
## Beyond theory

**A philosophical disease: bioethics, culture and identity**
Carl Elliott
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To grapple with Carl Elliott's important monograph, *A Philosophical Disease: Bioethics, Culture and Identity*, is to feel the relief of receiving a long-awaited diagnosis and the foreboding of facing an uncertain prognosis. Elliott challenges the limits of scientific and ethical theory in medical practice, including bioethics, showing how theory fails us when we reflect on everyday moral problems. As we look through his antitheoretical lens, it becomes apparent that some moral problems and moral experiences are overly circumscribed and that our responses to them are inadequate. Medical educators, bioethicists and anyone with an interest in ethical theory in health care will want to consider seriously what Elliott has to say.

This is a book that lives its message. Elliott's twin aims — exploring the institutions of medical life in the absence of agreed-upon ends and exploring the nature of bioethics in the absence of ethical theory — are (largely) achieved without recourse to the methodology he rejects. He identifies and develops his main themes by attending to and recording lived moral experience: his own, his family's and that of his philosophical and literary heroes. Ludwig Wittgenstein figures prominently, as do Walker Percy and Elliott's own father. In this manner the text, like our moral lives, becomes a tapestry of moral concepts and experiences.

For readers more accustomed to medical and philosophical authors who authoritatively take (or drag) them by the hand through a quandary of medical-moral problems, Elliott's approach may not make for easy reading. His style, though a remarkable testament to the belief that the bioethicist's role is to listen, read, and write about moral experience, risks serious disjointedness. His central chapters explore wide-ranging themes, including the role of clinical bioethicists in medical bureaucracy, the effect of illness on identity, the treatment of spiritual illness as psychiatric disease, the impact of disordered personalities on moral responsibility and the moral problem of living heart transplantation. Each of these chapters could stand alone as a useful and engaging reflection on a challenging issue, but because they are pieces of a single monograph, the reader is forced to ask: How does this fit? What is Elliott trying to say? The question of context also arises as the reader confronts Elliott's varied and unusual source material. What do Wittgenstein, Percy, Prozac, psychopathology and donating a living heart all have to tell us about the evils of theory and the responsibilities of medical practice?


Fred Sebastian

The need for contextualization is not an oversight on Elliott's part but part of his point. He wants us to *question* context. Theories and practices, he argues, too often give context short shrift, and the moral ramifications of this are serious. The ethical issues faced by people who provide and receive care arise from and depend on the prevailing ethos of medicine, which Elliott describes as a vast, relentlessly progressive, political and economic machine. Judgements about what is "normal" and what needs to be fixed depend on how that machine envisions the world. Elliott's portrayal of lived experience suggests that our moral imagination needs to expand to accommodate the particularities of social situations and experiences.

Elliott weaves these considerations of context together with considerations of identity. One's identity is formed against and changes with one's background, culture, history and relationships with others. It follows that identity cannot be understood or responded to in a meaningful way without considerations of context. Attention to contextual aspects of identity leads Elliott to question, among other things, the dominant medical understanding of autonomy, which categorizes emotional ties and moral commitments as constraints on autonomy.

Elliott's last two chapters are the most important. In chapter 7, "The point of the story," he draws attention to ways in which moral communication in medicine and bioethics is shaped by the way it is delivered. For example, despite the prevailing medical assumption that case presentations are value-neutral, Elliott shows that the manner in which a case is presented depends on the values the teller uses to interpret the world. Moreover, all use of language involves a values-based interpretation of the world. The trick is to determine which interpretations carry more moral weight.

Elliott's appreciation for narratives that honestly and comprehensively describe moral experience may explain his effective use of a confessional genre. Poignantly, he begins his book with the admission that his favourite part of Jean Jacques Rousseau's *Confessions* is Rousseau's description of himself as a flasher. Confessional literature closes the gap between

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moral description and moral experience. Medicine and bioethics must find ways to do the same.

In chapter 8, "A general antitheory of bioethics," Elliott finally pulls together his main themes while diagnosing where bioethics has gone wrong and recommending interventions that will direct it back on a healthy course. Part of the cure lies in recognizing the problem: we expect more from our ethical theories and moral concepts than they can deliver. The notion that tidy truths can be spun out of simple theories is unreasonable and inconsistent with the complexities of our moral intuitions. Values are deeply rooted in culture and life experience and, as a result, are inseparable from contexts, are not fully under our control, and cannot meet the standards of systematic ethical theory. Following Elliott, bioethicists need to understand the nature and limits of their theories and to move beyond them. We need to attend honestly to the intimate side of bioethics, to lived moral experience, and to the interweaving of moral concepts with moral life.

I thank Christy Simpson for her helpful comments on a draft of this review.

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*Room for a view*

# Mr. Mavrocki and the bees

Perhaps I have such a clear recollection of Mr. Mavrocki because he was the very first patient I saw when I started my surgical practice in Canada. But that isn't the only reason. There was something else, something touching, and something, I would say, a little mischievous about him. He was sitting up in bed when I went in to see him, and he greeted me with a wonderful rich accent and an easy smile. He was solidly built in a soft way and he told me, among other things, that he was 50 years old and long since retired.

This surprised me. Every retired person I knew had worked until much later in life. As for me, I was just setting out in my career and had not yet started to earn a living. Financial independence seemed a long way away. I suppose I had little knowledge of financial matters, and that made me somewhat curious about anyone who had. Mr. Mavrocki pointed out with a contented grin that he was not retired on account of ill health or any difficult circumstance, but because he had enough money. He seemed very pleased with himself. This seemed an enviable position to be in, and how anyone could ever achieve it was totally mysterious to me.

R.R. Sallows / National Archives of Canada / PA-021486

After the medical side of our meeting I steered back to the subject of retirement and told Mr. Mavrocki that I thought he must be very clever to have arranged it so early in life. He glowed with pride, and in a practised manner told me a little of his story.

He had been very poor when he first immigrated to Canada. He had little education and no special trade. After some hard times he managed to get a job on the railway. This job entitled him to live in a small house on a lonely stretch of railway in the prairies. As far as I could gather from his description, he had a hammer and would walk up and down the line, tapping the track to test it. Then he would walk up and back again, testing the other side. He was responsible for a few kilometres of track. He described how he grew vegetables in the garden of his little house. I found it hard to imagine how financial security could come from such a life, but of course I didn't say anything. He continued as follows.

One day his neighbour threw away a couple of broken bee hives. Mr. Mavrocki decided to repair them and put them to use. He bought some bees and a couple of queens and installed them in his hives. Now this was in northern Alberta, one of the best places in the world for honey. It has something to do with the length of the days and the hours of sunshine during which the bees can work, and, I suppose, the number of flowers that they have to feed on. The honey is excellent, and at the height of the season, if the bees are well looked after and the conditions are right, about 50 000 bees will be working in the hive. Thus the hives are made in modular form. During the summer, box goes on box until the hive is about six boxes high. The bees live in the bottom and in the top they store honey. Perhaps the bees sense that a long and cold winter is coming, because they certainly work very hard. By late summer, an average hive can contain about 225 pounds of honey! I knew that in England 30 to 60 pounds was considered a reasonable harvest, but I suppose the conditions are quite different there.

Mr. Mavrocki became more and more enthusiastic as he told me the story. I could see that he loved those bees and that they had been good to

him. He had so much honey, he said, that it was far too much for his family's use, even with bread and honey and honey cakes and the thousand uses and recipes they had tried. So he sold the surplus and, with the money, bought more hives and more bees. The next year he sold even more honey and did the same again; after a while, the bees kept him too busy for railway work, so he gave up his job and became a professional beekeeper. Eventually, he was the proud owner of a thousand hives.

After a number of successful years, he sold his bee business and was set for the rest of his days. And that's how he retired early. He grinned again and looked very happy. Then his expression changed. He looked momentarily sad, wistful, as if he were talking of a lost love. He sighed and then he started to tell me how wonderful the bees were and how he looked after them, and his face took on a beatific expression.

"You know," he said, "I loved those bees. On a warm sunny day I would go to the hives and watch them fly in and out and then I would lie on my back in the grass and look up at them. Hundreds and hundreds of them flying around, this way and that way, carrying honey, carrying pollen, busy, busy, busy. And you know..." (here he rolled his eyes and, suddenly, grinned a wide grin that revealed a couple of gold teeth) "...you know, I would lie on my back in the grass, and look up at them and think, 'How wonderful, thousands and thousands of bees, and each and every one of them working for Mr. Mavrocki!'"

I can still imagine him lying on his back in the long grass laughing at the world, his teeth flashing in the bright Canadian sun, and all around him flying to and fro and humming and buzzing gently as they went, thousands and thousands of busy yellow bees and every one wearing on its back a little yellow M.

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*Lifeworks*

# Eye on Uraba

A family practice clinic in Ottawa's Lowertown is not where you'd expect to learn about armed conflict in Colombia. But for Kevin Pottie, assistant professor of family medicine at the University of Ottawa, a busy health care facility whose clientele includes diplomats, artists and refugees is as good a place as any to promote internationalist perspectives. By the broadest definition, Pottie remarks, health comes "from opening things up." With some technical help from the National Gallery of Canada, a stone's-throw away, Pottie has transformed the main hallway of the Elisabeth Bruyère Family Medicine Centre into "The Bruyère Gallery," a place to reflect on cultural and societal determinants of health in our own communities and around the world.

**Ian Brown**, *Lost Between River and Sky*. "Riosucio, where MSF has their field base, is the most strategic prize in the Uraba conflict. Whoever controls Riosucio controls the Atrato River basin and the region."

The gallery's first installation, on view in November 1999, was photographer Ian Brown's *Lost Between River and Sky*. These 36 black-and-white images document the Médecins Sans Frontières / Doctors Without Borders (MSF) project in Uraba, northwest Colombia, a region of waterlogged jungle adjacent to the Panamanian border and separated from the rest of Colombia by mountains. There are no roads in Uraba; the only link to the outside world is the Rio Atrato, and travel within the region is by dugout canoe along the river's many tributaries. Uraba's strategic importance for arms and drug trafficking partly explains why, at the time the MSF project was begun in 1997, the region could be described as "the most violent area in the most violent country in the world." The region is beset by armed conflict involving four distinct guerilla fronts, the paramilitary and state forces.

Over 1 million Colombians have been displaced by conflict. Colombia has the fourth largest internally displaced population in the world; in 1998 alone, 300 000 people were forcibly displaced: this is equivalent to 8 families every hour. Given little or no support from government, these people lack access to food, shelter, sanitation, health care and education.[1]

In Uraba, MSF mobile brigades brought basic health care, including malaria diagnosis, treatment and prevention, to 20 000 people in 26 villages before acute security risks forced the suspension of the project in August 1999. The hospital at Riosucio, the only medical facility in the lower Atrato basin, has one doctor for a population of 30 000 and is often without power, fuel, refrigeration and supplies. Local staff refuse to travel upriver for fear of being abducted or killed. Uraba's villages are subject to repeated incursions by armed groups whose identities and allegiances are not always clear; when one group moves on another moves in, meting out violent retribution to anyone suspected of sympathizing with an opposing faction.

**Ian Brown**, *Lost Between River and Sky*. "Peace communities have been created to try and protect the civilian population. These communities impose rules that help maintain their neutrality amidst the conflict. Persons with guns are not allowed and community members cannot support any of the armed groups. It is a step to return people to the land of origin and a sign of hope for many displaced people."

Neutrality is crucial to the people of Uraba, and this is respected by the reticence of Brown's photographs, which represent a political situation without pointing the finger at any particular group. A soldier's uniform is a synecdoche for terror; a lump of melting ice sums up the limitations of material circumstance. These are not images from which one instinctively turns away; one wants to look at them more closely, to read between the lines, especially in view of the disjunction between the serenity of many of the photographs and the basic information provided in the captions.

**Ian Brown,** *Lost Between River and Sky*. "Ice is invaluable, especially during brigades. Without appropriate temperatures the vaccines will spoil and become useless. Enough ice must be transported by the MSF team to maintain these cool temperatures for up to six days. A formidable task when working deep in the jungle."

The Bruyère Gallery provides an opportunity for a community to become more involved in its local health care centre. And, in a subtle way, its focus on international issues redefines the community it serves. For populations living in conflict zones, some increment of security comes from increased visibility in the world's eye. As MSF workers resume their project in Uraba, it is our responsibility to keep watching. The optimistic view is that every bit of awareness helps, even when it is cultivated in unexpected places.

**Anne Marie Todkill**
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**Reference**

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