IS RORTY'S NEOPRAGMATISM THE "REAL" FOUNDATION OF MEDICAL ETHICS: A SEARCH FOR FOUNDATIONAL PRINCIPLES

WILLIAM T. BRANCH, MD, MACP

ATLANTA, GEORGIA

ABSTRACT

Principlism, the predominate approach to bioethics, has no foundational principles. This absence of foundations reflects the general intellectual climate of postmodern relativism. Even America's foremost public philosopher, Richard Rorty, whose pragmatism might suggest a philosophy of commonsense, seems to be swimming in the postmodern swamp. Alternatively, principlism's architects, Beauchamp and Childress, suggest a constantly evolving reflective equilibrium with some basis in common morality as a workable framework for twenty-first century bioethics. The flaw in their approach is failure to conform to real doctors' and patients' experiences. Real doctors adopt a scientific paradigm that assumes an objective reality. Patients experience real suffering and seek effective cures, treatments, palliation and solace. The foundation of medical ethics should be that doctors altruistically respond to their patients' suffering using scientifically acceptable modalities. Compassion, caring, and respect for human dignity are needed as guides in addition to justice, beneficence, nonmaleficence and respect for autonomy.

Introduction

Beneficence, nonmaleficence, justice and respect for autonomy, these four principles are widely accepted by the medical community to underlie medical ethics. Such has been the case since Beauchamp and Childress published the first edition of their classic text, *Principles of Biomedical Ethics*, in 1979 (1). Physicians who invoke the four principles presume that theirs is a deontological approach grounded in universal values. This is not at all the underlying method of the purveyors of "principlism," however. Beauchamp and Childress refer to mid-level principles.

One might ask, then, what is the basis for using four principles to guide ethical decisions? Perhaps the two authors are seeking to escape what is, I think, the bane of useful decision-making in fields like

From the Emory University School of Medicine, 1525 Clifton Road, Atlanta, Georgia 30322; Phone: 404-778-1600; Fax: 404-778-1602; E-mail: William.branch@emoryhealthcare.org

medicine, fields that require real decisions affecting the lives of real people. I am referring to postmodern relativism, a philosophy that seems capable of undermining any meaningful basis for belief, yet incapable in moral philosophy of providing a workable substitute. Relativists have so effectively undermined the foundations of normative values that one philosopher said he could propose only a "thin" foundation for human morality, one that has few if any real applications, in contradistinction to a "thick" foundation that could actually guide doctors in rationing of scarce resources, addressing inequalities in access to care, use of human stem cells for research, assisted death and suicide, and similar real-life issues (2).

I think Beauchamp and Childress chart their particular course, built largely but far from exclusively on "mid-level", some might consider free floating, principles precisely to escape from having a "thin" as opposed to a "thick" moral philosophy. They seek, if you will, an escape from relativism, but in a world where relativism seems to hold the philosophical trump cards. Before exploring their means of escape and its consequences, let me look at the relativists themselves, specifically, at Richard Rorty, father of neopragmatism, perhaps the least strident, most eloquent and convincing form of postmodern—though Rorty denies that categorization—antifoundationalism.

The Postmodern Reaction: Relativism, Neopragmatism and Antifoundationism

With devastating effects, postmodernism targeted a previously held confidence in human progress through science dubbed modernism (3). Foucault, Derrida, Lyotard and other Continental philosophers deconstructed well-accepted modern texts to unearth hidden power-laden cultural assumptions (4). Since these assumptions favored the traditionally privileged classes over those less privileged, such as women, minorities and third world citizens, postmodernism's exposure of previously uncritically held assumptions is often applauded by intellectuals. Postmodernism threatens to founder, however, once science and mathematics are included among the "texts" being deconstructed into just so many culturally biased relative truths. By undermining all sources of "truth" as only texts to be deconstructed, these philosophers have been accused of ending up "aimlessly wandering about" (4). They produce nihilism. This should cause medical scientists especially to reject postmodern relativism: precisely because of all sciences, those pertaining to medicine remain most firmly within the intellectual sphere called modernism. This is a critical point to be appreciated by

anyone undertaking to explicate medical ethics. I will return to it. For now, let me explore the ideas of Richard Rorty, who perhaps less subversively and with more supple intellectual force took up the anti-foundationalist, antiessentialist cause against scientific modernism; that is, against believing that science addresses a real world about which it develops verifiable theories that progressively approach truth (5–7).

A philosopher with common sense? When I first read Rorty, I thought he was a philosopher with common sense, a down home American pragmatist. He seemed like he might cut through the airy realms built by Continental philosophers to offer a method that corresponded to the way things really work in science and medicine. His neopragmatism seemed to say, truth is what proves useful, and how we determine "usefulness" is through the consensus of experts in an ongoing process of reflecting and deliberating on questions. Sounds just like science, doesn't it? Don't scientists accept or reject hypotheses by a consensus of experts' opinions applied openly in processes like peer review and critiquing the reproducibility of results. But Rorty is no scientist; in fact, his own assessment of where he stands on ethics and other issues seems tied quite closely to his self-identity: This defines who he is but also limits his ability to escape from the quagmire of postmodern thinking. He's too much of a postmodern thinker himself. Yet, Rorty identifies himself as a bourgeois liberal proponent of democratic values (8–10). Clearly, from his writings, he resides on the liberal arts side of the cultural divide. His affinity for democratic liberalism seems chiefly the basis for his vociferous disclaimer of being a relativist (8,11). When it comes to naming the persons most likely to influence pragmatic truths and progress, he calls them "strong poets."

Taking Rorty to be the spokesperson for postmodern intellectualism, an insider but one with common sense, consider his ideas. This is what Beauchamp and Childress are up against in building a workable, that is to say useful and acceptable to practitioners, medical ethics.

His first and most influential book, Philosophy and the Mirror of Nature, starts from a different place than Continental philosophers like Foucault and Derrida; he starts by examining the so-called mind-body problem and examining the nature of knowledge (12). Rorty stakes a claim that one cannot distinguish between an external world that is real and what is added by the mind; therefore, knowledge must be "a matter of conversation and social practice" (11). The latter claim, though I think not necessarily the former, denies the most fundamental character of science: that our beliefs are constrained by what we know of the world. For Rorty, science like art, poetry, literary criticism,

politics, and all other endeavors may be socially useful but has no claim on truth.

Rorty follows Thomas Kuhn's historicist approach to science whereby Kuhn described scientific revolutions as a series of changing paradigms, one of which always replaced another (e.g., Einstein's theory of relativity replaced Newtonian mechanics) when inconsistencies were noticed in the older, previously accepted paradigm and were shown to be better explained by the new paradigm (13,14). But, Kuhn did not believe that either paradigm was "closer" to the truth, because basic aspects of one are incommensurable with, hence falsify, the other. Assuming another paradigm will eventually replace and thereby falsify, for example, relativity, we must assume all paradigms ultimately are false; therefore, they do not lead closer to truth. Rorty applies this thinking to ever shifting intellectual fields like literature and politics, where one vocabulary replaces another according to—what? Fashion? Political correctness? Demographic and economic trends? So, how can Rorty deny being a postmodern relativist, embarked with all the other postmodern thinkers and writers on the same road to nihilism. He denies it by taking a historicist posture. Like Kuhn, he is willing to replace one paradigm with another, in this case bourgeois liberalism replaces fascism, communist totalitarianism, monarchism, and so forth, because we have tried the latter ways of doing things, and found we have more freedom and self-fulfillment under liberalism. We agree that liberalism is better. Rorty does not claim that liberalism is ultimately superior, just that we currently agree to prefer it.

This position leaves many unanswered questions. Some ground must exist for having knowledge and experiences, and for making observations; otherwise how could we "agree" on anything. It flies in the face of all experience to believe we are not constrained by an external world in some form. Finally, if there are no grounds beyond deliberation for choosing a free society over a totalitarian one; then, who are we to say ours is a better system compared to some fascists, for example, who may prefer living in a system where death camps are sanctioned by the state. Here, Rorty seems to have foundered. In a famous, and perhaps ill-advised statement, he admits he has nothing to say in the way of "you are acting against your nature," if torturers come to the door to take away one of us (15). On the other hand, he consistently expresses his personal view that he opposes cruelty and humiliation.

I think in his mind we must oppose cruelty not because it is fundamental to our nature. We must oppose it because we ourselves are

historically determined to be bourgeois liberals. I think this is an empirical observation reflecting Rorty's particular circumstances. It is an observation that someone would make who lives in a world of academic freedom and fashion, of brilliant dinner table conversations, of passion for books and ideas. In this cloistered society, one can oppose any and all slights and humiliations. But, those of us who live in that world know that one may oppose them by joining the conversation, and not necessarily by having to do anything that requires making genuine sacrifices for the sake of alleviating the suffering of persons.

So, this is how it looks from Rorty's relative perspective, that of a good man who lives the middleclass life of a tenured professor in an academic community. There are other worlds in which people live. What works in them may differ from Rorty's experience.

The Wide Reflective Equilibrium

John Rawls, a Harvard philosopher, focused his work on social and political issues. A liberal, democratic thinker like Rorty—some might call him a welfare statist—Rawls applied the principle of justice, defined as fairness, to the social order. Fully aware of postmodern thinking, he needed a method to apply fairness that avoided the now discredited invoking of fundamental or universal theories. How can justice be the principle that guides society without being a fundamental human value?

Rawls proposed the wide reflective equilibrium (16). I think it important to point out that, in many ways, this is a pragmatic method. If pragmatism seeks to adopt what works; then, we have to ask, works for whom, and to achieve what goals or purposes. Thus, pragmatism becomes value-laden. The wide reflective equilibrium is a pragmatic method that answers these questions in the context of a democratic society. Notice, however, we have made certain assumptions: that society is democratic, and that we seek justice. He assumes that impartial judges in their considered judgments would agree that justice should be fairness. Rawls then suggests that we may reach consensus by applying our best intuitions and judgments to cases or issues using principles, rights and rules that we believe also apply. Revising this approach as often as necessary, our judgments, principles, rules and rights become consistent with and supportive of each other (16). This evolving process may develop new principles for achieving a just society over time. Rawls' evolving reflective equilibrium sounds to me like a fairly accurate description of decision-making, definitely idealized, in twentieth century democratic welfare states. Faced with the

argument that society is pluralistic and never reaches total consensus, Rawls modified his theory to be a converging equilibrium. Groups representing different belief-systems could agree to follow the democratic process so as pragmatically to create a functioning social order despite privately adhering to opposing viewpoints.

I began this essay by defining the problem for anyone proposing an approach to medical ethics to be escaping from postmodern relativism. Rawls' was a social theory. In medicine, where decisions have concrete immediacy in affecting the lives of people, one can hardly depend on the shifting kaleidoscope of cultural relativism. The question is whether Beauchamp and Childress found a way out by adopting a Rawlsian reflective equilibrium?

Reflective Equilibrium as a Model for Medical Ethics

The wide reflective equilibrium as proposed by Rawls for social policy is a theoretical model that could serve medical ethics. It can encompass viewpoints ranging from those advocating a case-based approach to those who seek more generally applicable guiding norms. More than a set of competing vocabularies, the call for coherence by constant retesting with modification of moral beliefs based on cases allows for considerable consensus-building within an agreed framework. The framework proposed by Beauchamp and Childress consists of four semi-permanent mid-level principles. Their model recognizes that medical ethics is not a free-for-all. Considered judgments are developed by the stakeholders, who are trained ethicists; practicing physicians, other caregivers and their organized societies; governmental agencies; patient advocates; legal professionals; and representative voices from without the medical establishment. Arguably, the reflective equilibrium describes what exists in medical ethics. It does determine policy and opinion, and it is constantly evolving through the interaction of cases and issues with its stakeholders' judgments.

Principles of Biomedical Ethics influences the actual reflective equilibrium by convincing stakeholders to adopt its four principles (1). These authors give precedence to the so-called mid-level principles that guide decisions while also incorporating rules, which are more specific applications derived from or compatible with principles (like "Do not lie to patients" or "Maintain patient-confidentiality"). Cases (like Tarasoff) reverberate through the system and modify how rules and principles are applied. Virtues like honesty and integrity ensure right application of rules and principles, and rights, officially or legally

recognized, are also incorporated into the equilibrium, with which principles and rules must be compatible.

The Common Morality. Does anything fundamental within the evolving medical, social consensus justify choosing four mid-level principles? Beauchamp and Childress propose the common morality, shared moral norms, more basic than local customs. They are not grounded in any moral theory. One might say that the common morality is the basic human expression of right and wrong derived from our history and evolution as a species and society. Beauchamp and Childress believe that the common morality is always pluralistic, consisting of more than one principle; is pretheoretical but provides the basis for the moral convictions of all thoughtful and serious persons; and casts suspicion on any ethical theory inconsistent with it (1).

What is the Common Morality? Can we really agree on a common morality independently of societal mores? (see Table 1). Rorty goes no further than "avoiding cruelty," and that with no justification beyond his personal, historically determined beliefs. Engelhardt says that secular morality has proved to be culturally diverse with no content-rich, commonly shared morality beyond "the very sparse requirement that one may not use persons without their authorization" (2). Yet, Beauchamp and Childress find a rich common morality, which they say is based on benevolence and justice, and contains strictures like "one must not lie," "must not steal," and "must not kill." Among humans, in general, I think the rich common morality exists. We can say it is partly derived from our nature, partly derived from our families and small communities, partly from our civilizations. What brought about these? The human spirit? Random chance? Divine revelation? We are not now debating something's characteristics or existence, we are debating its essence. This is very much like debating the nature of a thing-in-itself, apart from its primary and secondary qualities. Well, being one of the essences that we are trying to define, by

TABLE 1

*Moral Foundations in the Postmodern World**

- Richard Rorty (15): opposes cruelty and humiliation (personal belief)
- Engelhardt (2): may not use persons without their authorization (moral reasoning)
- John Rawls (16): justice as fairness (considered judgment)
- Beauchamp and Childress (1): one must tell the truth, be loyal, not steal, not kill (common morality)

* How various twentieth century philosophers have or might express their version(s) of moral foundations, and the basis for the moral beliefs expressed. Note: Beauchamp and Childress discuss various viewpoints on the common morality in their most recent edition (1), but the elements listed above arguably conform to its commonality across societies.

definition we cannot know them. Whether the human nature that has a morality is in-itself a spirit or is purposeless energy changes nothing about the common morality as we know and experience it.

A Critique of Principlism

Principlism has dominated the teaching and practice of bioethics for twenty or more years. The wide reflective equilibrium is a robust model that in many ways conforms to real-world decision making. The model's self-correcting and evolving features allow principles, rules, virtues and cases to continually realign so as to reinforce and support each other while addressing new trends and issues. Simultaneously, the common morality provides a semi-permanent foundation on which to rest the model. However, potentially serious flaws may undermine Beauchamp and Childress' model of the reflective equilibrium and mid-level principles.

Is the Reflective Equilibrium Outdated? Does an unspoken subtext run throughout Beauchamp and Childress' description of the reflective equilibrium that if revealed would expose their thinking as being strongly influenced by a cultural assumption, namely, the assumption that we all are late twentieth century democratic liberals, that is to say, well intentioned, rational beings who can reach consensus leading toward the common good. You might say, the participants in Beauchamp and Childress' ongoing reflections are those same academic conversationalists who inhabited the worlds of John Rawls and Richard Rorty. But, the twenty first century shows signs of a fractured equilibrium. Voices are raised. Polarization replaces consensus. Perhaps the center will not hold. To the extent that the wide reflective equilibrium no longer accurately describes our struggles as moral agents, the model could be obsolete.

Did Beauchamp and Childress Embrace a Contradiction? Beauchamp and Childress state that their principles are prima facie obligations. They distinguish prima facie from actual obligations because the latter guide actions when two or more prima facie principles conflict and must be weighed in the context of a particular situation. Thus, moral agents, guided by prima facie principles, reach actual conclusions in particular situations. Now, here lies the rub. Not only could this approach lead to pragmatism as opposed to principlism, but also Beauchamp and Childress assert that their four principles and common morality from which they are derived are normative, that is, they establish obligatory moral standards. However, if there is legitimate debate over what constitutes the common morality, and if the guiding

principles of medical ethics are ultimately discovered by examining the history of medicine and societies; then, in fact, the content of common morality and the naming of mid-level ethical principles are empirically determined. They are therefore nonnormative. The inherent contradiction is that normative appeal is derived by empirically discovering nonnormative principles. So, it isn't easy to derive a foundation for medical ethics from the common morality. Even if not contradictory, this effort becomes problematic because normative cannot be cleanly separated from nonnormative (that is, empirically discoverable) principles, any more than theory is easily separable from empirical observation, as Quine pointed out (17).

This raises the possibility that biomedical ethics should seek a more firm foundation than provided by reflective equilibrium.

Post-postmodernism, Truth Defined by a Pragmatically Determined Scientific Realism

Pragmatism Applied to Medical Science. Rorty believes that science should have no exalted position. But, there is a difference between science and fields like poetry, fiction-writing, painting, even philosophy. Science is about understanding the "external" world (Figure 1). These other fields are subjective, in the sense they are the imaginative creations of human beings. Postmodernists seized on a logical conundrum: all human experience being subjective by definition, we cannot truly experience the "external" world. So, how can we say that biomedical scientific observations are real? Are many scientific models not imaginative creations of the human mind? Do they correspond to an "objective" reality? Here, I am forced to fall back on a pragmatic definition of truth: Truth is what works. But then, works in what way? For whom? And why? How can we reach a consensus?

Herein lies the distinction between science and other fields. In free-wheeling academia, a text can be deconstructed into any number of interpretations. Scientists pragmatically require their consensus to be based only on reproducibly observable phenomena. In particular, medical scientists have found that no other means for reaching consensus—clever arguments, religious authority, political correctness, wishful thinking, legislative action—works to treat disease. Does this prove that biomedical science is true. Scientific convention has it, being "true" is the only pragmatically workable criterion for reaching consensus. But are observations, for example of the circulatory system, true because they correspond in some way to external reality? Well, multiple interlocking pragmatically achieved successes support their

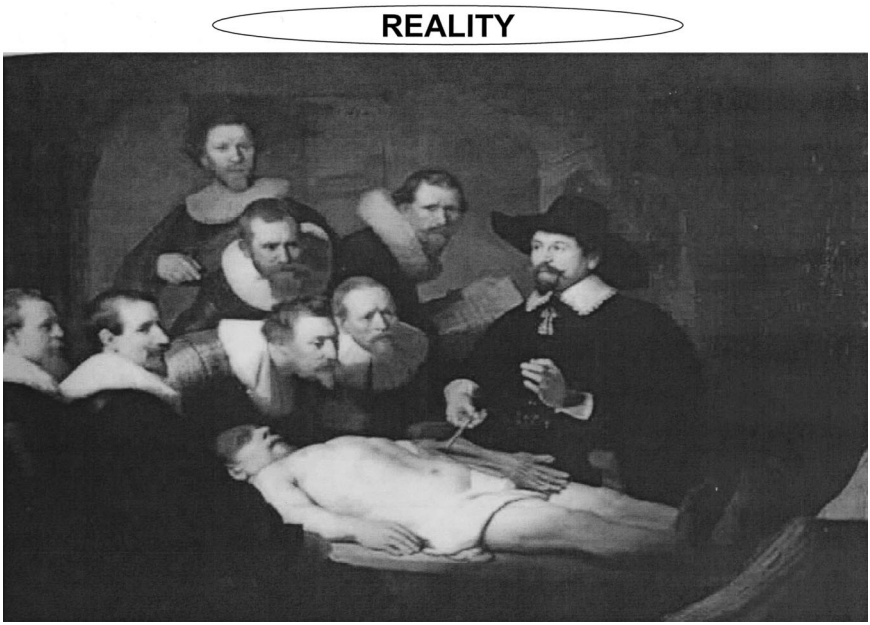

FIG. 1. Scientific Realism: The product of successful scientific research is knowledge of largely theory-independent phenomenon (7). Painting: Professor Tulp's Anatomy Lesson by Rembrandt van Rijn, 1606–1669, Mauritshuis Museum, The Hague.

truth. Likewise, their truth is coherent from these and other multiple interlocking perspectives. This may be as close as you can come logically to saying it corresponds to reality. I am saying their relational structures approximately correspond to reality irregardless of their indefinable natures, or essences. What about, then, the theory of reflective equilibrium, and Kuhn's theory of scientific paradigms? Is our current way of conceiving reality on the level of human biology just one more paradigm waiting to be discarded?

Does the Reflective Equilibrium Acknowledge Scientific Reality? In the Kuhnian sense, biomedical science is normal science. There has been no paradigm shift since Vesalius (see Figure 2). As pointed out above, physicians are working on a level which to all intents and purposes constitutes a permanent framework. Realities constructed by theory and experience at this middle spaciotemporal level have remained unaltered by theories of relativity and quantum mechanics. So, herein lies physicians' wide reflective equilibrium. Their consensus is that what happens to their patients is bound by a very real external world. It follows that their patients' suffering is real. And, in fact, their compassion and caring are real. And, in this all encompassing realism

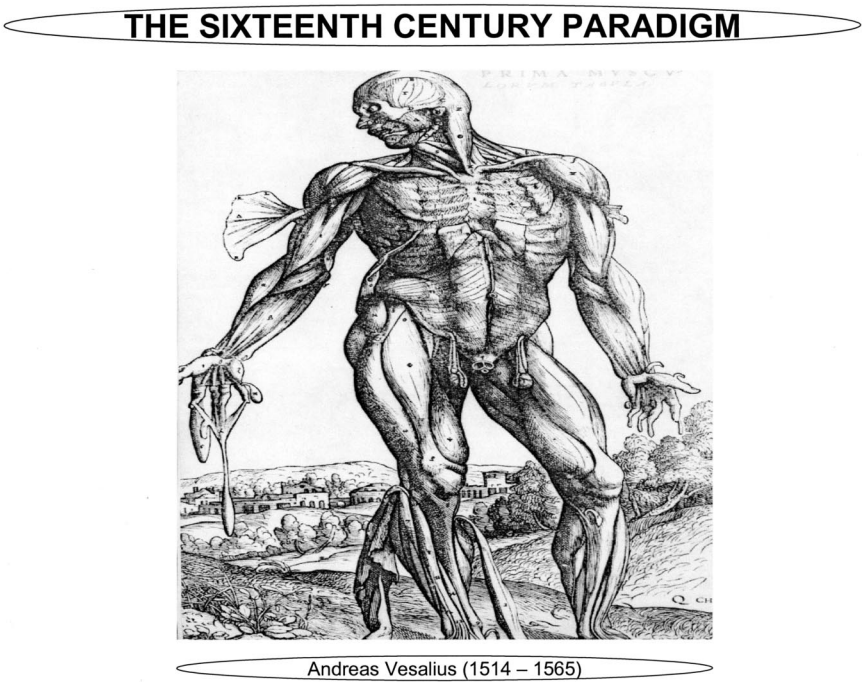

FIG. 2. The Sixteenth Century Paradigm: The scientific paradigm for biomedicine has not shifted since the sixteenth century but has expanded from gross anatomy to the molecular level. Illustration by Andeas Vesalius, 1514–1565, Library of the Faculty of Medicine, Paris.

(Figure 3), like all treatments, the physician's compassionate caring and therapeutic use of self is also subject to the scientific method. Though genuine and not counterfeit, and ethically desirable, even compassion has observable outcomes, and so lies within the realm of accepted practice consistent with the physician's unique role as the dispenser of science-based treatments.

Moral Implications. Knowing their patients are suffering, and knowing they know the best means to respond to that suffering, physicians are *called*—in the highest moral sense—to apply real science for the benefit of their patients (Table 2). Morality dictates they cannot employ alchemy, witch doctoring, exorcism or anything else but normal science. This moral purpose stares physicians in the face. It is in fact the foundation of medical ethics. It is defined by the very reason their patients seek a physician: "Apply your science to relieve my suffering."

Medical ethics should not be based on an effort to skirt postmodernism by reaching a purely intellectual reflective equilibrium subject to

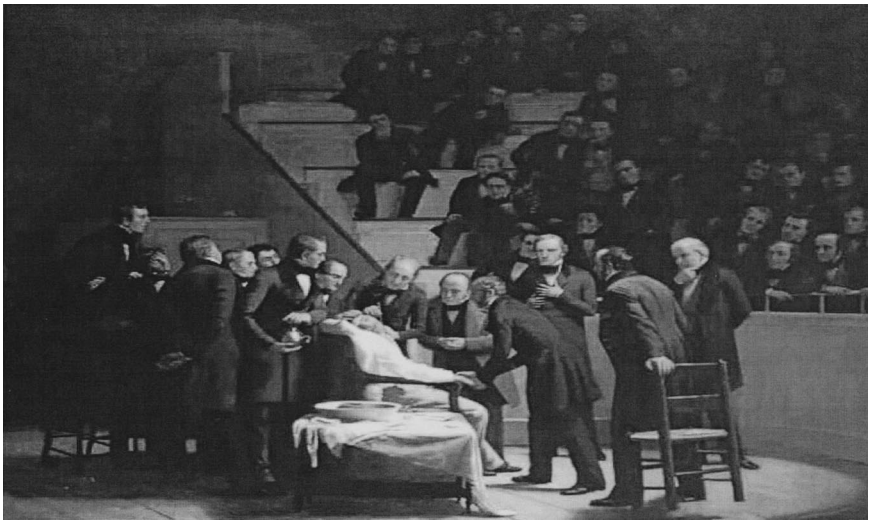

FIG. 3. "The mind and the world jointly make up the mind and the world." Aphorism attributed to the philosopher, Hilary Putnam, 1981 (20). Painting: First Operation Under Ether by Robert C. Hinckley. Harvard Medical School's Countway Library.

TABLE 2
*Biomedical Realism**

- Real Disease
- Real Suffering
- Real Compassion
- Real Treatment

* How realism in one's philosophical world-view translates to a moral mandate.

argument and revision. Medical ethics is based on an overriding reality, the scientific reality that bounds the context within which medicine is practiced. This reality is only modifiable by new reproducible observations accepted as such by the scientific community. For hundreds of years, all such observation have extended but have not altered the conceived nature of biomedical reality. Arguments advanced by Rorty and all postmodernists are then judged irrelevant. Truth is defined by the brute reality of an empirically experienced world that inflicts suffering. Moral truth is the existential call to respond to that suffering. This is a rather humbling observation—a physician cannot rely on his poetic imagination, his encounter with an authentic self (18); he must subordinate himself to working humbly and compassionately within reality.

Summary, Deontology After All (See Figure 4)

- Patients and their suffering exist in a real world described by biomedical science.
- The fundamental moral principle of medical ethics is altruism. The physician is altruistically called upon to respond to patients' suffering by applying science.
- This fundamental principle probably derives from our deepest human nature: our need to respond to someone else's suffering.
- Beneficence, nonmaleficence, justice and respect for autonomy are mid-level principles that can be derived from physicians' altruistic duty to respond to suffering. They are historically and experientially based guides that assist physicians in their efforts to respond to and relieve suffering.
- Altruistic response to suffering is an unwavering moral principle, but to derive from it a "thick" morality that actually guides decisions, one

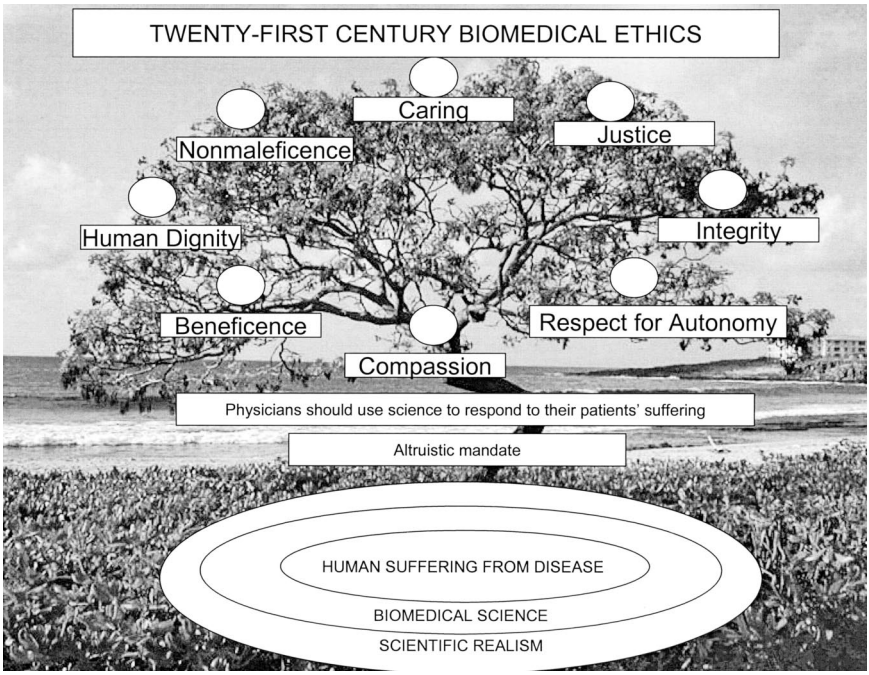

FIG. 4. Tentative schematic of how basing knowledge in scientific truth leads to an altruistic mandate for physicians founded on the reality of human suffering from disease, and on physicians' relationships with patients. Patients seek science-based treatments. A reflective equilibrium influenced by the basic mandate works to guide the necessary ethical decision-making and includes principles in addition to Beauchamp and Childress' four principles for dealing with increasingly complex twenty-first century problems.

must apply principles pragmatically. As Dewey defined it, moral values arise from an appraisal or reflection on (potential) actions (19).

- The four mid-level principles do not optimally address all dilemmas or exhaust the need for principles. To proceed with compassion and caring are perhaps equally valid principles, strongly applicable to many twenty-first century ethical dilemmas faced by physicians.
- Certainly, the rules, case-precedents and virtues derived through working with mid-level principles are constantly, pragmatically being modified and made coherent.

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DISCUSSION

Farrar, Williamsburg: Very interesting, Dr. Branch. I agree with everything you've said. However, I think, ethically, what you've talked about doesn't solve the problem that we have in this country and the world. It seems to me that the main problem we have to decide is whether life belongs to us here on earth or to God.

Branch: I don't think I can solve that problem.

Farrar: No, but I think that is the problem. I believe that, however we humans happened to be on this earth, we must make these decisions, rather than defer to some "higher power". You realize, I am sure, that many people in this country believe that we should not be making these decisions.

Branch: I understand that, and I think that if we believe that we have to respond using a science-based approach to the suffering of human beings, that we can come into that belief out of either a position of faith or a position of agnosticism and humanism.

Czeisler: Boston: Very interesting presentation. The importance of getting someone's consent before they participate in something made me think of a conversation and some of the results that I presented this morning. When I first presented them at our institution to all the different training program directors, there was about a half an hour conversation that ensued afterwards, that making mistakes in the middle of the night might be a very important part of training a physician, because the lessons that were learned from very serious mistakes resulting in adverse outcomes or even death were never forgotten by those trainees; and that was an essential part of their training experience. And as I listened to the discussion for about a half an hour, I was thinking about whether or not the extent to which the patients were involved in consenting to that process, and I just wanted your thoughts about—let's say—if that were essential to training, how would you think that it should be approached?

Branch: I can't totally agree with your premise that it is essential to training.

Czeisler: I'm not saying I agree with it myself. I'm just saying that this was the discussion that surprised me.

Branch: I think I would place the principle of treating the patient as an autonomous human being and getting their consent above the rate of learning of young trainees, and, frankly, I would have to believe that we could find better ways to teach them than to allow them to make mistakes. I think that mistakes are inevitable. I make mistakes, we all do. I also think there's an ethical way to approach learning from the mistakes, that we are just now beginning to grapple with bringing them out in the open. Actually telling patients about them, and talking about them a lot more among ourselves.