"Bioethics: Some Key Reflections on Culture and Geriatric Care"
Regional Geriatric Program, March 4, 2010

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There are three general topics I wish to present to you this morning:

1. I thought that it might be helpful to offer some thoughts on **pain and meaning**. Ironically, it's among our strongest unifying agents; we might not otherwise have much to do with each other. Even if pain originates in biological causes, our *relationship* to it is not strictly biological, since our interpretations of pain come from personal social, and even historical conditions.

2. **The Idea of Progress**. Even a couple of hundred years from now, people will look to our time as one of profound change. Unimaginable revolutions and huge advances are occurring in virtually all of the sciences. The Human Genome has been mapped. NASA is about to launch a series of space telescopes that will be able to detect breathable atmospheres on planets orbiting distant suns dozens and dozens of light years from earth. And, closer to home, we hear news of biomedical discoveries which offer new hope – and dangers – for the way human beings live and understand themselves.

3. Finally, I want to bring these first two points into some kind of cohesive perspective that has special significance for **the nursing profession**, and some of the ethical implications that this might have for the kind of work that you do.

I'm reminded of something Dr. Margaret Somerville, perhaps one of the foremost ethicists in Canada, wrote in an op-ed piece about one year ago. Coming to the end of one of her undergrad courses at McGill University that dealt with legal and bioethical issues – I think it was in respect to her moral arguments against assisted suicide and euthanasia – it was clear that her analysis of the subject was almost entirely ineffective with her students. She wasn't able to make a dent. She then made something of a confession to the class: "I have failed to get my point across. I don't know what else to say."

I often think about that story, and it seems to me that in all of the bioethical issues that pepper our conversations – stem cell research, cloning, euthanasia, assisted suicide, genetic screening, to name just a few - underneath it all is a powerful undertow, a cultural undercurrent that pulls at as and forms us, directs and misdirects.

Sometimes it's impossible to look at these issues without first addressing the culture itself as the condition of that difficulty. And this brings me to the first point: **pain and meaning**.

Sometimes society tells us what "pain" and "suffering" are and what they are not. It may happen that unless there is some tangible evidence of physical injury, or that the presence of pain is confirmed by medical tests, "having pain" is accepted on the word of the one who claims to have it. This explains why chronic fatigue syndrome, back pain, and neurogenic pain passed with difficulty into the accepted medical diagnostic standards. A period of gestation is needed before the diagnosis can be permanently grafted into medical practice. Other kinds of suffering are initially met with scepticism or social stigmatization. In these cases, the shift from suppression to recognition requires a significant social transformation. The Canadian and America militaries are now seeing that they have to catch up to the realities of battlefield trauma and its lasting effects on their soldiers.

Sometimes it's not society that censures our interpretations of pain. We do it for ourselves. For example, it's common knowledge that physical tolerance to pain differs from person to person, what we call the "pain threshold". Comparisons are made between the pain tolerance of men and women, medieval peasants and present-day civil servants, middle class Canadians with Chinese subsistence farmers. What comes out from these comparisons is that the physical

pain that someone is able to tolerate in one situation may be intolerable in another. Author Diane Ackerman cites an example that people here are well acquainted with: "Many woman experience extreme pain during their periods each month, but they accept the pain because they understand that it's not caused by someone else, it's not malicious, and it doesn't surprise them; and this makes all the difference."[1]

All the same, medical breakthroughs and technologies continue to undermine the limitations previously imposed by biology. And these breakthroughs are happening at a dizzying rate. We have our feet firmly planted in the threshold of what for thousands of years was accepted as a permanently shut door. Death isn't so "natural" anymore. Technology can postpone it. We have moved away from chance (or what used to be euphemistically called the "will of the gods" or God) to choice. Part of this shift involves continuing research and development in the areas of stem cell research, pain management, genetic screening, genetic manipulation, and , of course, new interpretations of the meaning of the "end of life" and how we relate to it technologically and morally.

The irony is that we seem to becoming increasingly ***vulnerable*** to suffering. Why? Because our *expectations* for technological success and medical breakthroughs is running ahead of the ***actual*** successes and the **real** breakthroughs! To borrow a saying from the dinner table, our eyes are bigger than our stomachs, or, as one observer put it, "The more we expect and demand in order to be 'healthy', the 'sicker' we discover we are."[2] We may or may not experience pain and suffering more deeply than our ancestors, but what we ***can*** be certain about is that we do experience it ***differently***.

As it happens, this obligation to avoid suffering, and having the capability to do so, is part of the modern self-identity. It may be that our increased intolerance of suffering and pain is the price we must pay in exchange for a heightened sense of our moral obligation to lessen it.

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[1] Diane Ackerman, *A Natural History of the Senses*, United States 1990, 103.

[2] Thomas M. Wilson, "Medicine, Morals, and Public Policy," *Modern Age,* 41/2 (1999) 127.

Perhaps this increased intolerance of suffering is part of the cultural undertow of the current discussion on **assisted suicide and euthanasia**. I know that as long as there have been wars and rural farmhouses, these things have happened. But now the debate on "end of life issues" is not a peripheral problem in the battlefield and farmhouses, but is being forward as a possible social policy, *a way of life*. Again, it goes to how technology has deepened our sensitivities to pain and suffering. This is neither a good or bad thing; it's a little bit of both.

The claim of **compassion** is often made to justify the deliberate and direct act of ending a life of pain or suffering. In fact, many of the current arguments in bioethics lean upon presumed "reasons of compassion".

It's difficult to refute an action when "compassion" is its justification. Compassion is one of the greatest human motivations. This is Mother Teresa stuff. Only a madman or a cold rationalist would have the temerity to object to something done out of compassion. In fact, I think that the argument of compassion keeps many of us quiet on the very subject of euthanasia.

However, not everything that moves us – even the suffering of others – is necessarily out of compassion. We can be "moved" through various types of psychological mechanisms. It can happen that someone so thoroughly identifies with the sufferer that they lose themselves in the other's pain, and the would-be comforter must now be comforted by others. This is called psychological projection or "transference"; it is most definitely a **type** of identification with suffering, but it is the farthest thing from compassion.

I would further distinguish compassion from "**sympathy**" and "**pity**". In contrast to the "feeling with" of compassion, **sympathy "feels for".** Sympathizers identify with a victim or cause, but they must suspend or set aside a particular moral value in order to make the identification. For example, in the aftermath of the terrorist attacks on the Twin Towers, public talk about the political significance of the event wavered between mourning the victims of the attack and sympathizing with the terrorists who felt they were striking back against American imperialism. I sympathize with vigilante justice, when someone takes the law into their own hands and does what the justice system seems reluctant or incapable of doing. But it doesn't make vigilante justice morally justifiable; only understandable. In **compassion**, one bends one's heart without bending one's principles, but in **sympathy** both principle and person are bent.

Finally, are we moved by compassion or by **pity**? Pity maintains a safe distance from the sufferer by insinuating their lower state: the distance between me and him protects me from discomfort or from some kind of contamination.

Pity wants the person away from view. In western culture, death is increasingly seen as the "answer" that gives meaning to suffering. However, as ethicist Stanley Hauerwas has said, "... the question is whether in allowing the suffering to die we are actually removing our own suffering."[3] Genuine *compassion* means *sharing* someone else's pain; it doesn't kill the person whose suffering I can't take.

We need to make these distinctions whenever we claim that such and such an action is the compassionate thing to do.

I would now like to move to the next issue: how we understand technological progress.

No one can deny that we are on the leading edge of a fast-moving technological revolution that is changing us individually and socially. It's hard not to feel overwhelmed. Even professional bioethicists - those who earn their bread and butter in the profession - stagger under the enormous volume of developments. It's a full time job just to keep up.

We usually lump all of thee innovations under the umbrella of "progress". Unfortunately, the way it is being framed today, the ***idea*** of progress makes the weighty assumption that *all* change is an improvement. This raises important questions about ***how*** these technologies ***ought*** to be used; I say "**ought**", because it is also a question of how our technological know-how may or may not come into conflict with certain human values. And so there arises a field of study called medical ethics or "bioethics" that aims to address these moral challenges.

Underneath all of these new developments we hear and read about, there is still that cultural undertow that I referred to earlier. Sometimes we react to these developments with something akin to a collective euphoria, like the bliss of a newlywed couple, perhaps with the hope that these biotechnologies will eventually solve just about everything that ails us. Admittedly, some of these conversations about what may transpire will remain little more than a pipe dream and science fiction, but I sometimes wonder if our expectations for biotechnology are flights from what it means to be human; namely, that we are limited and flawed. As someone has said, "No drug will ever be invented nor therapy ever devised by human beings that will prevent acts of evil or cure flaws of character. We remain, like it or not, moral and mortal beings."[4]

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[3] Stanley Hauerwas, *Suffering Presence*, Notre Dame, Indian 1986, 34.

[4] Wilson, "Medicine, Morals, and Public Policy," 131.

So is it possible we can take the idea of technological progress to a utopian extreme? Is our faith in technology creating a Fools Paradise? Throughout history utopian dreams have birthed nightmares. In his *A Short History of Progress*, Canadian scholar Ronald Wright remarks that many of our notions of progress are suffering from a fatal flaw: *technological naiveté*. He says, "Our ... faith in progress has ... hardened into an ideology – a secular religion which... is blind to certain flaws in its credentials.... [namely that] A seductive trail of successes may [actually] end in a trap."[5]

This "beautiful flower" of progress always has somewhere a patch of weeds which, if left unchecked, will actually destroy the good and beauty of the flower. This is the progress of technological zealotry. Technology is a wonderful and powerful tool, but it also "handles us"; we can become **its** tool! The relationship is a two way street, and without knowing it, the tail can start to wag the dog.

- **Cell phone**... convenient, safety, can be reached anywhere... BUT unlimited accessibility
- **Email**: convenience, multitasking, easy and instantaneous communication **BUT** email demands a response.... we have **created multiple digital personas of ourselves**, and each email means that we have an emissary representing ourselves to others, and this will demand a response. People expect contact **Now and Yesterday**. Andrew Cohen, president of the Historica-Dominion Institute, in a recent op-ed piece in *The Citizen*, wrote: "We are tethered to each other now;... Privacy is the first casualty. It no longer exists. A generation is growing up in public-sharing their lives on Facebook and YouTube,..."[6]
- **Splitting the atom**... a source of power and medical technology BUT also a deadly weapon.

Here we see the backlash of entering into a relationship with technology without keeping our senses and good judgment about us. What starts out as "a tool" can become "a trap". Giant leaps of technological progress, such as the ones we are witnessing in bioethics, always create the conditions for new and unforeseen problems. It's the nature of the beast. If left unchecked, the trend of minor digressions reaches a tipping point and begins to exert an influence greater

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[5] Ronald Wright, *A Short History of Progress*, Toronto 2004, 4-5.

[6] *The Citizen*, "Awash in Scandal and Sex, Dec. 29, 2009, A2.

than the benefits of progress. For example, few of us would deny the transformative good and real progress that followed the invention of the automobile. It changed everything. It arguably set the foundations for the existence of the middle class. But here we are today, seeing that the good of the car was slowly and inexorably creating problems for the environment. The progress of 80 years ago has become our problem.

In short, the promises of technology can make us individually and collectively blind to these trends. And the longer we remain in the dark about them, the more difficult it is to awaken and take in the whole picture.

Now I would like to raise some issues in respect to the nursing context.

More than half of the people employed in the medical profession are nurses... You make ninety percent of the decisions; next to the family, you are usually the ones who are closest to the patients. The strangeness of being hospitalized, the fear of some impending procedure or operation, seems to be directly mitigated by the care of nurses. You, more so than doctors, seem to have the most profound humanizing face that the medical profession offers. As **author Heather Menzies** has so beautifully described your vocation, "... it works as two people paying attention to each other and entering a curiously intimate dialogue in which they are attuned or tuned in to each other... This engaged sympathy is so simple and taken for granted that it doesn't get listed on the patient-care chart."[7]

The pain and suffering that medicine aims to diminish is not **only** a question of technological know-how and intervention. Media presentations such as the CBC's "White Coat Black Art", hosted by Dr. Brian Goldman, go a long way to put a human face on what seems to be an increasingly technological and mechanical enterprise. In my mind, Dr. Goldman **humanizes** the increasingly complex interactions that occur in the spheres of the medical practice. He keeps alive the individual and family stories which are the interpretative lenses of these medical interventions.

Menzies believes that "Today, nurses are caught in a tug-of-war. On one side are those who feel nursing should go with the flow and become more scientific... On the other side are those who argue that nurses should defend the legitimacy of their heritage in the caring human touch, even championing the need for a humanistic counterbalance to an increasingly technology-driven

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[7] Heather Menzies, *No Time; Stress and the Crisis of Modern Life*, Toronto 2005, 121.

medical profession..."[8] She notes how technological information systems and databases for tracking our transactions are a relatively new tool, and an indispensible one. But as with all technology, it can turn the tables on us when, for example, it dovetails with the so called "cult of efficiency" that is part of the complex network of accountability that we are answerable to. It's simply the way things work today. Janice Stein, author of *The Cult of Efficiency*, notes that "efficiency" used to be understood only in relationship to how human beings were being served. Now, efficiency has closed in upon itself and is evaluated no longer in respect to persons, but "by the standards of its own performance". This just may be the cell phone and the email of the health field.

In the art of nursing, how do we balance the science with practice? Again, Menzies describes this as part of the challenge – and the significance - of what you do: "Combining skills and ethics, subjective and objective knowledge, nurses create a context of caring interpretation in which patients can begin to make sense of what has befallen them and, if it is possible, heal. It's part, too, of what current policy theorists now champion as the 'virtuous circle' of a healthy health-care system involving healthy health care workers working well with each other in healthy health-care workplaces." (No Time, 122.)

When I recall a time that I spent in hospital when I was 18 - for something pretty serious I might add – one thing stands out – the kindness of my nurse. Her touch on my arm when I awoke after the operation. It was the one thing, besides the visits from my family and friends that made the difference between a human experience and being a clog in the machine. I was grateful to the doctor, of course. And I knew that he saved my life. But it was the nurse that made me "feel" different.

And I believe that maintaining the human, if I might put it that way, keeps us alert to what **is** human and what threatens to undermine it in the technologies and bioethical decisions we must make. Once we lose touch with touch, something in me diminishes my capacity to recognize the human implications of many of these current and up and coming issues in bioethics, especially as they touch upon health care.

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[8] Menzies, *No Time*, 124.

Wrapping it Up

Some fledgling biomedical technologies threaten to alienate us from aspects of our humanity. This doesn't mean that we should resist them, or run from them or denounce them. But we need to remember that they are also like cell-phones and email. Depending on the technology involved, there may be an underbelly, that takes awhile to manifest. Sometimes it seems that technology and time are conspiring to affect the quality of our work and our workplace relationships. The hurried state we live and the compression of time is also the same frenzied state of mind with which we are trying to process the implications of new biomedical technologies on the human being.

In all of the issues that I have raised, and in so many more that I have not mentioned this morning, most bioethical conflicts must eventually address 2 fundamental questions:

1. What is a human being? Are there any moral absolutes attached to being human?
2. What kind of society do we want to live in? What do we want to make of our lives together? What do we want our future to be?

An example of how these two questions are connected is the issues of torture in the United States.

Nurses know the system "from the inside", and can effect reform/changes based upon that knowledge. Rollo May, that great American psychologist and author, refers to the possibility to cultivate the capacity for what he calls **creative courage**, which is "... the discovery of new forms, new symbols, and new patterns [from which something new] can be built. Every profession can and does require some creative courage.... [and] the need for creative courage is in direct proportion to the degree of change the profession is undergoing."[9]

When we lose the human - the touch, the smile, tenderness, listening, relationships, teamwork - and I know that these interactions are at times difficult to maintain because of the systemic demands on our time and energy – but when we lose these, not only do we lose something of our capacity to deliberate morally; perhaps we also risk losing something invaluable in the nursing vocation.

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[9] Rollo May, The *Courage to Create*, 13.