
Editorials

Medicine and moral philosophy

Professor of medicine: '... ethical philosophy is qualitatively different from and irrelevant to clinical teaching' (1). General practitioner: '... the present debate provides an overwhelming case for teaching ethics in medical schools' (2). Moral philosopher and medical ethicist: '... ethics is not the spooky metaphysical business that Swales makes it out to be' (3). Professor of medicine: '... the burden of my article has clearly escaped Drs Arras and Murray' (4).

One of the clearer lessons which emerges from the symposium on medical ethics from which the above scene is taken is that doctors and philosophers are often intensely suspicious of each other and where suspicion is intense understanding is usually clouded. Yet with such a strong *prima facie* case existing that moral philosophy *can* offer a valuable perspective for the study of medico-moral dilemmas something surely needs to be done to reduce this suspicion and increase mutual understanding.

One of the stock complaints from both sides is that the other is too ignorant of its approach and basic practice. Thus doctors complain that philosophers produce airy fairy intellectual arguments, schemes and systems which ignore the realities of medical practice while philosophers complain that doctors make moral decisions often without even recognising that they are doing so and in general on a simplistic and *ad hoc* basis involving little or no awareness of the underlying moral assumptions and their complex implications, and little or no awareness of opposing moral positions.

How can matters be improved? One obvious answer is for both sides to acquire some more basic education in each other's discipline. So far as philosophers are concerned an idea offered *en passant* by the President of the Royal College of Physicians might perhaps be developed to include them. In a commentary on a paper by a scientist who among other things complained that medical scientists who were not medically qualified got a raw deal from the medical profession Sir Douglas Black suggested that 'some day a far-sighted and well endowed university may offer laboratory scientists a one-year MSc course in clinical medicine' (5). He envisages this starting with a three-month introductory course similar to those taken by medical students entering their clinical years and including lectures and seminars dealing with inborn and

environmental determinants of illness, with major patterns of disease and with the main methods of diagnosis and treatment. Concurrently there would be attachments to clinical work both in hospital and in the community, the type of attachment being chosen by the student. The course would lead to a qualification which 'would attest some real experience of clinical work but would not confer the right to practice.... Actual experience of practical medicine might make people less prone to the errors of either romanticising or trivialising medicine' (5).

The proposal seems to be an excellent one, and not just for scientists and social scientists as Sir Douglas suggests but also for philosophers, theologians, lawyers and others with a serious professional and/or academic interest in medical practice, including of course medico-moral aspects of medical practice.

There can be no doubt that the suspicious and already primed defence reflexes of many doctors are often triggered by the obvious lack of understanding of the realities of medical practice manifested by some of those who demonstrate a non-medical interest in medical ethics. The latter however, usually find themselves in a doublebind for if they wish to increase their experience of medical practice they are likely in Britain at least to be rejected because of their alien and medically ignorant backgrounds. (For example, the desire of a professor of philosophy – known to the writer of this editorial – to be involved in just such clinical experience has so far gone unrequited). Sir Douglas's proposal would surely benefit both sides.

Conversely it seems entirely feasible for interested doctors and/or medical students to have basic academic training in relevant non-medical subjects such as philosophy, law and theology. The possibility of a one-year master's degree in medico-moral philosophy orientated specifically to doctors is under active consideration in at least one British university. Although it will not satisfy some philosophy academics who will claim that the standards achievable in only one year will be too low, it would be unrealistic to expect doctors – even interested doctors – to spend longer. Provided the function of such a year was clearly defined as being introductory – just as the medical year for non-doctors proposed by Sir Douglas Black is seen as introductory – the benefits would surely greatly outweigh the

disadvantages. Among other possibilities are the introduction for interested undergraduates of an intercalated year of philosophy (specially tailored for medical needs) in the preclinical curriculum, along the same lines as those already developed in London University for sociology and psychology.

Philosophy departments might also consider taking up the Apothecaries' Society's idea of a diploma course for medical personnel in the philosophy of medicine, by providing an introduction, via a weekly or fortnightly series of lecture-seminars, to contemporary Anglo-American philosophical method.

Contacts between the relevant disciplines could also be profitably expanded by interdisciplinary lecturing, as already happens in Edinburgh University and King's College London, where philosophers, theologians and lawyers give lectures and seminars on medical ethics to medical students. And of course at an informal level the London Medical Group and associated student groups throughout Britain continue to provide valuable cross-disciplinary discussion. Imperial College (London, SW7) recently held the first British course on medical ethics for medical and nursing teachers and Oxford University External Studies Department (3-7, Wellington Square, Oxford) has begun to hold weekend seminars on morals and medicine.

One or two other opportunities for interested doctors to participate in philosophical activities are worth remarking. The Royal Institute of Philosophy, although its activities are aimed primarily at philosophers, also admits as members interested non-philosophers to whom its lectures and some of the papers published in its quarterly journal, *Philosophy*, will be accessible. The October 1982 issue for example, includes papers on 'The justification of morality', 'The choice between lives', 'Character, virtue and freedom' and 'Rationality and paternalism'. Membership of the Institute (14 Gordon Square, London, WC1) costs a mere £10 per annum and includes a subscription to *Philosophy* as well as access to the evening lectures.

A further opportunity for interdisciplinary discussion has been created with the establishment of the Society for Applied Philosophy, which holds conferences and intends to publish a journal of applied philosophy. The first medically orientated activity of the society is a workshop on philosophical and ethical issues in medicine and science policy, to be held on March 12 in London. Details of the society's activities are available from its Secretary, Brenda Cohen, Philosophy Department, University of Surrey, Guildford. Finally, other journals concerned with philosophical issues related to medicine include: *The Hastings Center Report* (bi-monthly - details from The Hastings Center, 360 Broadway, Hastings on Hudson New York 10706); *The Journal of Medicine and Philosophy* (quarterly; D Reidel Publishing Company, PO Box 17,3300 AA Dordrecht, Holland); *Theoretical Medicine* (formerly *Metamedicine*; quarterly; also published by D Reidel). And a new British journal called *Explorations in*

Medicine which concerns itself with the philosophy of medicine is also planned.

Moral philosophy needs real moral problems to keep its thought nearer the ground. Medical practice needs more philosophical awareness if it is to cope adequately with its endless supply of real moral problems. It would be a tragedy if the obvious potential for a symbiotic relationship between the two disciplines were to be frustrated by reciprocated ignorance and distrust.

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On paternalism and autonomy

One feature of Mark Komrad's stimulating and broad-ranging paper in this issue defending a limited medical paternalism designed to restore or maximise a patient's autonomy requires comment. Komrad argues that 'all illness represents a state of diminished autonomy' and that it is this which justifies paternalistic medical interventions to restore or maximise this impaired autonomy even if these over-ride or ignore the patient's own desires. In considering this claim it is important to distinguish not only as Komrad does between impairment of the ability to make autonomous choices (impairment of 'autonomy of will' and Komrad puts it) and impairment of the power to implement one's choices (impairment of 'autonomy of action') but also between these *concepts* of autonomy and the quite separate issue of what are the morally appropriate responses to such impairments. It is the latter which is addressed by the *principle* of autonomy. Even if a person's autonomy or freedom of action is almost entirely eliminated (for example by quadriplegia) this fact in no way entails that his freedom of autonomy of will need not be respected (the theme of the play *Whose life is it anyway*); and even if his freedom of autonomy of will is considerably impaired this in no way entails that what is left should not be respected.

Mill's principle of autonomy quoted by Komrad offers only two qualifications: we must not interfere with other people's freedom (or autonomy) of thought and action provided these do not harm others and provided that the people thus respected possess rather basic level of maturity (a capability 'of being improved by free and equal discussion'). Komrad, in suggesting that we need fully respect the autonomy only of those enjoying some (probably mythical) state of *maximal* and/or unimpaired autonomy of will and action is proposing a radical modification of Mill's widely accepted principle of autonomy. By his arguments *no* patient need have his autonomy fully respected since this autonomy is always impaired and 'never maximal'.

There will be those who for other reasons reject Mill's principle of autonomy: but Komrad's alternative proposal, attractive as it will be to many, simply does not follow from the alleged fact that illness always represents a state of diminished autonomy.

person, despite the danger that her deteriorating medical condition would make her more into an object to be appropriately managed. Once the question had been broadened out from the request for assisted suicide to this much more general and easily honoured request, the old relationship between doctor and patient could be re-established, without the parties feeling that their independence had been jeopardised as a result.

However, the outcome need not have been as fortunate as this and the moral issues remain important. Dr Carstairs questioned whether what he had done was either legal or moral. Leaving the question of legality aside, I would say that from a moral point of view a direct agreement to her request would certainly have been morally wrong. She wanted him to use his knowledge as a doctor to counsel her as to how she might effectively kill herself. This is a request which, as a doctor, he was bound to refuse. The knowledge he had acquired about the lethal nature of drugs should not have been put to this use, since the whole point of the knowledge is to enable him to diminish pain and, if possible restore health, not to administer death. The issue might be clouded by the friendship between the doctor and the patient, but this is precisely what the word 'clouded' suggests – an obscuring factor – which must be ignored in order to see clearly what might be involved. From an ethical point of view, if it had been right for Dr Carstairs to meet Miss Gentilian's request, it would be right for him to meet the request of any patient who wished to draw on his medical knowledge in order to kill herself.

At the same time Dr Carstairs showed considerable moral sensitivity by not attempting in any way to bully Miss Gentilian out of her desire to commit suicide. He

pointed out quite appropriately to her that the pain-killers she already possessed could, if she chose, be taken as an overdose. This left the responsibility where it belonged – with her. Her request might have tempted him into a paternalistic stance – into insisting on the return of all dangerous pills for fear that she might kill herself. His refusal to respond in this way safeguarded a second moral value, the value of autonomy of decision-making, which medicine too frequently hazards in the name of 'health'.

Let us suppose, however, that the patient had taken an overdose of the pain-killers which her doctor had deliberately left in her keeping. Would Dr Carstairs then be 'legally in the wrong but emotionally right'? From my layman's perspective on the law I cannot see that he would have been legally culpable in any way. He did not over-prescribe nor did he promise to be 'negligent' in any ordinary understanding of that term. His agreement not to resuscitate and not to call an ambulance seems to be in line with a general understanding of appropriate medical practice with someone who is so seriously and irremediably ill. So far as emotions are concerned, no doubt he would have felt considerable grief and guilt had his patient killed herself. In such a situation, however, someone would have had to help him see that much of this emerged from his deep involvement with the patient and her illness. Miss Gentilian was what could be described as a 'character' and if she had really wanted to commit suicide one might be sure that no one could have stopped her. As it happened, she just wanted to make a gesture about dying in her own way. Whatever she did she would have done it in her fashion and that remains the important moral value in such a case.

(Continued from page 4)

References

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- (5) Black Sir D. Commentary: We need to take a fresh look at medical research. *Journal of medical ethics* 1982; 8: 77.