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Against medical ethics: a response to Cassell

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Abstract

This paper responds to Dr Cassell's request for a fuller explanation of my argument in the paper, Against medical ethics: a philosopher's view. A distinction is made between two accounts of ethics in general, and the philosophical basis of health work ethics is briefly stated. The implications of applying this understanding of ethics to medical education are discussed.

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I am grateful to Dr Cassell for her perceptive attempt[1] to represent more completely my position in Against medical ethics: a philosopher's view.[2] She encourages me to argue for my Characterisation of Ethics, would like an explanation of my position on naturalism, and hopes I will declare the wide implications of my views. In what follows I try to meet her requests.

I would like to begin by remarking that I intended my paper neither to mislead nor trivialise. It was commissioned by *Medical Education* as a short editorial, which is why I had to leave so much unsaid. In any case, since I had already published extensively on the philosophy of health and medicine[3–5] by 1991, I felt entirely at liberty to write a "viewpoint" for a general audience.

Cassell seems unaware of my broader work,[6–8] yet despite this she comprehends some of my argument very well. She describes my position accurately in that :

1. "So far as relations between people are concerned, all our actions should be conceived of as 'ethical', and not just a special class of controversial or difficult decisions . . .. 'ethical' is to be understood here in the sense of having ethical content . . ."[1] (her words)

and

2. "It is not possible to distinguish ethical problems from non-ethical problems in the medical care of living beings" [2] (my words, quoted by her).

Cassell claims that because I hold 1. and 2. I must reject naturalism, which she says is:

" . . . roughly, the view that the claims of a field of knowledge - whether ethics, homoeopathy, astrology, or organic chemistry - can be fully represented in the language of natural science."

I think it would be an over-reaction to reject this idea, at least in regard to ethics. To describe ethical conduct as nothing other than a set of physical movements is arbitrarily to designate meaningful actions meaningless, and it is hard to see the point of this. Indeed, if Cassell's definition is accurate, naturalism is blind to the fact that :

i) actions, made by competent human beings, which have relevance for other human beings, inescapably have ethical content because they have the potential to affect others for better or worse

and

ii) all competent human beings have the capacity to recognise this.

Ethical A and ethical B

Because she has not had access to my extended thought Dr Cassell does not know the context in which the above statements sit, and I am unable to describe their full philosophical background here. However, it may be helpful to explain that i) and ii) form part of a theory of ethics in which there are two forms of the ethical, ethical A and ethical B, where ethical A means "ethical in the sense of having ethical content" and ethical B means "ethical in the sense of having a consistent view about what one ought to do in the social world".

Ethical A is a pervasive phenomenon of (competent) human life. Because we live with others in an ethical realm we constantly encounter ethical situations, whether or not we perceive them as such. To use one of Cassell's examples: being pleasant, unpleasant (or anything else) to the elderly and small children during a Saturday morning trip around Tesco's are ethical A actions - regardless of intent - because they have the

potential to produce different sorts of meaningful consequence.

Not every action is ethical A. Those of no relevance to other people lie outside the ethical realm. Idly playing with one's hair, tapping on the desk as one works, reflex responses such as the blink of an eye and so on, are not of ethical interest. Only if they become potentially or actually relevant to others are they ethical A actions (if desk-tapping is done in a shared office or if hair-twirling becomes an obsession which could interfere with one's relationships, for instance).

Ethical B actions stem from a person's awareness that what she does is socially important. The task for anyone who wishes to be ethical B is first to work out what "being ethical" means, and then to devise the most effective strategy to be it. Since the founding question of ethics is "How should I conduct my life in the presence of other lives?", the ethical challenge - at any time and in any place - is to work out what *commitment to living* to make. When a desk-tapper who wants to be ethical realises she is being irritating, it is up to her to work out what to do about it. She might decide to stop - or she might reason that she is entitled to continue - but whatever she decides, as she sees that her actions have implications for other people and resolves because of this to behave in a certain way, so she begins to create her ethical B.

Explaining ethical confusion

It may be further instructive to note that the ethical A/ethical B distinction can help explain why there is so much simultaneous consensus and dissent about ethics. Almost the whole of our waking adult lives are conducted in the ethical realm, and we find this overwhelming. We are quite unable to see it all at once and tend, therefore, to focus on (and sometimes become obsessed with) small parts of it only.

The scope and content of anyone's ethical B will be largely limited by the generally dominant perception of the ethical A (the cultural source of our consensus) - which is why most of us believe that some aspects of life are "ethical issues" and the majority are not. Everyday life offers endless illustrations of this phenomenon. To give just one example, it is nowadays common to consider the "extra-marital sexual exploits" of politicians "unethical", but their voting behaviours are rarely conceived of in this way. We are accustomed to seeing the former, but not the latter practices as ethical, even though both are equally part of the ethical realm.

Because people who live in complex societies are not always concerned about the same parts of the ethical A, or view them differently, it is common for us to disagree about what is ethically significant. For instance, many people who think of abortion as a central ethical issue do not worry at all about Third World debt, which others regard as responsible for considerably more fetal and infant mortality than abortion in the developed world. In this case, as in so many others, different people see the same aspect of the ethical A - the protection of young children and the unborn - from different angles.

Furthermore, we tend to assume that either a practice is ethical or not. And thus we are easily baffled when we discover that not everyone is ethically troubled by what troubles us, and regularly nonplussed when someone defines as unethical something which we are convinced is ethical. We may, for example, never have given a thought to "the ethics of modern farming", and be surprised to hear someone talk of farming's devastation of naturally occurring flora and fauna as unethical. We may quite fail to see the force of the anti-farming argument - deeming agriculture necessary, normal and ethically acceptable - not understanding how anyone can think of a field of wheat as an ethical issue.

Health work ethics

Dr Cassell may not have appreciated that my argument in *Medical Education* was based not only on the above general understanding of ethics, but also on the rather less comprehensive argument that work for health is a certain sort of moral endeavour[4] - a certain sort of ethical B. When I wrote, "It is not possible to distinguish ethical problems from non-ethical problems in the medical care of living beings" [2] I had both forms of ethics in mind. Firstly, not only is it generally true that actions made in the social world by competent human beings inevitably have ethical content, but health work - probably more than any other work - *exposes* this ethical A. Even something habitually dismissed as trivial - a smile for instance - is more obviously within the ethical realm in health work than it is in most other fields of human endeavour: a condescending smile offered to a sensitive and vulnerable patient might be extremely damaging, while a sincere smile of welcome could emancipate. Secondly, because the ethical A is so visible in health work, most health workers find it necessary to commit to some ethical B or other. Normally these ethical Bs are either vague (forms of "everyday ethics")[4] or based on principles and beliefs derived from sources outside health work (as is the case with almost all positions in contemporary medical ethics). Yet it is immeasurably preferable that health workers

practise according to a properly thought-out theory about what health work is and why they ought to do it.

The full explanation of my belief that health workers should make a commitment to a theory of health is long and involved[3–8] ("work for health" has a detailed and extensive meaning in my writing). Suffice it to say here that work for health is a moral endeavour because it necessarily involves the prevention or elimination of obstacles in the way of desirable and normal human potentials.[3] To work for health is deliberately to intervene in the lives of other human beings, hoping to improve or protect their circumstances in specific ways. If these interventions are consistently to achieve the highest degree of morality[4] a reasoned ethics B, based on a theory of purpose which sets various limits on health work, is essential.

Health workers must continually decide how best to conduct themselves in the presence of other - usually more vulnerable - lives. And if they do not:

" . . . identify obstacles to desirable (or natural) human development . . . establish that (they) can offer assistance . . . (and) make every effort to avoid doing anything which might create fresh obstacles to desirable development . . .".[5]

they fail to work for health.

My idea, in a nutshell, is that health workers should take as much *command* as they can of the ethical A by committing to an ethical B based on the foundations theory[3] of work for health.[8] It is impossible to defend this position adequately in a short paper, so I shall not try. Instead, if she would like a graphic illustration of my thinking, I recommend to Dr Cassell that she study the Ethical Grid,[4] paying particular attention to its coloured layers. If she does so she will immediately recognise that the outer three layers (the black, green and red ones) are analogous to the ethical A, and the blue layer is a simple summary of the ethical B I recommend to health workers.[4–11] She will also see that it is this ethical B that is meant to govern the Ethical Grid.

The application of this understanding of ethics to medical education

I would like finally to comment on Dr Cassell's more prosaic concerns. She writes that:

" . . .the natural/non-natural distinction is one of the foundations of medicine's sense of itself as a discipline"

and regrets that this dichotomy has led to a "rampant naturalism". While I share Cassell's unhappiness about this state of affairs, rather than decry naturalism I have preferred to point out other (albeit related) theoretical mistakes made by the medical establishment. The worst of these are to think of "health status" as necessarily related to "disease status", to think of disease as a special problem of human life, and to think of medical ethics as a separate subject. These and other philosophical naivetés help ensure the perpetuation of a system insufficiently flexible to deal optimally with the abundance and complexity of the human circumstances it encounters.[5–7]

Damaging myth

Even in the most liberal medical schools most medical teachers act as if medicine is a wholly technical enterprise which can be divided into numerous, largely separate sub-disciplines. In this compartmentalised world a general practitioner knows when to refer a patient to the gynaecologist. The gynaecologist can readily identify the point at which her role ends and that of the oncologist begins. The oncologist knows just when to hand over to the palliative care specialist, and so on. Of course, medicine has to be organised like this to an extent since there is so much to know, and doctors must specialise. Indeed, these arrangements work well enough on their own terms, but there is no reason why the *nature* of medicine should be inferred from administrative necessity. As Cassell points out, this mode of practice (and consequent ontology) is so deeply embedded that doctors are inexorably led to think of ethics as yet one more specialism. Once the oncologist runs up against an "ethical issue" with which she cannot cope she has been comprehensively conditioned to respond by asking, "to which specialist can I refer this problem?". In the past she most likely will not have had any other consultant to hand on to - she will have had to resolve it herself, as best she could. Nowadays, however, she is increasingly likely to be able to consult an "ethics expert", but to do this is simply to sustain the damaging myth that "ethics is merely an adjunct to medical activity".[9]

Dr. Cassell writes:

"It is time for us to begin exploring the possibility of medical knowledge without the naturalistic assumption. If Seedhouse's claim can be defended - if the ethical/non-ethical, and natural/non-natural distinctions are unhelpful in understanding the actions of medicine - we will have made a useful first step towards a re-working of medical epistemology." [1]

But this step has already been taken. I humbly suggest that the epistemology exists. Over the last decade I have developed a philosophy of health

meant to enable doctors and other health workers to practise coherently in the world as it is rather than as they imagine or would like it to be. My chief aims, in my various publications, have been first to show to health workers that their field is *steeped* in the ethical A, and then to explain to them how, by adhering to a well-specified theory of purpose, they can bring their work fully (both technically and ethically) under control.

For example, in *Liberating Medicine*[5] I wrote:

"As long as doctors continue to offer extensive human assistance in an uncertain world they must make judgements which are not strictly clinical. To decide whether or not to intervene in another person's life in a world of limited resources is, by its very nature, a social, economic and ethical judgement . . . Medical education produces doctors adept only at a range of specifically clinical subjects even though most will work as generalist health workers, as flexible carers who must make effective, sensitive decisions about both clinical and non-clinical issues."

I argued further that the essential characteristic of medical work is uncertainty - whether clinical, legal, ethical, emotional or semantic - and it is obviously inadequate to try to deal with comprehensive uncertainty by trying to minimise only its scientific/clinical/technical aspects. Rather it is necessary to adopt a theoretical framework (such as the Rings of Uncertainty, which I offer in *Liberating Medicine*) which can accommodate uncertainty by enabling the thoughtful doctor to work out the best path through it.

I concluded that:

". . . the best medicine stems from a realistic appreciation of the reality of working to remove obstacles to people's mental and physical potentials in an environment which is steeped with a variety of uncertainties . . . it (is) essential that doctors develop a view of their work which allows them to delineate their roles more precisely. This can be done by thinking of medicine as work for health, and by noting the limits on medical practice which can be derived logically from this outlook . . . . If these embryonic ideas gain credence in medical circles then a crucial step toward the liberation of medicine will have been taken."

Unfortunately these ideas have not gained credence. As far as I know they have not even been noticed by anyone interested in improving medical education. No doubt there are many reasons why *Liberating Medicine* has made not a scrap of difference to the medical world. But surely one of the most telling is the "*Catch-22*" that there is no mechanism within the medical edifice that could act on the book's recommendations, even if there were sufficient people within the system with a will to do so.

Stop promoting medical ethics

Which brings me back to the topic of my editorial.[2] Thinking of medical ethics as one more medical sub-specialism is not only conceptually implausible, it is counter-productive to the goal of establishing a comprehensively ethically sensitive discipline. I well understand that it is argued that "some ethics is better than no ethics" and that "ethicists should seize whatever opportunity they can to enter medicine, and do good", but these assumptions just do not hold up to sustained scrutiny.

The medical world is profoundly traditional: once a precedent has been set it is very hard to change it: once ethics has been taught as an adjunct, particularly if it has been found worthwhile (as it is, if the reports of medical ethics teaching carried in this and other journals are to be believed) then the die is cast. Moreover, once enough people with a particular interest or experience exist we tend to form specialist groups (or clubs, or tribes, or gangs) and there is ample evidence that ethicists/bioethicists/medical ethicists are no exception to this rule.[10] Indeed, since they are often either isolated within medical schools or spurned by members of their parent discipline (and usually both) ethicists are even more likely to band tightly together, and to reinforce both amongst themselves and for others the idea that their "discipline" is a separate and appropriate specialism. This has been the problem in the US, and has had the inevitable result that journals devoted to medical ethics have become incestuous talking shops for a small crowd of professionals.

Sadly, a similar situation seems set to occur in the UK. A recent editorial in this journal is as good an example as any of the way things are going. Raanan Gillon, adding his support to a move to establish a "medical school core curriculum for medical ethics and law" asks:

"Rather than each medical school inventing or re-inventing the wheel would it not be worthwhile for representatives from medical schools to get together and try to establish some mutually agreed core contents . . .?" [12]

On one level this suggestion is eminently sensible: non-clinical teaching in medical schools has always developed haphazardly, and this is undesirable - if such teaching is good for medical students in Liverpool and Bristol, for instance, it is good for the rest of them too. Yet on another level the

suggestion is unsustainable. In my opinion it is exactly like advising a soccer coach to set up, within a much larger coaching programme, a core course on "the importance of the football".

Good intentions do not guarantee good outcomes and I hope that if a group of medical school representatives is ever given the brief to assess a core curriculum in ethics and law, they will consider my criticisms and will come to understand that setting out on such a programme in the present medical context virtually guarantees the unfortunate outcomes I predict. Much more in hope than expectation I state again that medical ethics cannot have a core subject matter because "there (is) a moral aspect to almost all aspects of medical practice".[12] This is not a quote from my paper (I would say that good medicine is a moral endeavour, full stop) but is very close to my position - certainly near enough to require further thought from those who made it: the very members of the "DeCamp conference" who are proposing the core.

The way forward is not to sanctify another specialist discipline, but to appoint generalist teachers - teachers of general analysis and problem-solving in medicine - and to afford them equal status with clinicians. This is where the ethical glue really is.

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