Journal of Medical Ethics 1999;**25**:340–343

Debate

In defence of medical ethics

Michael H Kottow *Faculty of Philosophy, University of Chile, Santiago, Chile*

Abstract

A number of recent publications by the philosopher David Seedhouse are discussed. Although medicine is an eminently ethical enterprise, the technical and ethical aspects of health care practices can be distinguished, therefore justifying the existence of medical ethics and its teaching as a specific part of every medical curriculum. The goal of teaching medical ethics is to make health care practitioners aware of the essential ethical aspects of their work. Furthermore, the contention that rational bioethics is a fruitless enterprise because it analyses non-rational social events seems neither theoretically tenable nor to be borne out by actual practice. Medical ethics in particular and bioethics in general, constitute a field of expertise that must make itself understandable and convincing to relevant audiences in health care.

(*Journal of Medical Ethics* 1999;**25**:340–343)

Keywords: Bioethics; medical ethics; teaching; health care practices; rational ethics

A vivid discussion has ensued between David Seedhouse, a philosopher active in health care, and a number of practitioners, concerning the position of ethics in medical teaching and practice, as well as the value of bioethics in health care policies. Responses and clarifications have hardly brought about agreements, and it therefore seems pertinent to try and unravel the issues involved.

Is ethics a natural feature of medicine?

It all started with Seedhouse's contention that it is "not possible to distinguish ethical problems from non-ethical problems in the medical care of living beings".[1] This somewhat surprising conclusion which, if true, could mean the demise of medical ethics, is drawn from his more general premiss, that "actions, made by competent human beings, which have relevance for other human beings, inescapably have ethical content".[2] This may be going too far, for buying a newspaper, ordering a bottle of wine or competing in a marathon may be relevantly interactive and require a certain amount of etiquette, but thorough ethical analysis in these situations would constitute an over-kill. Interactions that are predominantly ethical are therefore different from those where decency and fair play may be called for without requiring a deep ethical commitment.

As applied to medicine, unquestionably all medical actions have dominant ethical components, although it is hard to understand why these components cannot be distinguished from the pragmatic aspects of health care. When an appendectomy is proposed, the physician-patient relationship is strongly charged with value considerations, but when actually performing the surgery, technical excellence will carry the day, because the ethical aspects - competence, accuracy, commitment, avoidance of maleficence - are presupposed as underlying constants of every action that involves the interest of others.

Such a pondering upon the ethical components of actions and the extent to which the agent is involving the interests and values of the affected others proves how distinctly we do in fact separate ethical from pragmatic aspects. Ethical analysis doesn't artificially dissect the moral from the practical aspects of actions. Rather, it makes obvious that the scientific, technical and pragmatic components of medicine can be looked at separately and distinguished from value considerations.

In Percival's writings, patient autonomy was of no concern.[3] Only since the 1950s has it become an ethico-medical issue how people die; the relevance of discussing the stand of Jehovah's Witnesses regarding blood transfusion is even more recent. All these examples show marked shifts in ethical concerns. On the other hand, medicine has been willing to adapt its practice to self-generated and often highly arbitrary ethical considerations, as is illustrated in the field of sexual surgery.[4] All these and many other situations where ethical stances were taken to justify abusive and innovative medical interventions are examples of a turbulent relationship between

J Med Ethics: first published as 10.1136/jme.25.4.340 on 1 August 1999. Downloaded from http://jme.bmj.com/ on January 27, 2023 by guest. Protected by copyright.

the practice and the ethics of health care, a relationship that varies throughout history, in the wake of social change and with ongoing analysis.

If one agrees that medicine is a strongly value-laden activity were practical and ethical matters are intertwined, one nevertheless can insist that the practice and the ethics can be distinguished from one another and their mutual relationships reassessed. The last 30 years have seen the growth of a discipline especially attuned to knowing enough about both medicine and philosophical ethics to develop a certain expertise called medical ethics which, like any other expertise, can be cultivated and passed on to others. After all, Seedhouse signs himself as "senior lecturer in medical ethics", making it hard to understand how he teaches a subject he believes is lacking in a "definitive core of knowledge" and devoid of its own theory, therefore "being parasitic on moral philosophy and clinical practice".[5]

Two moral levels

Perhaps it would be usefull to distinguish two moral levels in medical endeavours. The quest to help, to be of therapeutic use, which defines the essence of medical practice, is always inspired by the ethically benevolent and the technically most efficient way of curing with minimal harm. This level, in fact, is hardly amenable to ethical analysis because it pertains to the essence of medicine and is not unlike Seedhouse's "ethics A". On a second level, one finds all the moral issues concerning the significance of healing the body and the different values involved. Inasmuch as human beings seek to give meaning to their lives, specific ethical dimensions ensue in the particular medical act or health care decision. The major insight brought by medical ethics is that technical excellence must take into account, and at times may well become subordinate to, ethical considerations.

The practice of medicine is naturally ethical inasmuch as it always endeavours to do good and avoid harm in the context of deranged or disease-prone human biology. The nature of medicine is to cure and care in an intrinsically ethical fashion, as Seedhouse would have it. Medical acts are, in addition, ethically non-natural, that is, amenable to moral analysis that is distinct and at times even contrary to natural sciences. The whole issue of quality of life is a non-natural way of evaluating the efforts of life-sustaining measures. Criticism of the present system of medical care as being "unreal", whatever is meant by that, is only valid inasmuch as medicine may at times ignore the bioethical level of analysis. It is at this level that medical ethics will distinguish and comment on the values involved in medical practice, and these values vary and shift according to social contexts and individual actions, thus permanently requiring vigilant reflection.

The teaching of medical ethics

After being degraded to such a lowly species of academic activity, medical ethics should either not be taught "at all", or be taught in such a way that instructors make themselves "redundant as ethicists as soon as possible".[5] Seedhouse appears to be pretty much alone in holding such a view, for it is generally agreed that medical ethics must be taught, even though vast discrepancies prevail about how this teaching should be done. Against his contention, it seems quite appropriate for medical students to be taught by people who know what they are talking about because they have devoted time and efforts to culling the literature and reflecting upon medical ethics, in the quest for some clarity in the field. Having well-trained specialists teach medical ethics must be distinguished from the mistaken aim of generating "ethics experts". Physicians should become neither moral generalists nor specialists, but rather develop into practitioners who are aware of the ethical aspects of their work and remain receptive enough to accept new views as both practice and ethical analysis evolve.

Seedhouse may be falling into his own trap when quoting from his *Liberating Medicine*:

"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."[6]

One can easily read this text as proposing that physicians reach such high degrees of insight and sensibility, that they will be in danger of reverting to a strong brand of paternalism that takes decisions in the name of patients. At least in the text quoted, there is no mention that medical ethics will teach health workers to emphasise counselling rather than decision making, learning to defer to the wishes of autonomous patients even to the point of occasionally accepting that a bad technical decision taken by the patient may for his or her situation be the most adequate form of medical care.

Acknowledging medical ethics as a discipline will serve to enrich medical curricula, but it may also have the ill effect of creating elite groups, Seedhouse fears, which will become ineffective. That US "ethicists/bioethicists/medical ethicists" have created a club, actually three associations,

J Med Ethics: first published as 10.1136/jme.25.4.340 on 1 August 1999. Downloaded from http://jme.bmj.com/ on January 27, 2023 by guest. Protected by copyright.

and supposedly become "isolated within medical schools",[7] if at all true, is due less to the creation of a discipline, and rather more to the fact that, especially in the US, bioethicists have largely emerged from non-medical professions.

Rational bioethics and non-rational health policies and practices

Another area of discord unfolds in a paper where Seedhouse addresses bioethics,[8] apparently using the term to be synonymous with medical ethics, although the author had previously requested that medical students "at least" appreciate the difference between "medical philosophy", "bioethics", and "medical ethics". The point Seedhouse wishes to make is that medical situations and health care policies are "non-rational or irrational" systems where bioethical analysis can hardly "say anything useful....". I perceive some weakness in the argument, which begins by describing three family units that belong to a common larger family. The core families have very different material assets, an injustice to which a "conventional bioethical response" is suggested. Together with creating this situation and calling for its rational analysis, Seedhouse criticises the possible outcomes of such an exercise in ethical reflection. But his criticism stands on two weak tiers: different analysts would reach diverse solutions depending on their philosophical premisses; and second, the advice would not be heeded because it is unrealistic.

In the first place, it is by no means made clear why a bioethicist should be the appropriate consultant concerning unequal familial wealth distribution outside of a health care scenario. Second, ethicists certainly reach different conclusions, just as doctors often prefer different treatments or educators use a variety of teaching methods. It is the coherence of arguments that validates them, not the fact that they reach uniform conclusions; that is one good reason why ethics committees are preferable to single-person counselling. After all, prescriptive soundness differs from descriptive accuracy and from scientific truth.

Moving to the medical context, Seedhouse laments that clinical interactions in terminally ill neonates are based on "hunches and feelings". But that is exactly the point where medical ethics will rationally place its aims: to increase the precision of reflective argumentation, to enrich the texture of hunches and feelings in order to make them more generally acceptable, and to specify whose hunches, feelings and rationale must prevail in a clinical dilemma.

The second medical example presented by Seedhouse actually works against his contention that "rational bioethics" is impossible. Hepatitis C screening is described as "highly uncertain" but nevertheless pursued under the spur of political forces and economic lobbies, creating a situation where rationality is obscured by vested interests that bioethics is hopelessly inadequate to cope with. Now, the uncertainties of a screening test can be epidemiologically measured in terms of sensitivity and specificity, thus offering a fairly accurate quantitative assessment. In the light of this knowledge, bioethics will be able to judge how moral it is either to implement or to oppose screening, unveiling spurious forces that may be clouding what should and could be an ethically sound decision. Most communities have consequently decided that ample screening for HIV was not rational and therefore would be unethical. The fact that political or economic powers will not heed well-thought advice does not make it less rational or less mandatory. Sound bioethic reflection considers, and is itself influenced by, not only problems and dilemmas, but also by the circumstances where such problems and dilemmas occur, and by the individual idiosyncrasies involved.

The adequacy of ethical analysis is not to be measured by its actual impact on decisions and policies. In fact, Seedhouse himself acknowledges as much when lamenting that his views have been largely ignored, although he considers them correct and well argued.[8] Admittedly, physicians have at times been concerned that medical ethics might nibble at their authority and social power, but the same medical ethics has been welcomed by patients and would-be patients, having served well to make medical decisions more rational, more ethical and more humane. To press a point previously suggested, teaching medical ethics will, it is to be hoped, make all health care workers consistently aware of the strong ethical commitment that is expected of them.

Lazy bioethics

Finally, Seedhouse contends that bioethics has not done its homework, has avoided tackling major issues and lacks semiotic analysis of key concepts in health care. These deficiencies lead to an uncritical participation in medical discourse and excessive confidence in "reason and logic to solve bioethical dilemmas". There are only two ways out of these quandaries, he suggests: to be a philosophically alert and competent outside observer, or to get into the thicket of health systems and work in a "partially logical, partially emotional fashion".[8] As for the accusation of bioethical indolence, space will not permit the listing of

J Med Ethics: first published as 10.1136/jme.25.4.340 on 1 August 1999. Downloaded from http://jme.bmj.com/ on January 29, 2023 by guest. Protected by copyright.

all the publications that do in fact address the fundamental aspects of health, disease and medicine. Suffice it to remember that a number of journals carry titles that represent their dedication to the intertwinement of theory, philosophy and medicine. And Seedhouse's propositions about how to face the prevailing situation are not convincing, nor do they represent current academic attitudes. Bioethicists will continue to present their most stringent arguments as a contribution to solving clinical and public health dilemmas, but they will also acknowledge and honour less rational aspects such as fear, weakness, religious values and compassion. As for becoming a philosophically competent bystander, this may possibly enrich the philosopher's views, but it would be of no help in increasing the ethical excellence of clinical decisions in health care.

It would seem that the vast majority of scholars working in the field of practical ethics prefer to apply rational thinking to bioethical issues even in the light of adverse social realities, fully recognising that values and preferences have an ultimate core that is not amenable to logic. These scholars seek, I believe, by rational analysis to reduce this core to its true dimensions and to see that all those involved receive equal respect for their needs and interests.

Michael H Kottow, MD, MA Sociology, is an Ophthalmologist and Professor in the Faculties of Medicine and Philosophy, University of Chile, Santiago, Chile.

References

1 Seedhouse DF. Against medical ethics: a philosopher's view. *Medical education* 1991; **25**:280-2.
2 Seedhouse DF. Against medical ethics: a response to Cassell. *Journal of Medical Ethics* 1998; **24**:13-17.
3 Percival T. *Medical ethics* [3rd ed].Oxford: John Henry Parker, 1848: 27-68. Reprinted in: Reiser SJ, Dyck AJ, Curran WJ. *Ethics in medicine*. Cambridge, Mass: The MIT Press, 1978: 18-25.
4 Szasz T. Routine neonatal circumcision: symbol of the birth of the therapeutic state. *The Journal of Medicine and Philosophy* 1996; **1**:137-48.
5 Seedhouse DF. What I actually said about medical ethics: a brief response to Toon. *Journal of Medical Ethics* 1995;**21**:45-6.
6 Seedhouse DF. *Liberating medicine*. Chichester: John Wiley and Sons, 1988. (As quoted in reference 2: 16).
7 See reference 2: 16.
8 Seedhouse DF. Why bioethicists have nothing useful to say about health care rationing. *Journal of Medical Ethics* 1995;**21**: 288-91.
9 Childress J. Mandatory HIV screening and testing. In: Childress J. *Practical reasoning in bioethics*. Bloomington: Indiana University Press, 1997: 95-118.

J Med Ethics: first published as 10.1136/jme.25.4.340 on 1 August 1999. Downloaded from http://jme.bmj.com/ on January 27, 2023 by guest. Protected by copyright.