In a Different Voice: Technology, Culture, and Post-Modern Bioethics

by Douglas McNair

Technology inevitably challenges culture-bound values. When this happens in health care, values of individuals and organizations who speak for the dominant technological Western culture impinge upon the most personal aspects of life of people of different cultures. Those affected have difficulty resisting the infringements and, in some cases, even have difficulty recognizing them as infringements. This essay suggests how bioethics may evolve in years to come, in response to medicalized, bureaucratized, and technology-mediated care, multiculturalism, and postmodern trends in philosophy.

Our Tacit Modernity

The influence of technology on bioethics is undoubtedly pervasive; some even suggest that modern technology creates the ethical dilemmas that we confront as individuals and as a society. To say that dilemmas in contemporary bioethics would not have arisen were it not for advances in materialistic culture may go a step too far, but it is doubtful that technology can ever be value neutral, morally neutral, or politically neutral. Social theorists hold that technology entails a sort of soft determinism: technology encourages and discourages (rather than fully determines) specific kinds of political and social institutions, which may or may not be consistent with a given culture's or subculture's values. Langdon Winner, for example, likens technologies to political constitutions or legislation. Winner asserts that technology, once implemented, inevitably influences the rules by which people live (Winner 1977, 317-325), regardless of whether people mean for these things to happen.

> *The logic here is a wonder to behold. Both proximity and distance count as excuses. The closer you are, the more innocent; the farther away you are, the more innocent. It is a magnificent arrangement in which everyone is safe except the victims. In a system of this kind the very notion of a 'deed' seems to evaporate.*
>
> Langdon Winner, 1977, *Autonomous Technology*

And if the rules change, so does the balance of power. Political inequality refers to differences across individuals and groups in their influence over decisions. Political *inequality* and inequality in other domains are closely interrelated. In capitalistic societies, as contrasted with certain subservient societies, wealth tends to be convertible into political influence. Conversely, political influence in capitalistic societies is liquid, too, and is extensively used to create and conserve wealth.

How are these correlations explained? Historians attribute the origins of modern society to the emergence of an attitude toward the world which conceives of a meaningful life in terms of comprehensively rational behavior and a conquest of materialistic scarcity. In other words, natural scarcities were always a constant companion of humankind down through the ages, but from the seventeenth century onward, unlimited desire was rational and morally acceptable. The real mission of Western civilization came to be over

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coming scarcity in response to *infinite desire*. What is now referred to as technology really encompasses all of those things that have served as means to this end.

During the nineteenth century, the principles of modern management science took root and later blossomed in the works of Taylor and Weber—in expositions on industrial capitalism, top-down management, maximizing efficiency, standardizing and routinizing operations, and other principles in the modern spirit of domination and control.

With the decades passing, though, new ideas of flexible and humane organization have emerged in the workplace. In philosophy and social science there are initiatives that advocate modesty of desire (Baum 93, Benhabib 1987, Cards 1991, Cixous 1986, Deleuze 84, Gilligan 1982, Pursell 1993, Slote 1989] and oppose cultures of unbridled infinite desire. However, in health care there as yet seems to be little evidence that we have progressed beyond the thinking of Taylor and Weber (or their contemporary intellectual descendants, like W. Edwards Deming, whose programs such as Continuous Quality Improvement are well-intended but are perfectionistic and potentially dehumanizing).

Even today, many in the United States seem preoccupied with "cure" and with indefinite technological prolongation of life. Furthermore, despite expressions by government and health care organizations emphasizing their earnest intentions, the contrary experience of patients with whom these institutions come into contact—who feel as if they are depersonalized products on an assembly line—remains a common one.

Technology is an accomplice here, for it contributes to the content and form that this contact takes. For example, clinical observations that presume to adequately represent the individual as a human being are stored in computers that, all too often, have been predominantly designed to serve the interests of payors and providers, and not the interests of consumers.

Is technology dysfunctional, or is it capable of facilitating positive desire? Postmodern philosophers (Cooper 1988) assert that there is no such thing as a dysfunctional organization, only contested, fragmented, and subverted discourses which may be uncorrelated with the flow of desires. For the purpose of this article, social organization is not viewed as oppressing *per se*. Rather, consider that the individual has before her a suite of actions that are possible within the context that a specific organization provides and the decisions and actions within this context are what constitute her subjectivity. Generalizing from the individual to the group, each subculture has a suite of possibilities that are conditioned by, and may be contested or subverted by other cultural groups. These constitute the subjectivity of the group.

Postmodern Politics and Economies of Desire

Individualistic vs. group-oriented or other-oriented: Is this how we would distinguish modern philosophy from the postmodern? Yes, but there are other distinctions, too. We can reasonably summarize modernity and modernism as (1) committedness to truth, rationality, and progress, combined with the belief that objective analysis is the way in which the world will become known and mastered, and (2) committedness to humanism, with the human individual as the source of both knowledge and value [Sarup 1988]. Individualism and rationalism are the *core* of contemporary bioethics.

But postmodernism offers alternatives to the modernist conception of the self and subjectivity and these alternative conceptions may be expected to affect how bioethics is constituted and practiced in years to come. By way of background, one might regard modernism's notion of self as having an inner part (a mind, a soul a motivating force of a human agent) and an outer part (a public image); postmodernism views subjectivity, not as a phenomenon of an inner self, but as an effect of political power, power which is inscribed on the political surface of the self through discourses in which the self engages.

One-way love
will die.
Indeed!
But love
for each other
will live
for a long time.
That's how it is!
That's how my feelings are.
Thank you.

Charlie Joseph and George Davis, in Nora and Richard Dauenhauer, 1990, *Haa Tuwunaagu Yis*

Deleuze and Guattari explain the idea that each self has a political surface by suggesting that this surface is territorialized through discourse between individuals, or between individuals and groups—discourse through which shifts of power may occur directly or indirectly. Such discourse may involve agents of government, our employers or employees, spouses, children, friends, students, our patients or those who provide care to us—anyone who influences us or with whom we have influence. The outcome of bilateral or multilateral discourse involving the exchange of power yields the inscription and territorialization of the self of which Deleuze and Guattari speak. In some cases, the territorializing is classificatory and so fundamental to the process at hand that the implications and side effects may not be noticed. In triage, for example, we might not realize that we ascribe membership in good and bad categories to individuals or divide them among promising and unpromising, or deserving and undeserving, or compliant and noncompliant, or some similar set of categories (Leiderman 1985).

What is bad? To postmodern theorists a bad patient is a participant in a clinical setting involving a discursive exchange of power, who is regarded as a problem (by those who would apply the label bad to her) in direct proportion to her resisting types of discourse that are culturally valued or accepted in health care relationships. Apropos of nonclinician participants in such discourse (and apropos also of autonomy and integrity in today's bioethics), we note that some individuals lack the capacity not only to decide, but also lack the capacity to resist. The deck is stacked; the outcome a foregone conclusion.

Where modern bioethics dwells mainly on the outcome or result, a postmodern bioethics places more emphasis on the participants (or other structural features) and on the tensions and processes by which the discourse proceeds. In a book that explains discourse-oriented differences between modern and postmodern bioethics, Nicholas Fox has recently examined the notion of a politics of health-talk (Fox 94), which he carries over and adapts from Nancy Fraser's theory of needs-talk (Fraser 1989). Health-talk, according to Fox, entails a concern with the subjectivity of each person that is generated through discourse, knowledge, and power. It also concerns the interplay of roles and narratives which may be interpersonal or intra-personal, the latter kind including such things as self-reflective elaboration of one's own life story, and the awareness that telling one's story is what one is doing while one is doing it.

Perhaps all human progress stems from the tension between two basic drives: to have just what everyone else has, and to have what no one has.
Judith Stone, 1991, *Light Elements: Essays in Science*

Taking or giving a clinical history provides rich illustrations of the interpersonal politics of health talk. In analogy to Roman Catholic and other traditions, "by confessing, one is subjectified by another, for one confesses in the. . .presence of a figure who prescribes the form of the confession . . In confessing, one also constitutes oneself (Rose 1989).

Along similar lines, Foucault tells us that subjectivity inevitably involves tension between community and individuality and involves a confessional of sorts: society pressures one to continually reconsider and evaluate and regulate one's own conduct as an ethical subject. Subjectivity is multilateral and social. Instead of a unitary, prior,

nonpolitical subject, a fragmented political subject creates herself as she goes. Subjectivity is thus multilateral, dynamic, and social.

But subjectivity need not involve subordinating or dominating asymmetry of power in the manner that is so common in traditional, modernist-technological medical care. Subjectivity of each of the participants in social contact may instead be mutually permissive, mutually allowing: 'de-territorialized,'in the postmodernist's view. In a clinical setting, for example, the receiver of care invests trust in the caregiver, persuaded by demonstrations that the caregiver has made, which denote her intent to empower the patient, respect his dignity, and so on. The caregiver desires to help and allow; the receiver of care desires to collaborate with the efforts of the giver. But if the flows of desire become codified by either individual, or by some third-party such as the state or a managed care plan, or by some other authority, then what began as a fair and mutually empowering relationship is converted to disenfranchisement and dependency. In other words, the outcomes that are possible are in no way changed; the modern and postmodern accounts differ only in their view of what is happening, and in the values that influence thoughtful participants' planning and words and deeds.

Under a postmodern conception of what is happening, clinical discourse that occurs in the process of obtaining informed consent and in other interactions between givers and receivers of care *works* precisely because caregivers act as if they have authority or a formal right to say what they are saying. In caring for people who are sick, the facticity of anatomy and of medical terminology and the technical knowledge that providers possess about clinical procedures enable the caregivers to perform, at least with individuals who are members of their own culture, interventions that might otherwise be assaults on the dignity of the receiver.

Very often among members of our technocratic modern culture, the effect of mutually familiar and enculturated forms of medical discourse is to render patients passive. When participants are members of different cultures, resistance and conflict are much more likely.

In attempting to harmonize the plurality of cultures, modernism is plagued by relativism, placing diversity above other values. By contrast, postmodernism answers diversity with an ethics and politics of action and mutual desire. Fox proposes a concept called arche-health, based in flows of desire among individuals and groups in contact. It is not an underlying historically-prior health nor an idealized notion of health. According to Fox, a postmodern arche-health perspective does not obsessively try to enhance health or minimize illness, although those goals have merit. The postmodern arche-health perspective consists in investing each participant with positive desire (Fox 1994; Slote 1989) This gift of care is equivalent to Deleuze's and Guattari's discursive 'facilitation of positive, productive desire.'

Discursive Caring

"Imagine these rival versions of desire. . .On the one hand, there is 'Desire as a lack': she is saying 'Be this. . .I want you to be like this. . .' On the other, 'Desire as a positive force' is saying 'Here is some space for you. . .Go for it! I have trust and confidence in you!"

Nicholas Fox, 1994, *Postmodernism, Sociology and Health*

Discourse isn't everything. Nevertheless, language, including gestures and other nonverbal signs such as those that are engendered by technology, exerts a powerful influence. Hugman believes that health care professions inherently dominate individuals by labeling them patients, clients, by assigning to them diagnoses of disease, by incarcerating them in various sick roles, by controlling access to scarce resources and services, and by dichotomizing the relationship between the carer and the caree (Hugman 1991).

By contrast, postmodern approaches emphasize desire as the primary factor disposing toward such a state of affairs. This emphasis, in turn, entails a sort of process-ethics and a politics of resistance—the *possibility* of freedom and struggle. Foucault and other postmodern writers take

power to be primary, while Deleuze and Guattari give primacy to a territorialized form of desire, the kind manifested by materialistic regimes, with their disciplines of workplace, family, community, school, and clinic, as contrasted with de-territorialized forms such as exist in some subsistence cultures (traditional Aboriginal Australian tribes, for instance). Unlike Foucault, Deleuze and Guattari think of de-territorialization in terms of 'nomad thought'—a perpetual enabling and becoming something other than what one presently is. (However persuasive other of Deleuze's and Guattari's arguments may be, the relationship between the giver and the receiver of care is made of mutual expectations, including reciprocity, and these expectations tend to have a stability or permanence that we find hard to call nomadic.)

The following example may help explain the effects that discourse involving an interplay of power or desire in a health care setting may have.

A caregiver saved my life through the exercise of clinical knowledge and skills. Does this action territorialize me? Does my gratitude territorialize the caregiver? Perhaps both parties view expertise and professionalism as particular forms of executable knowledge and power, which readily transform the object of their holder's desire. In place of a relationship of generosity, there may arise aspects of possession and control. Is the caregiver's act of other-regarding giving then an act of aggression, merely because it signifies a difference in power?

> *We must work harder at being human, all of us: those who are disabled, those who are normal, those who are professional helpers.*
> **Anonymous Patient, in Arthur Kleinman, 1988, *The Illness Narratives***

This is not the case, as Bennet has observed in caregivers who have themselves been afflicted and confronted illness in their own lives (Bennett 1987, 216). Just as there is a patient in each of us, there is also a healer in each of us, says Bennet. The patient dimension of us is not concerned with dependency and fear and helplessness, but with openness and trust and sharing: it is concerned with 'the gift.' Bennet argues that medical bureaucracy and the Western cultural ascendancy of experts both tend to suppress this natural generosity, or misconstrue it as a demand for dependency. What Bennet terms self-healing amounts to a Foucauldian de-territorializing of the self, so that the individual may effectively resist the discourses imposed by professional care.

In other words, we are catalysts of the good in one another. Within each episode of care, there is a two-way flow of desire between the giver and receiver of care. Owing to this, an important part of quality as a measure of caring for others consists in the matching of needs: the needs of the recipient, but also the needs of the giver—a Bennet-like recognition of the symmetry and comingling of giving and receiving.

Few would argue that the processes of giving and receiving care were ever really one-sided, with one or more purely active givers and a purely passive receiver of care. But what is increasingly clear—what is evident in sociological examinations of effective health care—is that the needs of each person who ministers to others and provides care to others are correlated closely to the needs of those who are ministered to; that the cared-for others do contribute meaningfully to the life of the nominal giver; and that the intentions (as well as the beliefs and actions) of each do matter.

It has recently become commonplace (see, for example, JCAHO and NCQA standards) to acknowledge that we do have a constellation of agents and structures through which we can give care with dignity and integrity, resources which we hope are adequate but sometimes are not. This is the structural aspect of quality care. Further, we tend to admit that we usually do have a plan, albeit an imperfect one: a sequence of thoughts and acts—actions possible and permissible, and also an appreciation of actions doubtful or forbidden. Without a plan the process of giving-caring reduces to a tournament, a process unworthy of the label "quality."

Yet we know that, above and beyond the struc-

tures and agents and processes, quality includes a third aspect —anticipatible outcomes that a receiver of care would want, and want indefinitely, in much the manner set forth in Nietzsche's concept of *eternal return*. A postmodern concept of quality implies the notion of repeatable, universalizable *intention* toward desired outcomes, something that may or may not be consequent upon modernist conceptions of bioethics. It implies the necessity of such understanding as would properly direct the striving of the giver and, whenever possible, the receiver of care. It implies a loving propulsion toward the end of desire, a desired end.

The notion of quality that emerges from postmodern, discourse-oriented approaches is one that is reproducible *in-the-small*, time and again. Quality in caring is individual and personal; there is no way that collective-aggregative entities like corporations can care about each other, no way to fit what they may do or intend within the scope and usage and the ordinary sense of the word caring. Like love, caring (of the sort to which quality might be ascribed or to which health care aspires) proves itself through interconnected, individual stories of pain, beauty, joy and truth. It does not prove itself through statistical measures and epilogues in-the-large, only through special and complete individual stories in-the-small. In the future, I believe we will increasingly find these ethnographic and interpersonal political aspects of quality of care connected with bioethics, namely, an ethics of mutual intention, between the human agents involved in the two-way discursive flow, involved in matching their respective needs in a process that is often more symmetrical than had been recognized heretofore under traditional, medical, modernist models.

> *A gift may be the actual agent of change, the bearer of new life. Gifts carry an identity with them, and to accept the gift amounts to incorporating the new identity. It is as if such a gift passes through the body and leaves us altered.*
> **Lewis Hyde, 1983, *The Gift***

The Gift

Returning to Bennet's *gift*, we reflect on the postmodern notion of caring. The inspired giver perceives in her or his companion a need or a desire, and the giver accepts that need and assimilates that desire, internalizing it to some degree as her or his own.Ultimately, the giver acts vigorously to serve it or resist it—to cause a state of the world in which this need-desire is either resolved, vanishes, or is allowed to remain unresolved, yet valued in itself.

This concept is very different from a bioethics of justice or utility or rationality. It is not purely governed by reason, nor is it necessarily altruistic. It is an ethics of *attentiveness*, attentiveness of the giver, but also of the receiver of care.

An element of quality in the giving and receiving of care consists simply in the closeness and responsiveness with which the participants' attention shifts and is refocused on each other. The situation evolves. Each change in situation corresponds to some change in the desires, the needs, the trajectories towards the goal. It is not just the *giver* who ought to recognize this, but also the *receiver*.

Some would say that the attention of each participant needs to be refocused. Refocussing is an apt expression so far as it goes, but it is also enigmatic. The expression is *apt* because it makes an abstract idea meaningful by invoking familiar imagery: scenes blurred becoming sharper, thus susceptible to decision making and action; a finite scope of vision that admits only so much within view at a time, so that when I look in front of me I cannot see what is behind; I must turn my head before more and useful information can be apprehended or made available to me.

Refocussing is enigmatic because it presumes that there is a solitary *right* or *best* (this devalues other realities as poorer or wrong). It is enigmatic because it presumes that, if one were in sufficient possession of one's senses, then one could will the shift in attention from one thing to another,

much as one would do any other ordinary, voluntary thing, like ceasing to lie down and choosing now to get up. We have no difficulty with willing and intending to act, but we do have trouble with willing and intending to believe or to know.

> *The role of the health professional is not so much to ferret out the innermost secrets. . .as it is to assist the chronically ill to come to terms with . . .those personal significances that can be shown to be operating in their [patientsí] lives.*
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> **Arthur Kleinman, 1988, *The Illness Narratives***

The postmodern Giver of care awakens to the dawning need of the intended Receiver. The alert Receiver of care experiences a complementary awakening, an awakening not only to the abundance of the Giver, but also to the Giver's need-to-give and, so, helps the Giver to quench her need.

The net effect of the foregoing is that a postmodern bioethics is an ethics of giving. Is the Need of a shipwrecked Giver, or of any lover, any less terrible or compelling than the Suffering of a Receiver who is sick and in pain?

Does a postmodern ethic of care displace justice or utility or virtue or other principles of moral conduct? I don't think so. Care-oriented ethics is just one of many facets on a jewel; I still admire the other facets and I find it satisfying to turn the jewel around. Even writers who would not likely regard themselves as postmodern thinkers and who still cleave to other moral theories periodically take up postmodern points of view on topics such as the subverting of generosity by suffering (see Bauman 1993; Kleinman 1988, 48; de Swaan 1990, 42-54; Brody 1987, 5). I cannot abandon the other facets of the jewel; the internal imperfections that are obscured when viewed through one facet are revealed by the view through another, and the perspectives do not necessarily corroborate each other. I will tolerate a few exceptions and inconsistencies. The force of The Gift is an open-ended allowing which actually stands in place of discourse; in place of rights and duties; even in place of a discourse on freedom and alternatives. It does not classify; it does not say what is or is not. To those who are well or have never experienced catastrophic troubles, such a conception of ethics may not be so easy to comprehend, let alone apply. But to those who are sick or in some way disadvantaged, the idea comes naturally.

> *Discussing advance directives with the Inupiat is difficult. To even mention death is, to them, to invite it. It is hard to know, of course, what informed consent would consist in when there are such strong culturally-conditioned beliefs that constrain or inhibit certain kinds of dialogue. Our main concen is to be sensitive, to be true to their wishes.*
>
> **Peter Mjos, M.D., 1994, director of clinical ethics, USPHS Alaska Native Medical Center, Anchorage, Alaska**

In modern Western culture, we whose worldview honors the ideal of youth and health and devalues states of advancing age and debility tend, when we become ill, to resent the healthy, by reference to whose health status our own diseases and deficits are defined. We may resent our afflictions and hate the suffering that marks us as different and impairs our ability to maintain satisfying interactions with others. We resent the organizations which commodify us and turn us into objects. We resent our resentfulness, because it consumes us and deprives us of a more meaningful life. We construct a mythical heritage in which the elderly and the sick were cared for by saintly family members or communities—an imagined past where things were more nearly ideal and perfect.

In fact, sociologists (see Rose 1989, 226) view the progressive transformation of familial relationships grounded in rights, toward commodified relations, as the culmination of the rise of industrial capitalistic society. Deleuze and Guattari suggest that the family is itself a territorializing force in free market societies. Fox goes a step further (Fox 1994,116), and considers the growing intrusions of "objective clinical gaze" into the community, coupled with location of the processes of health and illness in a family context. According to Fox, public health management

at a community level currently means systems of control and surveillance to monitor the decentralized implementation of care. It means subordinating the individual to social policy.

To counter these trends, Wiles and others have advised that health care professionals—and the organizations and bureaucracies and technologies that concern themselves with health—ought to focus less on expertise and control, and more on facilitating individualsí choice (Wiles 1993).

This is consistent with the emerging concept of the difference between a postmodern ethics and a modern ethics (White 1991): the difference between a postmodernist's *duty to become* and a modernist's *duty to act.* The latter is a moral obligation to acquire reliable knowledge and act to achieve practical ends in a thoroughly rational manner. Modernism is a tacit commitment to optimization and mastery —a goal that is one among many, and not necessarily one that is more privileged than any other. It is a goal that is incompatible with uncertainties and imperfections that constitute the human condition. By contrast, post-structuralist theory "discloses that everything is political. . . What makes post-structuralism postmodern is not only the recognition of a responsibility to otherness, but also a continuing responsibility to act. . .Modernism pretended that it could go beyond politics. If only it could be rational, objective, scientific enough, it could be value-neutral . . .Interests are dressed up (or obscured) with scientific pretensions, or often, in the case of clinical enterprise, by technological pragmatism. . .It is. . .the deconstructive concern of postmodern social theories of health to expose the politics of those interests" (Fox 1994, 122-126).

Conclusion

Improving the health status of society's members (and the content of health services and the care process) is a major challenge facing all nations today. Doing so in a manner that is just and multiculturally defensible is extraordinarily difficult, especially insofar as technology represents a medium of social discourse that competes with and supplants and hegemonizes other forms. It obscures, even more than the paternalistic medical traditions of the past, the nature and basis of judgments about what to do or not do, and why, and when.

As we approach the year two thousand, we should be mindful that there is no redemptive technology that can turn every object of desire into a free good: some objects of our desire are intangibles of the heart that no technology can produce. Constrained as we are by our human condition, yet others shall forever be beyond our reach. Advancements in technology *do* affect bioethics issues, and they may cause some issues to arise more often. They may add to the issue's complexity. Technology shapes the context in which the issues are identified and addressed and, many times, it shapes the alternative approaches that are available. But technology does not create these issues. The questions have always existed; it is only the possibilities that have changed. We are inclined to agree with Ezekiel Emanuel, who proposes that "It is the failure of modern political philosophy that underlies . . .the current preoccupation with and irresolution of medical ethical questions."

In the future, postmodern accounts of bioethics will emphasize the incommensurability of individual values and social values. White and others maintain that "large and complex societies will always be heavily constructed around organizational routines and institutional projects, from the perspective of which the appearance of difference will often elicit more irritation than delight. . .The real issue is. . .how to create slack and space within which the mood of delight can flourish "(White 1991, 90-129). For postmodern thinkers, such space is afforded through the idea of eternal return: whatever you will, will it in such a way that you could also, without regret, be willing its endless repetition. This is a very strong filter, eliminating many half-hearted wishes and undeliberated intentions. But it is not a perfectionistic or immobilizing one. A postmodern bioethics that is informed by the thought-experiment of eternal return disposes us to continue to choose and choose again, to actively

desire to see what will happen, to see what we will become--as individuals and as a people.

TLINGIT VALUES

T'aaw Chan Kaajaakwktì(Dr. Walter A. Soboleff), 1992 Associate Pastor, Northern Lights Church Angoon, Alaska

- Be obedient; the wise never test a rule.
- Respect elders. Also respect yourself so that others may respect you.
- Be considerate and patient.
- Be careful of how you speak, for words can be either pleasing or like a club.
- Your food comes from the land and sea. To abuse either may diminish its generosity. Use just what is needed.
- Pride in family, clan, and traditions is found in love, loyalty, and generosity. Share burdens and support each other. This is caring.
- Trespass not on others' rights. Or offer royalty or restitution.
- Parents and relatives are responsible for the family education of children.
- Care and good health are important for success of the person and clan.
- Take not the property of others. An error reflects on the family and clan.
- In peace, living is better.
- Through famine, ice age, sickness, war and other obstacles, unity and self-determination are essential to survival.
- Good conduct is encouraged to please the Spirit we believe is near.

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