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Do We – and Should We – Have a Canadian Bioethics?

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Article abstract

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Do We – and Should We – Have a Canadian Bioethics?

Eric Racine[a,b,c]

Résumé
Avons-nous une bioéthique véritablement *canadienne* – et pas seulement une pratique de la bioéthique au Canada? Cette question, et le présent article, portent sur le lien entre la bioéthique et les expériences réelles des Canadiens en matière de soins de santé, de recherche et de santé publique. En l'abordant, je m'inspire du pragmatisme philosophique qui souligne l'importance de l'expérience quotidienne comme point de départ de l'éthique, et de l'épanouissement humain comme objectif de l'éthique. À travers cette optique, un idéal bioéthique canadien est un idéal qui s'enracine dans les expériences vécues par les Canadiens ; il reflète l'idéal d'épanouissement projeté par les individus canadiens, y compris leurs opinions sur leurs communautés politiques. Toutefois, il n'est pas certain qu'une bioéthique canadienne à part entière ait pris forme, étant donné l'uniformisation croissante des recherches dans le monde entier, qui crée des attentes quant aux types de problèmes moraux qui méritent d'être étudiés et aux types de solutions à adopter. Dans un esprit de réflexion sur cette question, j'aborde les aspects de la société canadienne qui pourraient façonner le développement d'une bioéthique canadienne : (a) l'existence de récits politiques canadiens concurrents, (b) le caractère distinct des systèmes de santé et des expériences en matière de soins de santé au Canada, (c) l'engagement des Canadiens envers certaines valeurs et aspirations, (d) les aspects institutionnels et procéduraux de la sphère publique canadienne, (e) les défis posés par l'uniformisation croissante de l'enseignement dans les différents contextes géographiques et nationaux, et (f) les obstacles pratiques au développement d'une bioéthique canadienne. Ces défis auxquels la bioéthique canadienne fait face sont probablement pertinents à l'échelle internationale pour tous les contextes dans lesquels des problèmes moraux d'origine sociale sont discutés et des solutions envisagées.

Mots-clés
bioéthique, Canada, histoire, pragmatisme, systèmes de santé, politique

Abstract
Do we have a genuinely *Canadian* bioethics – and not only a practice of bioethics in Canada? This question, and this paper, are about the connection between bioethics and the actual healthcare, research, and public health experiences of Canadians. In addressing it, I am inspired by the philosophy of pragmatism that stresses the importance of everyday experience as a starting point for ethics, and of human flourishing as a goal for ethics. Through this lens, an ideal Canadian bioethics is one that is rooted in the lived experiences of Canadians; it reflects the ideal of flourishing projected by Canadian individuals, including their views on their political communities. However, it is unclear if a full-fledged Canadian bioethics has taken shape given increasingly uniform scholarship worldwide that sets expectations about the kinds of moral problems worth investigating and the kinds of solutions to be adopted. In the spirit of thinking about this question, I discuss aspects of Canadian society that could shape the development of a Canadian bioethics: (a) the existence of competing Canadian political narratives, (b) the distinctiveness of Canadian healthcare systems and healthcare experiences, (c) the commitment of Canadians to certain values and aspirations, (d) the institutional and procedural aspects of the Canadian public sphere, (e) the challenges of increasingly uniform scholarship across geographic and national contexts, and (f) the practical obstacles to developing a Canadian bioethics. These challenges that Canadian bioethics faces are likely relevant internationally for all contexts in which socially shaped moral problems are discussed and solutions envisioned.

Keywords
bioethics, Canada, history, pragmatism, health systems, policy

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INTRODUCTION

Do we – and should we – have a *Canadian* bioethics or health ethics[1], or even, perhaps many forms of it?[2] Why ask ourselves this question, years after the beginning of Canadian bioethics activities and previous discussion of this question (1)? After so many years, there is now a Canadian Bioethics Society, created in 1988 by the merger of older societies; the Canadian Society for Medical Bioethics and the Canadian Society of Bioethics, both founded in 1986. There are also a fair number of Canadian academic bioethicists and bioethics centres (e.g., the first Bioethics Center, created in 1976 at IRCM, but with now many more

[1] I would favor using the term "health ethics" instead of bioethics to signal a certain orientation toward the positive values (notably that of health and wellness) sought by ethicists in the contexts of healthcare and biomedical science as well as the need for a general constructive and positive orientation that supports the flourishing of individuals and communities. However, in this paper, I am discussing the field of bioethics as it is most often understood and will follow the convention of designating it by that term. It is possible that the problem I describe is most readily felt in scholarly contexts than in more practical clinical ethics contexts which can hardly lose sight of the problems experienced by patients and those around them.
[2] I mention the possibility of multiple forms of a Canadian bioethics because of Canada's significant individual and national diversity. I come back to this topic later in this paper.

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centres across the country with different goals and orientations). There is also a Canada-wide community of clinical ethicists and of research ethics boards and their members. Canadian bioethics scholars are productive, and they have trail blazed the study of many topical bioethics issues in genetics, reproductive technology, and neuroscience. There have long been textbooks about Canadian bioethics (2) and more recent textbooks cover explicitly Canadian cases and issues (3). There is an established demand for bioethics in, for example, the training of Canadian healthcare professionals (e.g., physicians, nurses), as well as mandatory ethics requirements for the accreditation of Canadian hospitals (4). Canadian public policy discussions and legislation have tackled ethical aspects of research ethics governance, health law reform within the work of the land mark Law Reform Commission of Canada, reproductive rights and new reproductive technologies (5), and more recently, medical aid in dying (6,7). Clearly, Canadian bioethics has exhibited its own original scholarly and practical activities. Perhaps an even livelier and stronger Canadian bioethics community with more faculty positions, an increased presence in healthcare institutions, and greater impact on policy and research is desirable. But we cannot contend that there are no substantial bioethics activities in the country. Canada might even be considered a leading force in the field, internationally speaking.

But the question I am asking is this: do we have a genuinely *Canadian* bioethics – and not only a practice of bioethics in Canada? Here I want to dispel any concerns about short-sighted nationalism or parochialism (3). My goal and intention are not to define Canadian health ethics by seclusion from a dominant American bioethics. My question is foremost about the connection between bioethics and the actual lived experience of Canadian patients, Canadian research participants, and Canadian citizens, who are the beneficiaries of various health policies and public health initiatives.

Bioethics, as we know it, was initially (8) and is still first and foremost an American intellectual and social production (9,10). Contemporary bioethics took root in the US and represents, according to many scholars, a typically American way of dealing with the moral challenges of contemporary biomedical science and health care, especially with respect to the predominant value of autonomy, and perhaps also its practical orientations (9,11-13). Though it may currently be serving many legitimate purposes, its descriptive and prescriptive adequacy for Canadians should remain hypothetical until we understand concretely the nature of existing and emerging problematic situations faced by Canadians and the kinds of solutions that work here. This is important as some problems encountered in Canada may not exist to the same extent in the US (e.g., linguistic minority access to healthcare; medical aid in dying, which is currently not legal in most American states; major changes recommended to healthcare delivery following the Truth and Reconciliation Commission). There may be issues to which Canadian society desires to respond to in significantly different ways based on differences in values and public opinion (e.g., LGTBQ2+ access to healthcare, Indigenous Peoples health, refugee and immigrant healthcare). Being so close culturally and physically to the US has perhaps sometimes blinded Canadian scholars and practitioners to the genuine need to understand and think about the principles and values guiding healthcare institutions in Canada specifically, and perhaps more importantly, the kinds of processes that reflect our realities and our aspirations (1,14). Canadian scholarship may frame itself according to international trends – in addition to American trends – to maintain international relevance (15). This issue, I daresay, is relevant to all political[3] communities in which bioethical concerns surface (16).

The scope of this paper and the question of the existence (and need) of a Canadian bioethics is undoubtedly large. In addressing it, I am inspired by the philosophy of pragmatism that stresses, amongst other things, the importance of a focus on everyday experience as the alpha and omega of human existence (17). According to this philosophy, human beings strive to flourish in their existence, and this concept of flourishing (a.k.a. growth, Eudaimonia, well-being) – or the lack thereof – offers a critical lens through which to examine all major dimensions of human and social life (e.g., education, politics, economics, health) (18-20). Through this lens, an ideal Canadian bioethics is one that is rooted in the lived experience of Canadians; it reflects the ideal of flourishing as expressed by Canadian individuals, including their views on what is the Canadian political community (21). I presume that as a political community, Canadians share both a past and a present such that they desire to imagine their future together even though there are competing Canadian political narratives. Within this, bioethics plays a role in examining and imagining what kind of health care, health research, and health policy is most conducive to the flourishing of Canadians. And to do so, Canadian bioethics needs to reconsider its relationships to scholarship that describes these important spheres of activity from the standpoint of other political communities which may not reflect its aspirations. Attention has been brought to these issues before (i.e., the nature of Canadian bioethics, its history, its relationship to American bioethics) (1,3,14). I submit that there are a number of important questions we should examine critically in thinking about a Canadian bioethics, keeping in mind differences in what is considered to be the “Canadian” political narrative (see below).

To further the discussion on this topic, I bring attention to and discuss the following points and how they could affect the development of a Canadian bioethics:

- Competing Canadian political narratives;
- The distinctiveness of Canadian healthcare systems and healthcare experiences;[4]
- The commitment of Canadians to certain values and aspirations;
- Institutional and procedural aspects of the Canadian public sphere;

[3] Politics here refers not to partisan politics but to considerations of the public good. A political community by my definition is a community that gives itself common goals and orientations.

[4] I stress the plural form since no single Canadian health care system exists. Healthcare is a shared jurisdiction between the provinces and the federal government. The federal government’s Canada Health Act (1985) provides general guidelines, but provinces have leeway in operating their provincial systems. Provinces also assume the greater share of the costs of these systems. Between provinces, there is also considerable diversity in orientations with corresponding strengths and weaknesses. The Canadian federal government initially paid for half of healthcare costs, but its share will soon be under 20 percent, leaving the 10 Canadian provinces with struggling public finances and a clear incentive to diminish their involvement in this increasingly expensive sector of activity.

- Challenges of increasingly uniform scholarship across geographic and national contexts;
- Practical obstacles to developing a Canadian bioethics.

These points are not addressed so as to make definitive arguments showing the inapplicability (lack of descriptive or prescriptive adequacy) of American bioethics to Canadian healthcare settings. Rather, they signal modestly the need to think more profoundly about our aspirations and ways of enacting them in our own realities. There is a sense in which all claims I am making in this essay are contentious; they are somewhat speculative and in need of further analysis and evidence. But the conversation needs to start somewhere with topics to explore. In other words, I am not making definitive material claims about differences between American and Canadian bioethics but rather calling attention to points in need of exploration and discussion with the hope of stimulating reflection and conversations about this topic. Although seemingly abstract and theoretical, the topic is really about asking whether the multiple ways we understand and attempt to resolve moral problems in healthcare in Canada are adequate and empower those concerned. Tackling this question could be important to strengthen cohesion within Canadian bioethics, develop common approaches and foster self-reflection amongst bioethicists.

COMPETING CANADIAN POLITICAL NARRATIVES

At the beginning of this paper, I alluded to the challenge of thinking about bioethics in the singular form, a problem well discussed in international bioethics, where pluralism has been advocated for (11,16). This issue also exists within Canada, a federative state made up of different provinces and territories, and more meaningfully, of different nations (24). Accordingly, I recognize that by using the term “Canadian”, that no simple and single monolithic ethics exists or could exist in Canada. For example, one narrative states that Canada is a multicultural nation, i.e., a nation made up of individuals who have various cultural backgrounds but who are connected through common adhesion to certain constitutional rights and fundamental values. This is a common political narrative in Canadian bioethics (25), and it fits the multicultural spirit of the Constitution Act of 1982 (never signed by the province of Quebec), which brought the Canadian Charter of Rights and Freedoms (26). But there are competing political narratives: one describes Canada as a multi-national (and not only a multicultural) state wherein political communities with different historical foundations exist (e.g., a French-speaking nation[5], Indigenous nations). These nations have, in some cases, existed long before the multicultural narrative, with distinct languages, values, and beliefs, as well as aspirations to establish themselves as political communities and not only as a set of individuals[6] (27). This largely explains Quebec’s resistance to signing the Constitution Act of 1982, which undermines the recognition of a French speaking nation. This resistance was exposed during discussions surrounding the failed Meech Lake and Charlottetown Accords. Another powerful political narrative underscores the colonial roots of Canada as a country. First Peoples inhabited Canada for thousands of years before European settlers and formed organized and prosperous political communities. European authorities and settlers were granted permission to initially establish themselves and their activities by some First Peoples with an understanding and a promise to interact with Indigenous Peoples as equals (e.g., as described in historical treatises), but went on to rapidly break their promise when it did not align with their interests (28,29). Subsequently, the Canadian government expanded upon European colonialism to further this political alienation. Canada is therefore not a foundational political narrative for First Peoples; their previously existing political narratives were significantly disrupted when European settlers occupied their territories and broke their promise to deal in good faith.

The point of this paper is not to argue for one of those specific political narratives[7] – I will remain open here about such political narrative – especially because I think being open about it is necessary to properly reflect the diverse experiences (including in healthcare) and help understand each other as Canadians coming from different nations for the time being. Acknowledging the complexity of what “Canadian” means is a first step in thinking about how ethical issues are rooted in Canadian public life. Canada is a country that, not only from an individual standpoint but from a collective and political standpoint, is the object of fundamentally different visions or narratives; any well-being (or ill-being such as that caused, for example, by colonialism) attributed to this country as a political project and community varies profoundly (24). This may imply that Canadian bioethics must be plural in a deep, political sense; it may somewhat have to resemble a multi-national federation. Failing to understand this deep pluralism may mean that some groups of Canadians may feel alienated from Canadian bioethics and experience different forms of epistemic injustice (30) since bioethics scholars and practitioners may naturally adopt mainstream views about what is the Canadian political community. It may also limit bioethics’ ability to deal with deep pluralism, pluralism that questions assumptions about the superiority of a single kind of bioethics or even about the value of bioethics itself in connection with a certain vision of what the Canadian community should be. Not acknowledging these competing political narratives may also undermine bioethics’ ability to learn from non-European traditions in understanding and resolving moral problems. Some describe American (or Western) bioethics as “moral imperialism” (11,16). This can certainly be true, thus the importance of consulting and being open to learning from other traditions and other views about what is the good life (9).

[5] I leave aside the complexity of discussing whether there is still only one single French-speaking nation in Canada or many nations or one nation and many communities. Historically, French Canadians designated inhabitants of New France, a distinct colony from Acadia. The distinctiveness of Acadia, its language, its history, its identity, and traditions is often overshadowed in these discussions. There are also other French-speaking communities in central and western Canada.
[6] I admit being attracted to the respect of the political autonomy of communities, even if discrepant with the multicultural model. Human beings, in order to flourish, need to be able to project who they are as members of nations and communities and make collective decisions that promote their communal well-being. In my eyes, a deeper commitment to diversity is one that grants communities the ability to become political and not only remain aggregations of individuals. I leave aside this thorny but inescapable issue.
[7] But I do hope to make readers mindful that Canada is not a monolithic country and that it features disputed national identities as evidenced in the various political narratives.

THE DISTINCTIVENESS OF CANADIAN HEALTHCARE SYSTEMS AND EXPERIENCES

Canadian healthcare systems are structured very differently than American healthcare institutions and networks (e.g., the Veterans Health Administration, Health Maintenance Organizations), and large for-profit (e.g., HCA Healthcare) or not-for-profit networks (e.g., Kaiser Permanente). The goals of such American institutions are, beyond providing healthcare, differently influenced by the need to generate profit (or not). Healthcare professionals are also regulated differently in both countries. For example, some American physicians receive a salary (e.g., those working for Kaiser Permanente), whereas others are compensated based on medical acts performed (31). In many cases, American institutions such as healthcare maintenance organizations (HMOs) can have much more influence over physician behavior in the US (e.g., seeing only patients from a certain network or organization and in ways that are prescribed by that network or organization) than in Canada, where physicians make up influential colleges of medicine that structure and orient provincial healthcare systems. In Canada, physicians are typically paid by fee-for-service and some receive a salary (32-35), though their work conditions resemble those of salaried professionals because their honoraria are paid by a single public insurer and there is much less competition than in American healthcare (36). These differences in healthcare systems lead to different kinds of situations (e.g., delays in access to health services) for different patients (e.g., depending on or irrespective of their wealth) and yield different kinds of healthcare experiences because of the different incentive structure they embed and promote (37,38).

Some of the medical and ethics literature may not necessarily reflect Canadian experiences and practices, as the institutional setting is fundamentally different than that of the US. For example, the idea of having choices can resonate very differently for someone in the US who has the wealth and the ability to choose between a greater number of providers and health networks than in Canada were long waiting times can increase helplessness (39), especially in chronic conditions (40). However, the ideal of autonomy can also be harmful to someone who, in the US, has limited coverage and very limited, if any, options. It is possible that Canadian healthcare systems are structured differently with less emphasis on pure autonomy (41), more emphasis on solidarity with less ability to shop around for healthcare services (14). Canadians are also constrained by systems-level orientations and, to some extent, the distribution of resources (e.g., rural areas) based on governmental planning or policies (e.g., federal government involvement in healthcare for Indigenous Peoples).

The distinctiveness that Canadian healthcare systems hold, their institutional culture, the kind of healthcare experiences they foster, and how these translate into different kinds of moral situations is worth considering further. Failing to grasp this distinctiveness may lead bioethics to miss out on positive or negative healthcare, research, or public policy experiences. If too aligned to an agenda set out by American or international trends, Canadian bioethics could ignore problems encountered by Canadians.

THE COMMITMENT OF CANADIANS TO CERTAIN VALUES AND ASPIRATIONS

An important and inescapable topic is that of the understandably strong affection Canadians have for their healthcare systems and what they represent. Canadians pull part of their identity (especially in relation to their southern neighbours) and the collective project of Canadian society from their healthcare systems (42). This is not trivial or gratuitous. Anyone having benefited substantially from publicly-funded health coverage appreciates how valuable and reassuring the idea is of a safety net for everyone: everyone you love, everyone around you, irrespective (in theory) of wealth, ethnicity, language, gender, etc. All healthcare systems are imperfect, and some current shortcomings of the Canadian systems may be blatantly, even outrageously, wrong (43). But the expression of solidarity, connection, community, and regard for each other captured by Canadian healthcare systems resonates very deeply with Canadians and is a source of pride for many. It is therefore not without surprise that politicians have tremendous difficulty talking about any structural reform to those systems, as they have been bestowed a quasi-sacred status (44,45). This is an especially touchy subject when we consider that Canadian society is also one fragmented by competing political narratives such that issues with identity-raising potential such as healthcare can shake national unity and exhibit deep rifts in Canadian society.

The value attributed to sharing the burden of disease can hardly be criticized and is a sign of deep compassion and humanism, but its identification with existing healthcare structures (and its intersection with national identity politics) do not easily allow for dialogue about its future and its challenges. The downside of the affection of Canadians for their current healthcare systems is that it can breed quasi-dogmatic adherence to the status quo (44). But clearly, Canadians are struggling and will continue to struggle with raising health expenditures (23). If nothing is done, many expect that most provinces will simply go broke; many provinces, especially those with ageing populations, are currently heavily investing (e.g., almost half their provincial budgets) into healthcare (23,46). This means fewer resources, proportionally speaking, toward education and the younger generations, with important implications. The implications of this and options to save costs should be urgently discussed but, in Canada, healthcare is simply not ordinary business to be discussed coldly (45). There are also deeper narrative aspects at stake, which play out differently for different nations (e.g., Indigenous Peoples, Quebecers), as well as the meaning of healthcare for these nations and regions (e.g., Western Canadians may feel alienated from major orientations while funding much of the federal transfers). In discussing the future of our healthcare system, I believe that we need a local effort to create our own solutions to this challenge. This is what other smaller socio-democratic nations have done in Northern Europe to salvage their deep commitment to general healthcare access while containing costs and ensuring more perennial structures by, for example, using competition within institutions and opting for performance-based funding (47).

Solidarity and the esteem associated with Canadian healthcare systems are but one example illustrating how the commitment of Canadians to certain values informs their views on ethically relevant matters with respect to health and healthcare. There would also be much to say about the need to incorporate the spirit of reconciliation between Indigenous Peoples and other Canadians in healthcare and what that entails concretely (29). This spirit of reconciliation is arguably stronger than ever before (28), although its practical impact may not yet be clear in Canadian politics. Another important value is bilingualism, but its application to healthcare and its impact on access to healthcare have not been given as much attention as has bilingual access to education (22,27,48).

These commitments to ideals, and their tensions with realities, have a unique configuration in discussions about good healthcare, good research, and good public policy in Canada. Likewise, they have a unique place in how we envision the future of healthcare practices and healthcare systems and their alignment with important moral values. No solution – even those crafted for Canadians for the Canadian public – is a magic bullet, but the failure to understand our commitments and their implications may imperil our future ability to pursue what we value. If we neglect attending to these substantive commitments, we may not develop a bioethics that aligns with the valuations and aspirations of those it is supposed to serve. In worse case scenarios, the imposition of an externally developed bioethics may generate alienation, resentment, and impractical ideas instead of growth, maturation, and ideas connected to deep aspirations (49). The solutions offered by a bioethics inattentive to local insights and commitments could end-up simply generating more problems than solutions.

THE INSTITUTIONAL AND PROCEDURAL ASPECTS OF THE CANADIAN PUBLIC SPHERE

Many bioethical questions evoke stakes of general interest to the public (e.g., fair resource allocation in health, the impact of new technologies such as artificial intelligence (AI) on health, the ethical orientation of public health interventions such as vaccinations or fluoridation) or raise issues that concern most everyone in some way (e.g., debates about medical aid in dying). The crises surrounding the management of the COVID-19 pandemic has made this very clear. Bioethical questions are directly connected to the public sphere and to views about what is the public sphere. In this matter, Canada and the US may appear to share much, given their similar legal traditions and their participation in the Anglosphere. However, the two countries have very different histories, one hallmark being that the US separated from English rule while the loyalist influence in Canada cultivated a political, economic, and cultural attachment to the United Kingdom. Institutionally, this means that Canada has remained influenced by monarchism, aristocratic orientations, and British-style parliamentarism (e.g., at least in name, Canada is still is a constitutional monarchy headed by the Crown of the United Kingdom, not a republic; senators are nominated and not elected) (50). Even though this parliamentary tradition creates recognized obstacles for dialogue (e.g., staunch partisan politics enshrined in the government and its opposition structure) and embeds a lack of separation of the legislative and executive powers, it appears that American politics generally, and with concern to issues of bioethics, have generated even greater partisanry and divide (51,52). Although its political institutions should be more conducive to open dialogue, the American public seems to be greatly fragmented (e.g., poor versus rich, elite versus working class, liberal coast cities versus more rural central areas). Accordingly, the way bioethics issues are discussed and the advocacy-style American bioethics scholarship (51) may not reflect the culture of consensus-building seen in Canada where opposition and division tend to be frowned upon in the search for consensus and shared orientations (5), somewhat like the social democracies of Northern Europe (47).

Fragmentation of the American public has been described by Hunter as Culture Wars (53), and it finds unambiguous resonance in bioethical debates about abortion, end-of-life matters, and stem cell research (52). It is my impression from having lived in the US during the highly mediatized Schiavo controversy and having investigated public discussion about it (54,55) that, in Canada, a similar case would likely never raise as much passion from politicians, religious groups, and members of the public engaged in legal pursuits and legislative maneuvers (14). In contrast, the rather quiet public debate around medical aid in dying in Canada (56,57) has had little resemblance to the passionate nature of the debate about Schiavo's case. I recognize though that there is a difference between the concrete Schiavo case and the more general public policy debate concerning medical aid in dying.

The differences between American and Canadian public spheres should not be exaggerated, but they are enough to cause pause before American debates – and the structure of these and the positions that are defended by parties involved – are imported as if they were our own (14). Simply discussing some important American bioethics debates without an effort to think about their connection to our local contexts is clearly inadequate in understanding how bioethical questions emerge in our own country and the lives of our fellow citizens. Questions surrounding new reproductive technologies, stem cells, and other health technologies tend to be discussed differently in the US and Canada, in particular because of the public role of faith-based arguments about the beginnings of human life and the sanctity of life in the US (58). Accordingly, in the context of discussing bioethics questions for Canadians, due attention should be paid to importing the sometimes-debatable divides and Manicheism characteristic of American political debates (51,52). Failing to attend to the spirit and workings of the Canadian public sphere may lead to the importation of what are false debates and false dichotomies for Canadians. It may also lead to a failure to understand the structure of our own debates and moral tensions while borrowing language that simply does not resonate with our own public sphere, our institutions, and more importantly, our experiences and aspirations as a political community.

THE CHALLENGES OF INCREASINGLY UNIFORM SCHOLARSHIP ACROSS GEOGRAPHIC AND NATIONAL CONTEXTS

The unequal weight and contribution of different countries and areas of the world has important drawbacks, such as preventing the publication of work that touches upon local realities and experiences of care, which may seem uninteresting to the American or international reader and scholar. This has been on some account my own experience as a scholar and that of others as well when investigating and publishing about Canadian realities (15).

In this paper, I tend to depict external and imperialistic frameworks of bioethics such that they may seem to be coming entirely from the US only and that they also inherently constitute an alienating, disempowering, colonizing agent to other countries and nations – but this would be greatly inaccurate. First, there is an incredible amount of exchange and learning based on the writings of American bioethics thinkers (1). It would be a grave mistake and over-simplification to reject and dismiss American bioethics due to identity politics and to sweeping statements about its alienating and disempowering effects. American bioethics is a rich intellectual movement (9).

Second, the possible disempowering effects of American bioethics occur within the US itself (59). The mainstream American bioethics agenda, with its focus on the ethics of new technological innovation in fields such as AI, stem cells, neuroscience, and genomics (60) may not correspond to the vast bulk of problem situations encountered by most Americans in their everyday lives as patients, research participants, and citizens (61). It may not readily reflect the aspirations of the American public itself and the interests of a broad range of stakeholders who feel excluded or marginalized from bioethics (62-64). Whole segments of the population may be unconcerned by some salient topics discussed in bioethics journals, especially regarding unreachable technologies (61,65). American elites and agencies have a dominant influence both in the US and internationally (66,67). They gain even more weight when bioethics scholarship in the UK, continental Europe, Canada, and Australasia serve as echo chambers for mainstream socially disembodied research and practice agendas (16).

Within the Western world, the interests of the populations of the Anglosphere and its dominant traditions are best and most readily served by publication standards that make of English the *lingua franca* and that logically suit the traditions and cultures of countries with strong legal and institutional Anglo-Saxon traditions, their socio-economic model (capitalism), their moral sensibilities, their understanding of human rights, of the community, of politics, etc. (8,9). This force is so powerful, that countries – and their bioethics communities – that challenge some of these ideas are often viewed quasi-automatically as backward and inferior in some moral sense. This tension also exists within Canada.

Because it is international, although with dominant Anglo-Saxon influences, the mainstream bioethics agenda may seem natural for some Canadians, at least those who associate more easily with the Anglo-Saxon tradition. But Canadians with different political narratives and backgrounds may experience more readily the difference in language, in models, in a way of understanding their realities that differs from their own histories, aspirations, and worldviews (15).

Internally in Canada, and internationally, there are strong incentives to develop a cohesive international bioethics agenda for genomics and genetics, neuroscience, stem cells, new reproductive technologies, etc. Economic exchanges benefits from the development of consolidated legal standards and the uniformization of our valuations of right and wrong, good and bad, desirable and undesirable, to facilitate the introduction and dissemination of new technologies (64). However, the socially embedded considerations about human flourishing can be easily evacuated from this standardization process. Bioethics journals – like in other fields – desire to be of the broadest interest possible and are published increasingly in a common language, with an interest in discussing problems of wide, international relevance (68). The same goes for international conferences and guideline development, which sometimes project an international discourse despite the singular dialogue clearly underlying these developments (69). The need to build mutual understandings and learn from each other is tremendous, and international efforts are invaluable in this regard. But my experience has also been that international efforts can be overly ambitious and the outcomes predetermined to ensure “success” and rapid “deliverables” to their initiators and their sponsors. This leaves no time for the extensive dialogue needed to understand cultural, social, and institutional differences and create something out of deepened and open-minded understandings of differing worldviews. Seriously questioning our valuations and understanding each other takes time.

Reflecting critically on the development of a Canadian bioethics is not an argument for exclusion; rather, it is an opportunity to renew our thinking; to consider our individual and social realities and their connections to our individual and political existence, and our human and financial resources. It is an argument for connecting all bioethics development to concrete human realities, which is relevant not only for Canadians but for all internationally (69). Failing to do risks perpetuating the forces that have led to, in Canada and elsewhere, colonialism and linguistic assimilation.

PRACTICAL OBSTACLES TO DEVELOPING A CANADIAN BIOETHICS

Envisioning a Canadian bioethics leads to an appreciation of the practical obstacles of the development of a form of bioethics that takes heed of the important relationships between lived realities and bioethics scholarship in the Canadian context.

Perhaps due to personal bias, a first practical obstacle coming to mind is language (15). It is unclear whether the fact of writing about issues in a language other than one’s own or other than that in which the issues are occurring (e.g., in qualitative

research) introduces limitations. However, one clear drawback is that it prevents non-English speakers from being connected directly to the work of the academics in their communities. For example, in the mostly French-speaking Quebec healthcare system, many professionals are not at ease in English and they probably find it much more difficult to read about bioethics scholarship in English than were it published in French (70). This becomes an obstacle for the development of bioethics, not only as a purely academic exercise, but as an exercise of improving practices based on research. This is true in many other areas of health and/or social science/humanities research, given the international trend of publishing in English. The issue is magnitudes more significant for Canadian Indigenous populations whose languages are facing existential concerns and healthcare actually respectful of their language, values, and traditions is very hard to find (29). Canada is no exception to an international trend, which has direct repercussions in Canada given its multi-national composition.

Apart from language, the distance between urban centers and the isolation of some communities, their health professionals, and their health networks are other barriers to the development of much everything in Canada (71). It also replicates emerging tensions between rural and urban areas in other countries, consistent with differentiated values and opinions (72). In terms of bioethics, it means that the extremely low population density likely creates issues (e.g., access, transportation) that effect the ability of Canadians to use healthcare, perhaps with the exception of the Greater Toronto Area, and to some extent some of other larger urban centres. In comparison, the population density of the US is strikingly different (35/km^2 versus 3.7/km^2 in Canada) and allows for the possibility of more sustained and intense networks in smaller geographical units.

Another important systemic obstacle is the amount of resources and support available to Canadian bioethics institutions. While not being negligible at all, resources available in Canada may not compare to those of American colleagues and society. They also vary and may exhibit different patterns to the advantage or the detriment of the US. The difficult research funding situation in the US (e.g., at NIH) in the following of the 2007-2009 Great Recession (which affected the US much more than Canada) may have considerably effected American bioethics while levels of funding in Canada via the Canadian Institutes of Health Research (CIHR), the Social Science and Humanities Research Council of Canada (SSHRC) and Fonds de recherche du Québec (FRQ) have been largely sustained (73,74). However, American hospitals may have greater incentives than Canadian counterparts to respond to consumer demand and to institutional and management trends such as equipping their institutions with full blown clinical ethics services. And they have injected more private resources into the development of clinical ethics in the US (75). In terms of other resources, Canada does not have a country-wide national bioethics committee; Quebec does have a Commission on Ethics, Science and Technology (CEST). It only benefited relatively recently from a bilingual *Canadian Journal of Bioethics/Revue Canadienne de Bioéthique*, under the leadership of Bryn Williams-Jones at Université de Montréal (68). The Canadian Bioethics Society does not have the numbers of its much larger American counterpart (ASBH). The Canadian Bioethics Society also suffers from the large distances between major Canadian cities which makes communication and exchanges harder between its members.

There are undoubtedly several other geo-political and cultural considerations that indicate possible practical challenges of developing a Canadian bioethics that would need to be taken into account before adopting American solutions and recommendations. The important point here is that if bioethics and bioethicists are instruments in the flourishing of individuals, then like any other instruments, they need to be reconsidered and rethought to assess their ability to fulfill the job they are intended to do, including the complex question of what are the jobs or functions accomplished by bioethics. Canada's physical proximity to the epicenter of mainstream bioethics, the US, can be both advantageous (e.g., opportunity for extensive collaborations between the US and Canada) and challenging. It is perhaps that the US's influence is greatest in Canada, as its culture is almost insipient here and is imported without much questioning (1,14). In countries where language, culture, or other differences are more obvious, there is a clearer sense of the limitations of mainstream scholarship and practices. Notwithstanding, Canadian bioethics needs to take heed of the unique practical challenges it faces to pursue its development.

CONCLUSION

In this essay, I brought attention to the fact that much of bioethics scholarship is discussed without questions about its practical connection to lived experience. I used the situation of Canadian bioethics and its development largely influenced by American bioethics to discuss this problem. In so doing, and following others (9,11,13), I adopted the view that bioethics is a specific kind of response to a set of moral situations in healthcare, health policy and biomedical science. Mainstream bioethics scholarship coming from the US and other leading centres worldwide represents a dominant agenda-setting force internationally, but its use in making sense of lived problematic experiences should be bracketed – which does not mean dismissed – in order to assess whether the ways moral problems are understood is shaped in ways that do not reflect the nature of healthcare systems, values and aspirations, and institutional and procedural aspects of different political communities. American bioethics may not be able to guide successful ethical resolution in Canada because it may not reflect uniquely Canadian challenges and solutions. Even in the US, there are fundamental questions about the applicability of mainstream bioethics ideas and their connection to everyday life of citizens (61,62). We should be critical users of this scholarship, and keep in mind its positionality as a discourse that emerges in a distinct social and cultural context.

The kinds of challenges I describe in this essay are relevant internationally for all contexts in which socially shaped moral problems are discussed, and solutions are envisioned. The increasingly uniform scholarship worldwide and its associated agenda(s) raise issues not only of language and culture, but more profoundly in terms of the kinds of problems that count and are worth investigating. Ultimately, ethics is an instrument that allows the move from problematic situations to resolutions that hopefully lead to greater wellbeing and flourishing. Ethics, whether in the form of "bioethics" or in its manifestation in specific

cultures, is not an end; it is an instrument where the goal of a flourishing life is both a process and an actualization of deeply entrenched, intrinsically motivated goals. The guiding question of Canadian bioethics should be whether it is making a genuine difference in this respect, including, as discussed in this paper, whether the thinking and practices generating outside of these contexts is useful or not in moving in this direction.

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