

Debate

Camouflage is no defence - a response to Kottow

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Abstract

The author responds to Professor Kottow's criticisms, explaining numerous errors and misconceptions.

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I have criticised medical ethics/bioethics for not seating ethical analysis in social context, implicit conservatism, poor scholarship and inadequate reasoning. Professor Kottow's attempt to discount my critique serves only to provide further evidence of each of these shortcomings.

There is little sense in restating my assessment of the state of contemporary medical ethics, but it may ultimately be constructive to point out the considerable number of flaws in Kottow's reading of my position.

The nature of ethics

Professor Kottow thinks I may go too far when I say that:

"... 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".¹

In his opinion:

"... 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 overkill."²

But Kottow synthesises two points that ought to be separate. The first is meant to deflate my claim that human interactions inescapably have ethical content. The ethical content of buying wine, newspapers and running marathons is merely "etiquette", he says. Yet despite their ordinariness,

Kottow's examples do not support his case. Although such interactions usually will turn out to be ethically unimportant, each always has massive ethical potential. If you buy a bottle of wine arrogantly from an already downtrodden waitress, exchange cheerful conversation with a forlorn newsagent, or decide to cross the finish line holding hands with a fellow competitor then your actions may have profound ethical implications. The ethical realm is where each of us can affect others' lives for better or worse, and Kottow's examples are squarely in it.

His second point is that to undertake thorough ethical analysis in commonplace situations would "constitute an overkill". Of course this is right. It usually would. It would be foolish to advocate comprehensive ethical contemplation in every life situation, but this doesn't mean that commonplace actions don't have ethical content.

Professor Kottow continues:

"Interactions that are predominantly ethical are therefore different from those where decency and fair play may be called for without requiring deep ethical commitment".²

This statement is so vague - Kottow defines neither "predominantly ethical" nor "decency and fair play" - that it is impossible to tell whether it is tautologous or paradoxical. It may merely be circular, saying nothing more than "predominantly/deeply ethical actions don't involve decency and fair play because being decent and fair are not predominantly/deeply ethical actions". But it is more likely that by "decent and fair" he means "following socially accepted conventions" (like not cheating in marathons, for instance). If so, he is wrong.

I can't speak for Professor Kottow, but most people know it isn't always easy constantly to be decent and fair. To behave according to social rules when it is tempting to break them is a personal challenge which does require deep ethical commitment (to notice the waitress

demeanour and be kind when you are feeling self-important, to force yourself to chat happily when you are miserable, to cross the line with a competitor when you could have won - ethical resolution is essential for decisions like these). Furthermore, decency and fair play are hardly minor matters to those who think they are being treated indecently and unfairly. Amnesty International, for instance, would rightly be jubilant if their understanding of human decency were to prevail universally.

Kottow's version of medical ethics

For clarity's sake I paraphrase Kottow's understanding of medical ethics. He is of the opinion that medicine is "intrinsically ethical" - its ethical constants "presupposed" (though he does not say by whom):

"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."²

Sometimes, he observes, medicine may "ignore the bioethical level of analysis" and so we need a vigilant medical ethics to distinguish and comment on the values involved, which change over time and social context. In short, Kottow believes that:

- a) It is easy to tell the difference between ethical and technical aspects of health care.
- b) Medicine is both technically excellent and fundamentally ethically sound (as a matter of fact, it seems).
- c) The ethical basis of medicine - the benevolent quest to help - underlies all medical practice and is unquestionably morally admirable.
- d) There is a second level of ethical analysis (the only level of concern to medical ethics) in which transient social trends may be identified and their values applied by medical ethicists from time to time, to mediate medicine's undoubted technical excellence.

And that's about it, as far as I can tell from Professor's Kottow's paper: medicine is essentially morally perfect, all doctors have their patients' interests at heart, occasionally doctors may get a little carried away by their technical brilliance, but we can rest assured that medical ethicists will keep clinicians' values on the right track. He may have defined his terms and made an extended case in other publications (he doesn't reference any), but on this evidence his thinking is typical of the com-

placent, scarcely argued establishment protectionism which is by no means always benevolent.

It is hard to know how to respond politely to such a self-satisfied parody. I am tempted to say: tell that to the women with cervical cancer experimented on at National Women's Hospital in Auckland,³ tell that to the psychiatric survivors movement, tell that to patients of doctors happy to take whatever inducement drug companies throw onto their expense accounts, and tell that to the children who have been severely damaged by incompetent surgery⁴ and negligent physiotherapy in two recent scandals. But these malpractices - and the countless others I continually encounter in my work⁵ - are not the heart of the problem. What I find so disturbing about Professor Kottow's serenity is that he seems unaware of the following demonstrable truths:

- a) The goals of medicine are disputed.⁶
- b) It is not always practically possible to be both benevolent and efficient.⁷
- c) There is not enough medicine to go around, even in the developed world.⁷
- d) Medical services are rarely equitably distributed, and those doctors who practise private medicine perpetuate this social injustice.⁸
- e) "Technical efficiency" depends on what your goals are. For example, according to an alternative understanding of the concept, it is more technically efficient to ensure full employment than to pay billions of dollars for mood-altering, physically damaging psychiatric chemicals.⁹

Scholarship

Professor Kottow's orthodoxy is based on precarious scholarship. He claims, for example, that:

"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."²

But he offers neither evidence nor references in support of this incredible claim.

Twenty minutes in my medical school library was sufficient to prove Kottow wildly wrong. My instant research uncovered *The Case for Euthanasia*,¹⁰ published in 1931 and *The Doctor Looks at Euthanasia*, which was published in 1939¹¹ and also a monograph¹² containing other references from the same era. *The Encyclopedia of Bioethics* has this to say about "historical perspectives" on euthanasia:

"... in prehistoric times, measures had been taken to hasten death ... the combination of tolerance

and unconcern that allowed such practices was ended during the rule of Christianity in the medieval West ... upon entering the domain of medicine, with Francis Bacon's *Advancement of Learning* (1605), 'euthanasia' increasingly came to connote specifically measures taken by the physician, including the possibility of hastening death."¹³

The same encyclopedia explains that the Jehovah's Witness sect has roots in the Protestantism of Martin Luther (1493 - 1546) and John Calvin (1509 -1564), and discusses other factions that have followed similarly radical policies in relation to medical care, many decades before the 1950s.

Professor Kottow also passes the comment that:

"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'"²

But if he had read my editorial in *Medical Education*¹⁴ at all properly he would have his answer (it is the first reference he cites). In it I wrote:

"It may seem paradoxical to be arguing from a Unit for the Study of Health Care Ethics that there is no such thing as medical ethics, and also to be teaching courses in ethics to undergraduate and postgraduate students. But it is not, for critical thinking about health care activity is a very different enterprise from establishment medical ethics. The aim of enhancing general thinking about health care activity is to refuse to take a specialised focus and instead to encourage students to think critically, drawing on as much relevant theory and evidence as possible, in order to resolve difficulties of intervention.

The reasons for working under the present label are simply political and pragmatic."¹⁴

Kottow also thinks that what he calls "the essence of medicine" "is not unlike Seedhouse's 'Ethics A'", but again he is completely wrong. In fact he is describing a vague example of ethics B, not ethics A.

He is not alone in this misunderstanding, so it may be worth repeating my position. I argue that: "...ethical A means 'ethical in the sense of having ethical content'"¹

and ethical B means:

"...ethical in the sense of having a consistent view about what one ought to do in the social world"¹

Thus Kottow is asserting an ethics B when he declares that the essence of medical practice is benevolence and efficiency and that it is based on

an intention to cure disease with minimal harm. He says that this essence is "hardly amenable to ethical analysis", but this is not so. It is only unanalysable if the terms are allowed to remain obscure. When rendered meaningful, benevolence, efficiency and harm are contestable ideas (they are ethical B notions, in other words): to practise medicine according to them is to behave in one way rather than another. Presumably "being benevolent" does *not* mean discriminating against the sickest patients; "to cure with minimal harm" does *not* mean causing damage to some patients in order to bring about greater good for others, and being "technically efficient" in Kottow's sense rarely implies a quest for an even distribution of services.

Even if it does not entail these understandings, Kottow's essence must mean something specific in practice. Medics - to be medics at all - must commit to particular ways of intervening. No one can commit to ethics A because:

"Ethical A is a pervasive phenomenon of (complicated) human life. Because we live with others in the ethical realm we constantly encounter ethical situations, whether or not we perceive them as such ... being pleasant, unpleasant (or anything else) to the elderly and small children during 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 Ethical B actions stem from a person's awareness that what she does is socially important 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."¹

You decide whether or not to be a doctor. Then you decide how to do it (and there are many choices open to you - not just Kottow's nebulous ideal). You live in the ethical A realm - you decide what ethical B (if any) you should be.

I should also add that I most certainly do not think that "the nature of medicine is to cure and care in an intrinsically ethical fashion" as Kottow imagines I do. In my view there is nothing *intrinsically* ethical in any Ethics B. Ethics A is the content of situations, Ethics B can be any of countless singular ways of *responding* to Ethics B.

Further misconceptions

Professor Kottow takes a single sentence, which I quoted from a 198-page textbook,¹⁵ and draws preposterous conclusions. He says:

“Seedhouse may be falling into his own trap when quoting from his *Liberating Medicine* ... (O)ne 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.”²

I have four objections to this suggestion. Firstly, it takes quite some imagination to turn “effective, sensitive decisions”^{2 15} into “strong paternalism”. It is certainly not *easy* to read this in, even from the isolated extract. Secondly, it is far easier to suppose that Kottow himself is in favour of strong paternalism, since he thinks medicine has a universal, benevolent essence which cannot be specified (a classic recipe for paternalism). Thirdly, because a brief quote makes no mention of “counselling” and “deferring to the wishes of autonomous patients” this is hardly evidence that these ideas are not advanced elsewhere in the book. Fourthly, it is astonishing that a learned professor should not bother to look at the book itself before making (and publishing) ridiculous guesses. If he had done even the most perfunctory research into my work he would have realised how woefully misdirected his criticism is.¹⁶

Kottow is further puzzled by my paper, Why bioethicists have nothing useful to say about health care rationing, in which I argue that bioethicists make inadequate assumptions about social reality and use rational methods to solve problems that have arisen in non-rational or irrational contexts. Like my other criticisms of medical ethics this observation is commonplace amongst health workers on the ground, who are well aware that what matters in the medical world is power and influence rather than reason and logic.¹⁸ Nevertheless Professor Kottow can't understand it.

He seems so blinded by convention (is it really the case that ethics committees produce arguments more coherent than those produced by individuals?) that he cannot read what is on the page. Apparently I “lament” that clinical interactions in terminally ill neonates are based on “hunches and feelings”. But I don't. I merely describe what is the case (and nowhere do I say the baby was terminally ill - she wasn't). Furthermore, enriching the “texture” of hunches is not bound to make them “more generally acceptable” as Kottow imagines - it can have quite the opposite effect, of course. Nor can medical ethics:

“... specify whose hunches, feelings and rationale (*sic*) must (*sic*) prevail in a clinical dilemma”²

because - even according to Kottow's conception of medical ethics as a second-order debating chamber - it is never definitive.

My point in using this example was that to think like Kottow (and most other bioethicists/medical ethicists) is to put a gloss of rationality on what are essentially arbitrary situations and decisions, and that if we are to change anything we must accept this first.

Professor Kottow totally misses the mark yet again when he mentions my Hepatitis C example. Remarkably, he thinks that because it is possible to judge the effectiveness of the testing kits bioethics is enabled to:

“... judge how moral it is to either implement or ... oppose screening”.²

But not only does this confuse what is for what ought to be, it is a wholly irrelevant point. The issue was never whether the kits give reliable results (apparently they do), but how to make meaningful decisions about the implications of possible test results when *everything else* in the situation was nakedly political.

Furthermore, a more measured scrutiny of my actual words shows that I made no reference to “highly uncertain” screening, as Kottow reports. I actually said:

“... prognosis, prevention, management and treatment of Hepatitis C are highly uncertain ...”.

Current attitudes

Finally, Kottow concludes that my propositions are:

“... neither convincing nor do they represent current academic attitudes.”²

To this I reply that I'm not convinced by the propositions Kottow thinks I'm making either. I do, however, place considerably more store by the actual argument and theory about the nature of health and ethics that I've developed in numerous journal papers and nine books.¹⁹ Furthermore, if “current academic attitudes” in medical ethics remain socially blinkered, conservative and philosophically insightful then I am delighted not to hold them. Kottow does not explain how:

“Bioethicists will continue to present their most stringent arguments as a contribution to solving clinical and public health dilemmas ...”

and

“... acknowledge and honour less rational aspects like fear, weakness, religious values, compassion”.²

Indeed he does not define any of these terms so it is impossible to judge whether fear and religion really are less rational than bioethics. We are left, as we almost always are in medical ethics/bioethics, with assertions passing for arguments, and fairytales about progress and unity. We are assured, for example, that rational analysis can reduce conflicts between logic and value so that everyone involved will be respected equally. But Kottow gives no examples either of how conflicts between values and logic can be reduced by rational analysis (is it really so obvious that they can?) or of actual situations in which bioethics has ensured universal equal respect for all involved.

Despite Professor Kottow's certainty that I am in a minority of one I am sure that I'm not alone in recognising that this - and many similar - circuitous apologies for medical ethics are designed to leave the status quo - with all its inequity and greed - untouched and as politically powerful as ever.

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