being of market actors over the well-being of citizens" (Kirby 2006, 94). Rules and regulations protecting society and the environment are weakened in order to promote global market expansion. A new social hierarchy emerged worldwide with the integrated at the top (those who are essential to the maintenance of the economic system), the precarious in the middle (those are not essential to the system and thus disposable), and the excluded at the bottom (the permanently unemployed) (Cox 2002, 85). More than exploitation, precariousness and exclusion are

characteristics of this new social order of globalization. Due to increasing risks and lower resilience, people all around the world, but especially in developing countries, have diminishing abilities to cope with threats and challenges.

The impact of globalization has significant consequences for bioethics. Since its emergence in the 1970s it has focused on empowering individuals. The main challenge was the impact of science and technology, and the main moral question was how the rational, individual decision-maker would be able to select benefits and avoid harms. The religious discourse, specifically Islamic biomedical ethics and Catholic bioethics, followed this pattern: they were concerned with the ethical issues raised by new scientific knowledge and technological interventions: reproductive medicine, genetics, transplantation and organ donation, and intensive care treatment.

However, confronted with globalization and facing challenges of poverty, inequality, environmental degradation, hunger, pandemics, and organ trafficking, such discourse is no longer sufficient. The main challenge for bioethics today is the impact of neoliberal market ideology worldwide. The usual discourse should therefore be complemented with a broader framework, for example, provided in the Universal Declaration on Bioethics and Human Rights, presenting a wider range of ethical principles going beyond the individual perspective, including solidarity, care, social responsibility, and respect for human vulnerability. It can therefore be argued that bioethics has now entered a new phase, that is, global bioethics (ten Have and Gordijn 2013). In this new stage, global bioethics needs to go beyond the focus on human beings as autonomous individuals, emphasizing the interconnectedness of human beings, and the interrelations between human beings and the environment. This means building bridges between the present and the future, science and values, nature and culture, and human beings and nature, exactly as argued by Potter (ten Have 2012).

Universal Ethical Framework

Warren Reich has pointed out that global bioethics utilizes a "comprehensive vision of methods" (Reich 1995, 24). The global perspective of bioethics is not a matter of geographical expansion, but rather it refers to phenomena that have a global dimension—that is, they are no longer dependent on the specifics of a particular culture or society. This is not the same as arguing that global bioethics is a unified field of inquiry in which bioethicists behave in similar ways everywhere in the world or that there is international agreement on fundamental values. That we have similar bioethical problems in different countries does not imply that we have the same ethical approach everywhere. The global dimension, however, invites us to rethink our usual approaches and ethical frameworks. It makes us

aware of the "locality" of our own moral views while, at the same time, encouraging us to search for moral views that are shared globally. In this challenge, bioethics is increasingly connected with international law, particularly human rights law, which has a similar global vision (ten Have 2013; Veatch 2012).

The growing importance of global bioethics has reactivated the significance of the notion of moral diversity. The development of global bioethics demands a broader framework of normative interpretation and assessment. Is it justified to apply the principle of informed consent in Nigeria where there is a significantly different culture? Should we respect the Chinese practice of harvesting organs from executed persons? In a global perspective, the ethical systems of different cultures need to be examined and moral values analyzed and applied in specific contexts. This is generally recognized as necessary. It has opened up new and fascinating fields of research, but the next step awakens the old controversy of universal values and local values. Is there a universal framework of principles and values or are principles and values different, depending on the local, cultural, and religious normative systems?

For some, global bioethics as such is an attempt to universalize a specific set of bioethical principles and to export or impose them in the rest of the world. They claim that the four principles formulated by Beauchamp and Childress (2012) are typically North American principles that are not valid in other parts of the world. Others maintain that global bioethics necessarily reaches beyond the Western individualist perspective of traditional bioethics (Kelly et al. 2013, specifically chapter 30). It is true that these principles have been formulated in Western countries but that does not imply that they have no validity outside of these countries. We should make a distinction between origin and validity. The fact that our numerical notation originated from the Arab culture (while they inherited it from the Hindu culture) does not mean that Arab colleagues can still claim it as theirs or that we can blame them for having their figures imposed on us. The same is true for ethical principles. Whether or not global bioethics is considered to be "ethical imperialism," it has increased sensitivity regarding the application of basic concepts such as individual autonomy and informed consent across the globe. In many non-Western cultures, the autonomy of individuals is not privileged over communities. Global bioethics, therefore, should recognize that in these countries responsibilities toward family, community, and society can have more significance than individual rights, but that does not mean that individual rights are insignificant. This was a major issue in the development of the UNESCO *Universal Declaration on Bioethics and Human Rights* (ten Have and Jean 2009).

The search for global ethical principles focuses on the values that we share as human beings. For some bioethicists, this will be a futile endeavor

because different and contradictory ethics systems exist. If there is no basis for verification of ethical judgments, then all efforts to formulate ethical principles as universal means in practice that the dominating system attempts to impose its principles as universal. But this is a mistaken view. This is demonstrated in the activities of the Parliament of the World's Religions. In 1993 approximately 200 leaders from more than 40 religious and spiritual traditions signed the "Declaration Toward a Global Ethic" (Parliament of the World's Religions 1993). This statement, drafted by German theologian Hans Küng, declared that all traditions share common values such as respect for life, solidarity, tolerance, and equal rights (Küng 1997). The document emphasizes that it is important to show what world religions have in common rather than how they differ.

The 191 member states of UNESCO negotiated for two years to reach consensus on the text of the Bioethics Declaration. In 2005 they unanimously adopted the Declaration. They agreed on 15 ethical principles as fundamental for global bioethics. These principles included the four principles of Beauchamp and Childress but also other principles that play a more significant role in non-Western countries, such as solidarity, social responsibility, and benefit-sharing. One of the principles was that of respect for cultural diversity. But this was the only principle that could not overrule the other principles. In other words, a health-care practice that violates human dignity can never be justified by this principle of respect for cultural diversity. The controversy was clear in the debate about informed consent. Although there was wide consensus that informed consent is a fundamental principle, it was also argued that in other cultures the emphasis is different. In African countries, a communitarian approach underlines the importance of the group or tribe. In health-care and research decisions the group discusses the issue and the community leader is the one taking the lead in decision-making. In Arab countries the head of the family is crucial, and the husband makes decisions rather than the spouse(s). Nonetheless, the principle requires that in the end the concerned individual needs to provide informed consent. Such different approaches to implementation of principles are common but they do not affect the validity of the principles. Informed consent in North America requires a great deal of bureaucracy; patients are required to sign extensive documentation. In many other countries, however, one's word is one's bond, and asking for a signature is a sign of distrust.

The emergence of global bioethics has not only stimulated interest in perspectives wider than those that focus on the individual but has also expanded the idea of the moral community (ten Have 2011a,b). This is demonstrated in debates on the new principle of protecting future generations and on intergenerational justice. The UNESCO Declaration on the Responsibilities of the Present Generations toward Future

Generations (UNESCO 1997) connects our responsibilities to posterity with the need to ensure the continued existence of humankind. These are the same concerns advocated in Potter's conception of global bioethics. The notion of the global moral community is furthermore introduced in global bioethics through the principle of benefit sharing. This novel principle is important in the context of bio-prospecting, that is, the search for and collection of natural substances for possible development of new medications. Those natural resources are abundantly available in developing countries with rich biodiversity such as Brazil and Indonesia. In many developing countries traditional medicine is based on such natural resources. These resources and the traditional knowledge of indigenous populations have been appropriated ("biopiracy") by Western companies to fabricate new profitable drugs without any compensation to the indigenous communities. These new debates in fact refer to a more fundamental discourse on "global community" or "world moral community," which regards humanity itself as a moral community. In this discourse two interrelated arguments are used (Agius 2005). One argument is that the global community includes all of nature and not merely human beings. The concept of community is broadened to include more than humans; nonhuman species need to be considered members of our community since we all share dependency and vulnerability. In fact, this is Potter's view. He argues that ethics should extend the idea of community from human community to a community that includes soil, water, plants, and animals. Humankind coexists with ecosystems; together they constitute the "entire biological community" (Potter 1988, 78). The second argument is that the earth is not the possession of one particular generation; each generation inherits it and should bequeath it to future generations, making sure that it is not irreversibly damaged. Because of the interdependence of human life and the fragility of our planet, we need a new vision of human community that encompasses past, present, and future generations. The future of the human species can only be guaranteed if humanity itself is regarded as a collectivity or a "global community."

The idea of humanity as a global community that should be the real focus of bioethics has become morally relevant because it refers no longer merely to extent (a worldwide scope involving "citizens of the world" who are increasingly connected and related due to processes of globalization) but also to content (the identification of global values and responsibilities as well as the establishment of global traditions and institutions). This development is related to the concept of the "common heritage of humankind" (Chemillier-Gendreau 2002; Joyner 1986; ten Have 2011a,b). Introduced in international law in the late 1960s to regulate common material resources, such as the ocean bed and outer space, the concept was expanded in the 1970s to include culture and cultural heritage. This has led to the construction of a new global geography of symbols indicating that humanity itself can be regarded as a community. Cultural heritage is

no longer only representative of a particular culture but of human culture in general. The temples in Abu Simbel in Egypt were entirely relocated in 1968 to avoid their destruction after the construction of the Aswan Dam in the Nile River. This relocation showed that the international community regarded the temples not merely as a product of the Egyptian civilization from the thirteenth century B.C. Although build by Pharaoh Ramses, they were the common property of humankind and needed to be preserved. Labeling some cultural products as a world heritage produces a global grammar in which diverse and local phenomena receive a universal significance and require global management. These cultural treasures are expressions of human identity at a global level. They are part of the quest of citizens of the world, and they become indicators of world culture. Regarding and categorizing cultural property as world heritage implies a global civilization project that seeks to create a new global community representing humanity as a whole, enable the identification of world citizens, and evoke a sense of global solidarity and responsibility. This process of creating the global community as a moral community was further promoted through the application of the concept of "common heritage" in global bioethics, first in the late 1990s in the field of genetics, followed in the 2000s by the adoption of a global framework of ethical principles by almost all countries in the world (ten Have and Jean 2009). With such a universal framework, global bioethics can now claim to represent a global geography of moral values that enables humanity itself to be regarded as a moral community. It implies that citizens of high-income countries can no longer be indifferent to clinical research practices or organ trade in low-income countries since the same moral values and standards apply within the global community, although the application is always modified according to local circumstances and local communities. Membership in the global community furthermore draws on a growing number of global institutions and movements (e.g., Doctors without Borders, Bioethics Beyond Borders, Oxfam, fair trade, UNESCO). In other words, there is no longer a necessary conflict between individualism and communitarianism. There is a working process toward establishing a global community of shared values. These values are the product of intensive and continuous negotiation, deliberation, and dialogue. They are reflected in a universal framework that overrides the diversity of principles and values in different parts of the world and in various religions and cultural traditions. But this framework proceeds without the articulation of absolute principles and values since there is not one supreme principle that trumps the others. Bioethics will continue to proceed with rational deliberation through interpreting, weighing and applying multiple ethical principles at the same time. It is also clear that the existence of a global framework of ethical principles does not eliminate ethical disagreements. Disputes will continue

to exist on specific issues such as abortion, reproductive technologies, and end-of-life issues.

Impacts on Islamic Bioethics

The rising awareness of the global dimension of bioethics has major impacts on Islamic bioethics (Brockopp and Eich 2008). These impacts can be distinguished at two different levels: the global and localized level. At the global level, bioethics is advancing a transcultural framework of ethical values and principles. Muslim scholars have contributed much to the international effort to identify global values and principles that are commonly shared among all human beings. They have been well represented in the international debate, for example, in UNESCO and its International Bioethics Committee, drafting the *Universal Declaration on Bioethics and Human Rights*. In 2004 the International Bioethics Committee brought together in Paris representatives of various world religions. It was concluded that universal principles could be formulated and common values identified although differing moral views on specific issues existed. In fact, reference was made to the Muslim religion exemplifying a common ethic among so many different cultures, nations, and traditions (IBC 2004). Of course, this was not the first time that it was underlined that Islam shared many foundational values with Judaism and Christianity (such as the value and equality of human life, dignity, altruism, beneficence, and solidarity) (Filiz 2011). Islamic bioethics also shares core moral principles with Buddhist medical ethics (Cummiskey 2011). Many efforts have been undertaken to show that there is no contradiction between the general principles of bioethics and the basic convictions of religions; all sacred texts demand to do good, to avoid evil, to apply justice, and to make responsible choices according to faith. The main principles of the first stage of bioethics (and canonized by Beauchamp and Childress 2012) are consistent with the primary values of Islamic bioethics (Filiz 2011). This compatibility is even stronger in the new, second phase of global bioethics in which 15 fundamental ethical principles have been identified (ten Have and Jean 2009). The new ethical framework presented in the UNESCO Declaration actually incorporates basic characteristics of Islamic bioethics: striking a better balance between the principle of autonomy (emphasizing individual decision-making) and the place accorded to family, community, and solidarity among human beings by particular religious and cultural traditions; but also focusing on duties and responsibilities, and not merely emphasizing rights. Global bioethics therefore represents a broader perspective that goes beyond the values and concerns of the first stage of bioethics that has emerged in the context of Western developed countries. The UNESCO Declaration reflects, what Veatch has called, the "convergence" of various ethical systems creating a single

normative framework and speaking "for virtually all citizens of the world" (Veatch 2012, 190).

At this global level, Islamic bioethics should not be understood as a separate bioethics; but it should be interpreted within the context of global bioethics and the *Universal Declaration on Bioethics and Human Rights*, of which it is a particular articulation. In this sense, there is not an Islamic bioethics that is incommensurable with, for example, Catholic bioethics. Both are species of the same genus of global bioethics. Islamic bioethics therefore is regarded as a distinctive interpretation and implementation of bioethics from the perspective of Islam. Such interpretation of fundamental bioethical principles as defined in the UNESCO Declaration will be inevitable when the principles are specified and applied within Muslim countries.

At the localized level of interpretation and application, diversity will arise. Major Muslim countries were quick to establish bioethics institutions to encourage bioethical debate and implement global principles. Egypt, Iran, Pakistan, and Saudi Arabia, for example, created national bioethics committees at an early stage. At the same time, Islamic bioethics is often considered as static and uniform. The medical literature, for example, presents a superficial and monolithic view of Islamic bioethics (Shanawani and Khalil 2008). But it is clear that at localized level there is not one monolithic Islamic bioethics, as there is not one Catholic bioethics; there is "internal plurality" (Atighetchi 2009, 354). There are different types of Muslim bioethics, all based on the same divine sources.

Global bioethics therefore is a two-level phenomenon. At one level there is a set of fundamental values on which traditions and cultures agree; this is expressed in global bioethics principles. At another level, there are many efforts to articulate more specific bioethics standards in the context of specific religious and cultural traditions. At this level, there is increasing interest in the heterogeneity of Islam and the diversity of bioethical opinions, countering the idea of Islamic essentialism and denying the rich variety of viewpoints on a multitude of bioethical subjects. While global bioethics has emerged with significant contributions from Islamic bioethics, it requires at the same time greater local specificity. It is precisely the dialectic of global and local perspectives that helps to construct and corroborate global bioethics (ten Have and Gordijn 2013).

Conclusion

Now that the original notion of bioethics initiated by Potter is revived as "global bioethics," many new issues are on the agenda, requiring analysis and research, but even more importantly requiring international action and policy—new issues such as systemic corruption, conflicts of interests, and protection of future generations, but also ecological problems such as

climate change. Bioethical discourse can no longer focus only on the quandaries of rich countries but must focus also on the problems of developing countries. This revival of global bioethics underlines the fact that bioethics no longer is solely an academic discipline, but is also an important topic for public discourse and political concern.

Note

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