



## Aboriginal Bioethics as Critical Bioethics: The Virtue of Narrative

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# Aboriginal Bioethics as Critical Bioethics: The Virtue of Narrative

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Kotalik and Martin (2016) raise the possibility of constructing an Aboriginal bioethics grounded in traditional Aboriginal knowledge and ethics, arguing that such an ethics would enrich the discipline of bioethics more generally. Building upon a growing trend in bioethics, they argue that “special attention needs to be paid to health care for patients from distinct cultural, social, and religious minorities,” given that the dominant bioethical paradigm is grounded in hegemonic Western tradition and culture. Indeed, mainstream bioethical frameworks and a “principle-based approach” may prove incommensurable with Aboriginal peoples’ worldviews. Thus, we need what could be called a culturally appropriate approach to bioethics. In this commentary, we suggest that the very question of an Aboriginal bioethics—and its conditions of possibility—calls for a critical bioethics, wherein mainstream bioethics is opened to cultural critique and solemn self-reflection.

Here, culture itself functions as a site of ethical contestation and an occasion for cross-cultural communication. We agree with the authors that principlism, which dominates bioethics, is limiting and can even be experienced as violent and colonizing. Typically formulated as four principles—respect for autonomy, nonmaleficence, beneficence, and justice—for many these principles are abstract and alienating. Principles say little about the ethics of living together, nor do they address the conditions under

which these principles have emerged as a priori “rational” or “self-evident.”

Through the telling of a traditional story, “The Seven Grandfathers and the Little Boy,” Kotalik and Martin seek to demonstrate how the “gifts” of the Seven Grandfathers correspond and contribute to the Western tradition of virtue ethics, enumerating the story’s gifts as a “list of virtues.” We contend, however, that it is the authors’ retelling of this story—conspicuously, in a mainstream bioethics journal—that is potentially more radical than the cross-cultural mapping they propose: If we attend to the narrativity of the story itself, the ways it is told and retold, as it is again by Kotalik and Martin, then the invocation of the story might well complicate or reframe what virtue ethics could mean for ethical practice. In this light, their iteration of the story invites a critical understanding of ethics as virtue, or what we might call a critical bioethics, for their (re)telling honors the critical narrative conditions in and by which an ethical life might be communicated and cultivated, within but also across cultures.

In the telling, the story eschews abstract principles and frameworks. The invocation emphasizes, instead, storytelling and story-listening, which call into question the prior social and etho-political conditions through which the moral significance of the story might be heard. Such a conception of the ethical role of storytelling relates to what Sto:lo educator Jo-ann Archibald has called “storywork”—

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the ability for story to foster “synergistic interaction between storyteller, listener, and story” (2008, 33). The social and relational conditions of storytelling are the ethical virtues, the synergies, in and moreover for which stories can be said to hold truth for individuals and communities. In other words, the ethical conditions of narrativity, and the stories for which they are both means and end, help us to navigate our distinct and often divergent ethical lives (see Stevenson 2016).

As Kotalik and Martin suggest, understanding ethics through the cultivated habits of storytelling and narrativity is a practice that can be found both in Indigenous methodologies (see Kovach 2009; Wilson 2008) and within Western philosophical tradition. In the *Nicomachean Ethics*, for example, Aristotle (1985) describes *eudaimonia*—the good life, or living well—as virtuous activity of the soul, which belongs to living beings and relates to a person’s character (*ēthos*), inculcated through habit (*ethos*). Here we stress that an ethics of virtue does not redound upon an autonomous individual: Individuals are not quite self- (*auto-*) regulating or self-governing (*nomos*). Rather, character (*ēthos*) and habit (*ethos*) are related to *ethnos*, to ethnicity, to one’s community. In the *Politics*, Aristotle explains that the *polis* “comes into being for the sake of living [*tou zēn*], but continues to be for the sake of living well [*tou eu zēn*]” (1957, 1252b, 29–30). It is the good life, living well or *eudaimonia*—the “highest good”—that binds together a living community and sustains that community over time as a *polis*. An ethics of virtue, then, has as its condition of possibility the ways that a community or *polis* will share and communicate the values and habits (*ethoi*) that inform ethical life. This relies in part on embodied practices, beliefs, customs (*doxata*), and traditions, as well as on stories or narratives that are “handed down” (tradition, *trādere*). It is an ethics of care and relationality, which, in concert with Aboriginal worldviews, refuses to privilege the sociolegal “fiction of an ethical ‘capacity’ imagined to be the inalienable property of the reasonable individual” (Murray and Lemieux 2016).

In his interrogation of the meaning of a critical bioethics, Vilhjálmur Arnason calls for a “bioethics enlightened by critical hermeneutics” (2015, 154). “Such hermeneutic bioethics,” Arnason continues, “is dialogical, which provides both a critical exercise of speech and a normative dimension implied in the free exchange of reasons and arguments” (154). Kotalik and Martin are engaged in this kind of dialogical exchange, and it is in this context that their retelling of a traditional story is most resonant and relevant. It is no doubt true that the story contains elements of moral guidance, even reasons and arguments; however, as a story, it calls for a hermeneutic act, an interpretation. And, moreover, before this is possible, it must presume a speech act, a narration, in and by which the story is both spoken and heard. What begins to surface—quite apart from any “list of virtues”—is the pressing question of how to speak ethically, and how to address, for example, the disproportionate burden of illness among

Aboriginal populations, or how to provide culturally appropriate ethical health care.

Language, discourse, and narrative are never neutral, nor are stories “tools” in the possession of autonomous subjects (see Murray and Holmes 2013). As we so quickly tend to adopt the governmental language of “social determinants of health,” for instance, we may find this idiom inadequate in speaking to the many historical and intersecting elements that underlie particular health inequities and our responses to them. Bioethics is not an empirical science, and to presume that it is subject to “measurements” and “indicators” delimits and regulates in advance what kinds of conversations will be possible. Even if those measurements and indicators are ethnographic, and remain sensitive to cultural difference, the bias toward the “graphic”—written and literate histories—will discount in advance oral cultures and traditions, which may well privilege other ways of knowing and interrelating, and the diverse forms that narratives assume in their communities of reception. When we speak, as we do when we enact socioeconomic policies, we must strive to understand—to lay bare—the critical conditions of that speech, the powers and social scenes that inform what we say: the historic crimes committed in and by Canada’s residential school system, where Aboriginal children were stolen from their families in order to be “civilized”; these were also the crimes of the Church, and a colonial history of institutional barriers to resources, of systemic racism, of a medical system that condoned human experimentation on Aboriginal persons, and so on.

As for the hope of developing a “framework” for Aboriginal bioethics, we remain less sanguine in the current context of biomedicine and health sciences. “Frameworks” imply a kind of operationalization, a regulation, that many would see as problematic. Indeed, an Aboriginal bioethics would need to start “from the ground up,” as Kotalik and Martin suggest. But what if that “ground” were the moral force of narrative? Would we then begin to account for the conditions under which certain stories can be told and heard, and why others are buried in silence? ■

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# Aboriginal Health Care: The Seven Grandfathers Trump the Four Principles

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The authors mean well. But their assumption is essentially colonialist. They assume that Western health care providers will (and should) learn another way of thinking in order to apply that way of thinking to Aboriginal patients. This is like British Colonial administrators learning the local languages in order to make Imperial rule smoother and more absolute.

This is rather patronizing and insufficiently radical. It assumes that the dominant paradigm will continue to be the Western one, and that the problems with implementing it are essentially problems of translation. It fails also to acknowledge sufficiently both the shortcomings of Western bioethics and the contribution to bioethics that Aboriginal approaches could make.

Western bioethics are both theoretically and practically unsatisfactory. Theoretically—because, despite a widespread feeling that respect for autonomy ought to be the primary objective (an approach that does not stand up well under interrogation), there is no semblance of agreement about the means of achieving even that limited, flawed objective. And practically, because patients complain constantly and vehemently about the “soft” aspects of the health care they receive.

I have suggested elsewhere that the intellectual crisis in bioethics is a consequence of failing to start bioethical reasoning at a sufficiently fundamental level (Foster 2016). The reasoning starts on the basis of (usually unexamined, and generally false) assumptions about human beings and what constitutes and produces their thriving.

There are two chief fallacies. The first is the notion that human beings are atomistic entities. “Good ethics,” goes the cliché, “start with good facts.” Human beings aren’t billiard balls, and if you assume that they are, you are unlikely to get a good philosophical result at the end of your train of reasoning.

Relational autonomy has done something to address this wrong assumption, but it has all the shortcomings of a reactive protest movement: It has been unattractively shrill, and too hastily rhetorical instead of reflectively analytic.

The second fallacy is the (unspoken) assumption that (at least clinical) bioethics concern only ill people. As soon as a patient is admitted to hospital she is subject to an entirely different philosophical jurisdiction from the one to which she was subject outside the hospital door. There is no real continuity in the eyes of bioethicists between the pathological world and the unpathological world. The unpathological world matters only as a desirable destination for the currently ill, and because the shape of its frontier determines the geography of the pathological realm.

There are many problems with this view of bioethics. One, against which patients constantly rail, is that it can lead to treatment of the illness rather than the patient. Patients become pathological problems. That is a process of dehumanization.

The problems of insufficiently realized relationality and of the pathologizing of health care ethics and patients are both exemplified by Pleschberger’s work on the end-of-life wishes of elderly residents in German care homes (Pleschberger 2007). There was a widespread fear of dementia. But why? Because it would affect their relationships. One resident’s response was typical: Could one have a dignified old age, despite dementia? The answer, summarized, was yes: if it did not affect one’s relationships (Pleschberger 2007). The purpose of health care, in that resident’s eyes, was not to treat the disease: Nothing could be done about that. It was to maintain, insofar as possible, the person herself. And she defined herself primarily in terms of her relationships.

In the same study, a good death was characterized by “saying goodbye” and happening “at the right time”—by

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