

## 'The implications of medical ethics'

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*Professor Goldworth takes up the cudgels in defence of the contemporary moral philosopher, who, he says, should indeed have a role in helping doctors to make clinical decisions based on philosophical theory; Mr Thompson in his reply says that Professor Goldworth has misinterpreted his earlier argument. Mr Thompson reiterates his view that the practice of medical ethics must begin with the professionals – the doctors and nurses – although the philosopher could perhaps find himself part of a medical team. In these circumstances Professor Goldworth and Mr Thompson would be in complete agreement. Both writers seem to be reflecting very clearly the ideas current in American and British climates of opinion.*

Mr Ian E Thompson's article, *The implications of medical ethics* (*Journal of medical ethics*, 1976, 2, 75–82), is so replete with uncommonly good insights that I hesitate to take issue with several points he made. My hesitation stems partly from the desire to be perceived as being in Mr Thompson's corner, notwithstanding my reservations, and partly out of fear that the expression of these reservations will be taken as nothing more than the grumblings of a contemporary philosopher who has been provoked by accusations of being pedantically irrelevant. However, I take heart in the possibility that those who are in the caring professions care enough to suspect that perhaps the moral problems arising from the complexities of modern medicine are so unsettling that medical practitioners can use all the help they can get: even, perhaps, from the contemporary philosopher.

### **Moral intervention in clinical practice neither irrelevant nor impertinent**

Mr Thompson observed that 'the very nature of the personal moral responsibility demanded of individuals (or groups of individuals) in making difficult moral decisions in clinical practice makes moral intervention from the outside – from the church or state, from lay pressure groups or commercial interests – both irrelevant and impertinent' (p 74). Mr Thompson would be perfectly correct in so viewing outside interests if the moral responsibility demanded of those in clinical practices resulted in satisfactory moral conduct. But in some instances practitioners are unaware

that a moral problem exists when, in fact, one does. And in other instances the conflicting judgments and attendant behaviour of practitioners, with respect to such moral issues as the boundaries of health care, the nature of the physician-patient relationship, truth telling, confidentiality, and paternalism suggest that the resolution of these issues require a good deal more detailed and systematic thinking than they heretofore have been given. One can appreciate the fact that moral intervention from the outside may seem particularly inappropriate to those who are confronted daily with the problems of the sick. But one must also recognize that such daily confrontations, however tinged with moral significance, do not automatically yield morally justified responses on the part of the clinician.

Mr Thompson observed, in support of his claim that contemporary moral philosophy is of little help in dealing with problems in the medical setting, that 'Philosophers appear to take refuge in meta-ethical descriptions of the "constitutive" and "regulative" principles of moral discourse as such or in sophisticated discussion of the trivia of the logic of the language of morals, thus avoiding the problems of our historical situation and the concrete dilemmas of individuals' (p 74). Unless Mr Thompson believes that all philosophers are of the sort described in the quotation, which is clearly false, or he assumes that all philosophers must provide 'practical moral wisdom, not theoretical knowledge', in the domain of medical ethics, which is clearly unwarranted, his observations are quite misleading. There have been simply too many books and articles written by philosophers which have attempted to deal directly with issues in medical ethics for me even to begin to enumerate. A perusal of the bibliographies offered by the Hastings Center, The Center for Bioethics of the Kennedy Institute, Washington DC, should help dissuade physicians and perhaps Mr Thompson that contemporary philosophy (along with contemporary law, economics, sociology and psychology) is irrelevant in the area of medical ethics.

### **Practical wisdom based on philosophical theory**

But, it is equally important to recognize that declaiming against theoretical knowledge of the

sort described in the above quotation does not constitute a reason for discounting all theoretical knowledge. Indeed, without theory what passes as practical wisdom may turn out to be incorrect. The following example should help make this last point clear.

For reasons which, I believe, have to do with the role of the physician as healer, and the physical and attendant psychological differences between letting something happen and making something happen, physicians generally believe that there is a clear moral difference between active and passive euthanasia: the former being categorically wrong; the latter, in appropriate circumstances, being morally permitted or right. Although I am unaware of the position on this issue of British medical organizations, I do know that the American Medical Association has endorsed this distinction. Yet, there has been a debate among philosophers for the past 10 years which has raised considerable doubts concerning the distinction made, and there is at least one philosopher who has concluded on powerful grounds that there is no significant moral difference between letting die and killing. It is not my purpose here to deal with the arguments and conclusions reached in this debate, but rather to call attention to the fact that theorizing on the part of the contemporary philosopher can determine what will legitimately pass for practical moral wisdom. To ignore such theorizing can convert purported wisdom into groundless opinion.

I have used the example cited to support my contention that not all contemporary philosophy is pedantically irrelevant. It does not follow that relevant philosophical theorizing will typically undermine the conventional moral wisdom of physicians. It is more likely to clarify and refine the moral outlook of a physician. And in doing so, it can serve as an indispensable aid in dealing with moral problems generated in the medical domain. Rather than viewing contemporary philosophy as irrelevant and its practitioners as worthy only of contempt, I would hope that what I have said provides a more balanced and positive perspective on the relationship between medicine and philosophy.

## The role of the philosopher in the medical team

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If the remarks which Professor Goldworth quotes are read as an expression of my own views rather than as a paraphrase of the views of the medical profession, then it is not surprising that he concludes that I am hostile to philosophy. However, as a moral philosopher I could hardly consider theo-

retical knowledge irrelevant or unimportant. In fact, I should have hoped that my own theoretical observations in the paper in question would have given the lie to that opinion. The article is, among other things, intended as a plea to academic philosophers to become more directly concerned with the problems of medical and professional education, and, insofar as they are concerned with medical ethics, to be less concerned with moral theory in general and more concerned with first-order moral problems in the context in which they arise. The relevance of moral theory has to be demonstrated in practice.

### Medical ethics must begin with the doctors

Professor Goldworth's argument is itself interesting because it seems to suggest (specifically in his discussion of the distinction between active and passive euthanasia) that philosophers have some special kind of theoretical advice to give doctors and ordinary people. What is this special theoretical knowledge to which philosophers are privy and which seems to be independent of particular situations and contexts? I would prefer to adopt a more agnostic position, for I do not believe that their skill in conceptual analysis gives philosophers some kind of privileged access to moral truth. The particular skills which philosophers have developed have relevance and significance only when they are applied to the examination of real life problems in the contexts in which they arise. If philosophers want to make a meaningful contribution to medical ethics they must get into medicine, get inside the institutions which shape our values and shape our lives. I am far from thinking that doctors have a monopoly of wisdom in medical morality. In fact, nurses are often more sensitive to the moral dilemmas in medicine, because they are closer to the patients. However, doctors are still, and likely to remain, the ones who take the final decisions, and who have to carry the final responsibility. Practical research in medical ethics must begin then with doctors, patients and nurses, and, if moral theory is to be brought in, it is only when the peculiar issues surrounding *this* patient in *this* situation have been clarified.

### Role of the philosopher in the medical team

If in some instances, as Dr Goldworth suggests, 'practitioners are unaware that a moral problem exists, when in fact, one does' is it the philosopher *qua* philosopher who must or can disclose the unrecognized moral problem? I suggest it is highly unlikely that the moral philosopher would even be aware of such a problem unless he was part of the clinical team, participating in the decision-making process. If that is what Professor Goldworth means I could not agree with him more, but how man-

moral philosophers are willing to get involved so directly in medical ethics? I would certainly endorse his comment that the conflicting judgments of health care professionals 'with respect to such moral issues as the boundaries of health care, the nature of the physician-patient relationship, truth telling, confidentiality' etc . . . 'require a good deal more detailed and systematic thinking than they heretofore have been given'. However, it does not follow that they cannot clarify these issues without the help of a philosopher. All that is required is that those involved should reason together about the moral problems in a philosophical manner.

There have obviously been some philosophers who have been prepared to concern themselves seriously with the substantive issues in medical ethics, but the number of British philosophers who

have shown any interest in this increasingly important area of social morality is very small. Few moral philosophers concern themselves with the practical problems of decision making and even fewer see their role to be concerned with moral education. Doctors, nurses and other health care professionals are confronted with the need for practical action, often in situations of crisis and stress. Their need is for a more practically orientated moral philosophy rather than for instruction in the niceties of moral theory. Health care professionals may need to be encouraged to be more self critical in their approach to moral questions, more detached perhaps. Philosophers need to be more involved, need the humility perhaps to work alongside their medical colleagues and to share some of their practical dilemmas and often painful responsibilities.