The Left Atrium

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?

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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.

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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