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IS "ETHICIST" ANYTHING TO CALL A PHILOSOPHER?

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Introduction

I have to confess at the outset that I have just not been able to keep this presentation under control. Each time I have set out to write something, the thing simply took off on its own, leading my poor pen willy-nilly through the bristling underbrush of first one then another cluster of crucial issues – all of which seem to me essential to gain any sort of significant purchase on this wild and unruly animal, "biomedical ethics." Some versions of this address grew to over 100 pages – making it clear, to me at least, that anything less would be a serious disservice to the discipline. The thing is made the more complicated by the fact that not very much about this discipline is very well understood – by the general public, by medical folks, by well-meaning academic colleagues, and even by the more dedicated of its practitioners. The "it," the "field" or "discipline" presents precisely the problem: what in the world is "it"? Expressed in a more usual form: "what in the hell is that philosopher doing in our hospital or medical school?" Or, as my academic friends wonder: "Is 'ethicist' anything to call a philosopher?"

I am fully cognizant of the fact that there are some of us who do indeed believe they have a handle on the creature: Robert Veatch has published a book, as you may know, with the audacious and probably presumptuous title, *A Theory of Medical Ethics*; Tom Beauchamp and James Childress have put another out, *Principles of Biomedical Ethics*. Numerous books and anthologies, conferences and symposia, have appeared over the past decade or so, many of which exhibit a phenomenal confidence about the field, its so-called problems, and even appropriate theories and methods by which to deal with them. I confess that all this has me quite baffled, and at times convinced that I have neither the wits nor the intelligence to see things clearly. I have

been involved in one way or another in this thing since 1971, have taught undergraduate, graduate, medical, nursing and other courses presumably related to the field, have participated in many of these conferences and have even dared to publish a thing or two about this or that: given all this, not to mention my own recent instance of audaciousness in accepting current position at Vanderbilt, it must seem odd, it surely does to me, to say what I have said about my own deep puzzlement.

As I would like very much to make you as puzzled as am I, not so much because I like mischief but because I have come to be convinced that we really do not understand very much about this field of work and study, I want to share with you some of the reasons why this venture is both strange and fascinating.

What was behind the initial idea, over twenty year ago, of asking philosophers (and others) to participate in medical education and in clinical situations?

To understand this is to understand a great deal about subsequent "biomedical ethics." It seemed, to physicians at least, fairly straightforward: considerable help from people trained in philosophy (and especially in ethics) was seen as critical.

With the astonishing new technologies and medical knowledge already then at hand, and even more remarkable prospects on the immediate horizon (Taylor, 1968), physicians had good reason to be troubled. New diagnostic tools and techniques promised more accurate, and earlier, detection hitherto not available of both present and possible damage. Coupled with these were emerging new surgical techniques, pharmacological interventions (Farber and Wilson, 1961), anaesthesias, and other treatments for conditions not previously treatable (or at least not as effectively). Resuscitative techniques and more refined biological/biomedical knowledge showed that different physiological systems functioned and ceased to function in different ways and paces, and that some could be artifically supported.

These effectively raised rather awesome, wholly new issues, and gave to many perennial issues a new force and content. (Gorovitz *et al.*, 1976) Not only was it increasingly possible to maintain patients who only a few years before would have died, often most painfully (e.g. renal disease), but the horizons of life's beginnings (the double helix of DNA, genetic research) and ceasings (CNS, whole brain) were be-

coming increasingly understood, and perforce redefined (Burnett, 1978; Eccles, 1970, 1979; Penfield, 1975). Not unproblematically, of course. Perceptive physicians and researchers were already agonizing over the value and moral issues inherent to these developments. Recognizing their lack of training in handling such issues, they quite naturally turned to others whose credentials seemed to bespeak competence. It might be mentioned, too, that many physicians and scientists continued to be haunted by the horrors of the concentration camps, and with the Nuremburg Trials and United Nations Charter they were anxious to reaffirm the existence of inalienable human rights, especially as regards the medical sciences.

The lingo of the times is indicative: the bureaucratic organization of the modern health science centers, as also the new technologies, tend invariably to "dehumanize" people; the increasing specialization in medicine after World War II seemed inevitably to fragment "the whole person," promoting more focus on "diseases" and "organ systems" than on "persons"; staying abreast of the new developments often meant that while physicians were obliged to be and remain "technically competent", they did not always, indeed rarely, have time or inclination to be alert to moral issues, religious values, sensitive caring (Pellegrino, 1979).

"The new physician" being discussed as the agenda for the 1970's and beyond, it was thought, needed to be "humanized" – but, as Samuel Martin put it, so did their teachers – and it was not really understood just what this would require. Nor who was going to be responsible for it. For many, medicine had to call on "humanist," as they were called: "experts in human values," and a new name was concocted for this breed: "ethicist," an occupation as unlikely as the name was awkward to pronounce. However, Martin and others had their doubts about this venture. In his poignant, if inelegant, terms:

> How can we humanize the humanist, the man who must help us all? Some are worried that our humanists are trying to get away from emotions, empathy, feeling, and other parts of our esthetic continuum, and that they are trying to outscience our scientists. At some time we must deal not only with what makes a humanist, but also with how we can facilitate the transmission of his art (Martin, 1972).

To be sure, he ought to have worried not only about the "outsciencers," but equally about those at work cultivating ever sharper and deeper divisions between "the two cultures." Both types in any case seemed to

make the appeal to such "value experts" rather improbable, an unlikely source for help of the sort the alarming new issues demanded.

What was the philosopher's response to the appeal?

At first, in the 1960's, only a few, rather venturesome people responded; in the early 1970's, a few more. Those of us who did so found the world of clinical medicine eerie, if also compelling. The existential cut of Martin's jibe about what makes a "humanist" – i.e. what is a philosopher and how can his art be transmitted? – was a keenly felt, daily reality. Separated from comfortable "home base," we were in this new world utter *naifs*, literal aliens listening in on a recondite babel of technical noise. When in deference to our lack of understanding it was translated ("What in the hell does 'PTA' mean?" "Oh, that's prior to admission!" – sometimes, our ignorance was not only pitiful but embarrassing); but often we found ourselves incapable of response, stunned into silence ("PDA?" "Patent ductus arteriosis, which means certain death for this baby."). When nonetheless encouraged to talk or offer an opinion – for instance, on whether a child born with developing hydrocephalus secondary to myelomeningocele should be operated on – found ourselves babbling in an equally alien tongue about persons and potential persons who yet could in all likelihood never become persons, but yet who perhaps should be treated as persons... .

Many of these philosophers recoiled in shock and dismay: *this* simply is no place for a philosophers, whose training and disposition included nothing which could prepare one for rendering judgments, much less definitive moral judgments. And even if one could begin to untangle some of the moral issues presented in such cases, one had neither the time to do so properly, nor the appropriately prepared audience to hear the discourse, much less participate in a philosophical discussion.

Nor did gradual familiarity with clinical settings, specific cases and patients, technical jargon, exotic technologies, and the rest go to ease the sharp sense many felt that the philosopher remains an interloper, a theorist in the land of therapists. The philosopher's stock-in-trade is principles and norms, and neither therapy nor guidance counseling. His business is foundations, ideas and logic, not, as often seemed the real agenda, sensitizing health professionals to value phenomena. The mind is to be *studied*, not expanded, by our labors! Even so, the movement showed remarkable growth during the late 1970's, and early 1980's.

What rapidly developed, especially in the last ten years, is readily understandable – even if, as I will suggest, somewhat dubious. This new arena of issues and, truth be told, of employment, began to be seen simply as a different place to conduct the usual business: writing scholarly tracts, and teaching courses (with appropriate modifications to accomodate oneself to the intensely practical, professionally motivated students of medicine).

Not only did this move to accustomed pedagogy tend to dull the knife-edged issues encountered in clinical situations, but it was widely urged that such encounters were quite unnecessary and possibly even obstacles to the doing of sound philosophy. Thus, many agreed with Jerome Shaffer's contention that the philosopher is quite out of place in those clinical settings, and that physicians are seriously misled if they would look to philosophers for solutions to the questions of human conduct and decisions faced by physicians. While medicine was seen as presenting fascinating and even demanding social and moral issues, it was widely received that these could only be properly addressed in philosophy's usual ways (Shaffer, 1975).

Ethics, for all its traditional emphasis on "practical reason," is *theoretical, not therapeutic or practical.* Hence, medicine was quickly, and with detectable relief, seen as merely one among many of the fields to which ethical principles, analysis and arguments could be "applied." Biomedical ethics rapidly became "applied ethics," a view which was to my knowledge never itself questioned. The ethicist's task is to study such tricky words as "good," "evil," "right," "wrong," "decision," "responsibility," "action," etc. In R.M. Hare's idiom:

> Philosophy is a training in the study of such tricky words and their logical properties, in order to establish canons of valid argument or reasoning, and so enable people who have mastered it to avoid errors in reasoning, and so answer their moral questioning with their eyes open. It is my belief that, once the issues are thoroughly clarified in this way, the problems will not seem so perplexing as they did at first... (Hare, 1978).

While it might be prudent for such a philosopher to make periodic forays into clinical situations, even to meet with patients, this is not in the last necessary nor relevant, and could be a hindrance.

Governed by the idea of "application," there quickly appeared what is by now the familiar range of articles, books, anthologies – and texts. First presented in the latter is the typical set of moral theories – utilitarianism, deontology, natural-law, etc. – and their variations,

usually coupled with a more or less harsh glance at medical oaths and codes to show their woeful inadequacy. Then there follows the by now familiar litany of presumable moral problems: abortion, euthanasia, damaged neonates, scarce resources, human experimentation, and the like. The idea is, having grasped something of the available theoretical alternatives in ethics, to show how each is applied (through text or collected articles) to the practical problems, as well as to suggest by now standard difficulties each faces in being thus applied. And, by now, too, biomedical ethics seems thoroughly familiarized into the usual packages of courses and conferences, speeches and articles. The bite of medicine's initial appeal seems, if you will, as completely coopted by official philosophy as blue jeans by the fashion world.

What has been the response of physicians to all this?

Although most would never be caught publicly saying harsh things about ethics – certainly not at a time when ethics is part of the daily menu of the media, not to say the agenda of such august bodies as Presidential Commissions – there is reason to believe that there is markedly less enthusiasm, even skepticism, than such talk might suggest. One can note, as Dan Callahan did, a definite "backlash" reaction (Callahan, 1975). Perhaps more pointedly, while many, like Alan R. Fleishman, encourage programs in ethical analysis for residents and students, their reports of these are monuments of doubletalk. Thus, Fleishman stated that these residents apparently learned that "their decisions were based on ethical principles," yet they "felt that the neonatal ethics rounds did not specifically affect medical care." Some of the "most frequently presented issues involved the rights of the fetus and of the newborn," and the "right to decide" of the parents. Yet just these issues and the principles applied to them were just as frequently "found to have little relevance in actually determining what was the right decision." And, while residents affirmed that "they did increase their understanding of ethical principles and the process of ethical analysis," they also stated that "they felt their general moral and ethical views had not been changed" by the program (Fleishman, 1981).

The message is clear to any physician: though expressed in glowing terms and recommended to other medical units, the program was a clear failure. It changed no one's behavior, decisions, or moral views. What the ethicist said had little relevance to clinical judgments. Yet,

the "moral conflicts" which regularly occurred there, it is also said, were handled by the "process of ethical analysis."

Lest the message be lost – for instance, by blaming the failure on the ethicist – other physicians have recorded similar dismay. Eric Siegler, himself deeply involved with philosophers for a long time, quite clearly is disillusioned by what he calls "the biomedical ethics establishment" (BME), arguing that it has been both too insensitive to the routine rigors of clinical practice, and hypercritical of the Hippocratic commitments of physicians (Sielger, 1979). He, with others, laments the proliferation of BME teaching (which he believes takes up issues quite different from those encountered by clinicians), and the virtual dominance of the field by non-physicians. Not only do those in the BME have quite different agendas from physicians, but they are in the end only observers having merely the "counterfeit courage of the non-combatant." Physicians are legally, morally, and professionally accountable to their patients, philosophers are not. As Fleishman put it, "Philosophers are theorists with no need to come to conclusions about specific patients or cases," and, he went on, physicians "must constantly deal with specific cases, decision-making, best guesses, and directed therapy."

For Seigler – and Fleishman would surely agree – BME must be countered by physicians themselves becoming expert in ethics. Only physicians are experienced and knowledgeable therapists, are held accountable for their decisions, and know the uncertainties and terrors of actual clinical practice. These physicians express gratitude to philosophers, even to the BME; but both are deeply skeptical about the supposed fruits of the two-decade-long attempt at serious flirtation between medicine and philosophy. R.M. Hare's unwitting admission may have come home to roost:

> I should like to say at once that if the moral philosopher *cannot* help with the problems of medical ethics, he ought to shut up shop. The problems of medical ethics are so typical of the moral problems that moral philosophy is supposed to be able to help with, that a failure here would be a sign either of the uselessness of the discipline or of the incompetence of the particular practitioner (Hare, 1978).

Of course, no philosopher I know, Hare in particular, would in the least concede to having to close shop. The rejoinder to such physicians, while it may give little comfort to them, may pacify philosophers: what physicians were initially asking was just a plain mistake – under-

standable, perhaps, for they are not philosophers. What philosophy can do, and do quite well, is study the tricky words of moral discourse for their logical properties, cultivate respect for the canons of clarity and valid argument, provide distinctions between fact and value, or medical and evaluative factors, and suggest ways by which moral theories, principles, and rules can be "applied to practical problems. To ask any more is to ask that philosophers go beyond their proper place and competence – i.e. to erode if not destroy the integrity of philosophy itself, as would occur to medicine were physicians invited to practice medicine in a department of philosophy.

What, then, are we to make of all this?

Well, among other things, some physicians who are fairly astute philosophically, still entertain the notion that philosophers have to become, as they say, "involved" in clinical medicine. Tomas Silber, for instance, believes that without such actual, regular involvement the "data base" for understanding, much less contending with, the moral issues inherent to the daily practice of pediatricians, would be plainly missing. Just that base is necessary, though, for the task at hand. Understandably, Silber laments "the absence of these professionals from our daily lives", even though, with Siegler, he warmly endorses the idea that physicians must for their part immerse themselves in philosophy and theology (Silber, 1981).

Edmund D. Pellegrino, by all odds the dean of this entire enterprise from its beginnings, goes even further. He believes that the times and issues are right for a "new Paideia" matching that of classical Greek culture, and that medicine occupies a pivotal place in that (Pellegrino, 1974). Medicine is, in his terms, the most scientific of the humanities and the most humanistic of the sciences – hence, provides precisely the kind of rich terrain within which to cultivate, along with philosophy and others of the humanities, that new Paideia (Pellegrino, 1979). Even more than that, he argues that a proper understanding of some of philosophy's own perennial issues positively requires a sound grasp of what medicine has learned – e.g. about the human body. He, too, continues to urge the need for philosophers to gain clinical experience and to be regularly "involved."

A few philosophers, too, have grown discontent with the very idea that ethics in medicine is an "application" of theories to practical problems. For instance, Arthur Caplan (1982) has given an interesting

critique of this notion. Stephen Toulmin (1982) trenchantly stresses that clinical medicine has in effect "saved the life of ethics" – perhaps a bit over-optimistically. Clearly, too, Alasdair MacIntyre (1981) has shot the pants off much current thinking in ethics, and strongly endorses the idea of clinical involvement on the part of ethicists. There are others – e.g. Samuel Gorovitz (1982) and H.T. Engelhardt, (1975) – who are similarly disposed. Still, it remains true that the "applied ethics" approach is the received view of biomedical ethics, even though it seems to me that the very idea behind it is question-begging, its central terms inherently unexamined, confused and probably incoherent, and its much-heralded usefulness to physicians far more pomp than substance.

I do not propose engaging in that critique here, even though it brings up a fascinating set of themes. What has rather preoccupied and puzzled me since I first accepted the invitation to enter the world of clinical medicine, and even more deeply since coming to Vanderbilt, concerns just what a philosopher is supposed, or is expected, to do when he or she becomes "involved" in clinical situations.

A most surprising prospect has begun to make itself felt, sometimes rather insistently: perhaps after all, physicians such as Pellegrino, Joseph White, and others, are right. Although no one has to my knowledge specified the sense of "clinical involvement" for philosophers, and even though it presents us with positively eerie prospects (such as engaging in empirical work deliberately to further philosophical understanding), I am increasingly convinced that there is something important to the idea, the discipline it marks out, however strange to our accustomed ways, is both demanding and quite unavoidable. I want now to share something of its character as I have come to understand it.

Can ethics in medicine be conceived as a clinical discipline?

Although I am not an Aristotelian scholar, nor am I aiming to use his work as an authoritative source, what I will suggest may well be, in some core way, at least as ancient as his *Nicomachean Ethics* (1962). Pointing out that "precisions cannot be expected in the treatment of all subjects alike" (I, 3), Aristotle believed that "when the subject and basis of a discussion consist of matters that hold good only as a general rule, but not always," as is the case with politics and ethics," the conclusions reached must be of the same order" (I, 3). So far as moral

actions are concerned, "although general statements have a wider application, statements on particular points have more truth in them: actions are concerned with particulars and our statements must harmonize with them" (II, 7). Concerned with emotions and actions, neither the study nor the mere discussion of ethics permits the kind of clarity and precision attainable in theoretical knowledge (II, 3).

Ethics concerns emotion and action, and "there are no fixed data in matters concerning action and questions of what is beneficial, any more than there are in matters of health" (II, 2). The treatment of particular problems will be even more characteristically imprecise; hence, here, "the agent must consider on each different occasion what the situation demands, just as in medicine and in navigation" (II, 2).

Perhaps not surprisingly, I have found much of this to be true in discussions of ethics in medicine. To use my own terms, the following points can be suggested as indicating the nature of ethics as a clinical discipline. These are neither exhaustive nor do they speak directly to the important issue concerning the practical conduct of clinical ethics. The clinical situations of medicine are, if you will, already constituted as having an inherently complex moral sense; the following theses are ways of giving expression to this sense. (More technically, they are components of the noematic-objective sense presented by every clinical context, and in this respect provide the significant "clues" (Leitfaden) for phenomenological explication of the phenomenon of the moral order as encountered in such situations.)

1 *Moral issues of medical practice are presented solely within the contexts of their actual occurrence.* It is thus nor reasonable to expect that one can know in advance of each different occasion what the situation demands, what must be taken into account – even if one can, especially as a function of relevant experience, have a general idea of these demands and considerations.

2. *Each specific case is in its own way imprecise*, and this in a number of ways:

a. Each presents a complex of issues with *relative uncertainty* and ambiguity, e.g. of diagnostic tests, medical regimens, results of therapies put in place, etc. But the same is true of expressions of desire, consent, preference, compliance, refusal, etc. Moral discernment ("practical wisdom"), therefore, on whosever part it may be, like clinical-medical assessment, requires the deliberate effort to gain greater clarity and precision, as far as the circumstances allow.

b. Each case, furthermore, so far as it consists of the emotion, actions, and efforts of the individuals whose "case" it is, *presents mul-*

tiple issues, not only during the course of a case, but also simultaneously, e.g. between patients and physicians, between physicians and institutions, family etc. Moral discernment, therefore, like clinical assessment and ongoing diagnostic procedures, requires continual alertness to conditions and circumstances (of all sorts) which change in various ways partly due to determinations and decisions being continually made during its course.

c. Accordingly, each case is inherently subject to the *fallibility of the persons involved and their various discernments*, assessments, decisions, and the like. As Gorovitz and MacIntyre have emphasized, medicine is an inherently fallible discipline (1976); the same is the case for ethics – to mention but one instance: withdrawal of dialysis after 2 months to allow to die, and the kidneys start functioning again.

d. Each specific case is in these terms *specifiably complex* in the ways indicated. This complexity, however, has further dimensions, as will be shortly clear.

3. *Medicine is governed by the effort to make sense of the healer's experience with the patient.* H.L. Coulter terms this the "therapeutic experience" governing all forms of medicine, ancient and modern (I, 1975) This is, however, a *dyad*, including not only the encounter with a distressed or damaged person (and its adherent effort to interpret presenting "symptoms"), but also the healer's efforts to heal, restore, ease pain, and the like; and this inherently presents its own type of complexity: interpreting of symptom in an effort to "help". As Pellegrino put it, talking about the nature of clinical judgment in modern medicine:

> The end of the medical encounter, and the process through which it is achieved...is restoration and healing – some corrective, remedial or preventive action is directed at what the doctor and the patient perceive as diminution of the patient's wholeness, each in his/her own fashion (Pellegrino, 1979).

4. *Thus, this therapeutic theme embodies a fundamental moral resolve or commitment*, to put one's knowledge, experience, time and technological wherewithal at the disposal of damaged or distressed human beings, individually or as groups or populations. This moral resolve – which is another name for caring, in the sense of acting on behalf of a person's "best interests," however these may be determined – is inherent to and thus textures every clinical encounter. It implies any of a number of possible *specifications* (or: specific obligations), depending on the demands of each specific clinical occasion. For

instance, if a physician is faced with a situation in which his or her limitations of knowledge, experience, or technical abilities make the best course of action uncertain, then, to use Grant Liddle's terms (1967) he or she "has an obligation to augment his or her knowledge so that benefits and risks of a particular regimen are as predictable as possible." It may similarly obligate the physician to seek consultations with others having one or another sort of competence beyond that of the attending physician.

This therapeutic theme with its governing moral resolve on the part of the professed healer, however, is but one facet of the dyad.

5. The *existential condition of the patient is an inseparable (although distinguishable) facet of the dyad.* Anyone who undergoes some disease, discomfort, injury, or other noxious experience presents as in need of relief, restoration, healing, or comfort – in whatever way this may be sought. If the patient presents to some professed healer, with his or her array of available regimens and therapies, this presentation is a form of *appeal*, and to that very extent is a concrete expression of *trust*. The patient, i.e., by presenting to a healer, enters into a remarkable complex network of trust-relationships, whose other side is the healer's profession of competence to treat (i.e. care).

6. *Therefore, the therapeutic dyad is a convenantal relationship most fundamentally*. The physician, should he or she agree to treat, convenants to act on behalf of the patient, doing whatever is reasonable to relieve the patient's *present* condition (pain medication, surgery, etc.), and to act with the patient's best interest as governing actions designed to enable, from the range of possible futures for this patient, the *future* which is agreed upon as preferable (cure disease, insure successful pregnancy, etc.). The patient who comes under the care of a professed healer, on the other hand, is one whose existential condition is one or another degree of uncommon reliance (trust) on those who profess to be able to help – whether the subsequent course merits such trust is another issue.

7. *The therapeutic dyad subsists solely within and is conditioned by multiple social relationships and variously complex social contexts* – whether it be a tribal shaman or a modern health science center. There are at least five distinctive levels of the latter which necessarily contexture the dyad:

a. That constituted by the healer/patient relationship – i.e., the therapeutic dyad in its narrowest form, including all the various matters which go to make any specific encounter precisely what it is – respective biographical situations of healer and patient, psychological traits

and dispositions, available therapeutic and diagnostic procedures, etc.

b. A variety of different issues arise, and affect patient care, in the specific sorts of *relationships among different professionals* (consulting physicians, residents, interns, nurses, social workers, dieticians; but also clerks, patient representatives, lawyers, etc.). These include both formal and informal mores, rules, regulations, codes, concerned with appropriate conducts of these professionals.

c. Similarly, distinctive issues affecting patient care and trust arise in view of the *socially established and legitimated institutions of practice* (office, partnerships, hospitals, clinics, laboratories, etc.). These, too, include distinctive formal and informal regulations, codes, etc., affecting the range of permissible and impermissible conducts of the professionals who practice within these institutions.

d. All medical practice is likewise governed by a network of *governmental rules, laws, legislative enactments and mandates* which impact patient care and trust by still further definitions of permissible and impermissible conducts. A clear instance of this is the "Baby Doe" ruling by the Department of Health and Human Services which prescribes and proscribes medical actions for handicapped infants with life threatening conditions.

e. Finally, medical practice is contextured in important, although less clear ways by *prevailing social values* about such matters as what "normal healthy life" is, what counts as a "disease," what is socially permissible/possible/appropriate when one is "sick," and so on.

Careful study of what it is to be a patient, of course, reveals similar, although less well-defined social contexts bearing directly on the dyad: a patient's values, character, occupation, etc.; the family and/or intimates and their respective biographical situations; the social and/or religious community within which the patient lives, along with their values, etc. (I think, for instance, of how the latter can impact medical recommendations for blood transfusion, treatment of cancer, and the like).

8. *Every case uniquely evokes prominent modalities of feeling.* Emotion, passion, striving, wanting...all are in many modalities invariably found as texturing every case of distress or damage. It is an important question always to ask, just what it is about this particular patient which evokes just these and those sorts of "feeling" and not others. In pursuit of this, clearly, the whole of emotive/valuative/volitional life must be probed with considerable skill and depth. Beyond that, to discern and eventually judge about the moral issues of any case requires clear recognition that damaged persons inherently

evoke such feelings, and these are most often the concrete displays of moral life. These modalities are displayed in different ways: at least the following are significant.

a. Perhaps most pervasive is the experience of accident or chance. Except for clearly pathological cases, affliction is not itself a value to be cultivated; it befalls us "by chance," and thus generates profound and disturbing feelings of "unfairness." Neither chosen nor deserved, illness occasions a deep sense of injustice in the world: "why me?" "why my child?" etc. (Zaner, 1982, 1983).

b. Affliction breeches the usual course of daily life with its taken-for-granted network of concerns and activities; if I break a leg or contract flu, I can no longer "do" (walk, drive, eat, etc.) as I have been accustomed to doing. Affliction thus evokes anxieties, dismay, frustration, worry (but also hope at easing of pain, and eventual "getting well again," etc.).

c. If I then go to a doctor or am brought to one, I find myself in a situation deeply textured by complex forms of necessary trust: I must perforce trust not only my physician, but also nurses, attendants, food, beds and rooms, that the equipment used will not break down, that medications were properly manufactured, that blood used to transfuse me is free from diseases, etc., etc. Here, too are contexturing modes of feeling expressing facets of moral life: trusting that nothing bad or contrary to my wishes/interests will be done to me especially while I am in a diminished condition (during illness, surgery, etc.); that when I am told of my condition, nothing has been hidden from me; that my distress at having to be so unusually reliant on other people will not be misused or misunderstood; and on and on. The whole set of issues here is both characterized by, and centered around, these multiple sorts of others on whom the patient finds himself having to rely: for the most part, in our times/culture, these are complete strangers. Hence, in our health science centers, one finds not only multiple reasons which serve to compromise or modify these forms of trust, but also a striking amount of reliance/trust based in routinized procedures (permission forms, consent forms, prominent displays of official licensures/degrees, etc.).

d. To appeal to and to trust these others-who-are-strangers, of course, is to place or be placed in necessarily imbalanced relationships with them: not only do they "know" what's going on with me, but they are "familiar" with the settings (hospital, X-ray machines, medications, etc.) whereas I am not (thus undergo additional grounds for suffering). Moreover, all power to do and to know lies on the side of

the healers, not the patient (even if the patient "knows" about these sorts of things, while a patient he/she often is unable to think about them, forgets them, and in any case is regularly encouraged in multiple ways to ignore such knowledge). The more grievously ill a patient, the greater is the imbalance, and the more exposed to others' actions, judgments, and decisions. Even though they "want" to "do the right thing" for me, I am nevertheless within their world, not my own, within their range of power-to-act; and the more debilitated I am, the more reliant on their opinions and actions have I become.

e. In all, these complexes of feeling are centered: they occur uniquely around illness/affliction, etc. They are *evoked by* the afflicted person; they are moreover *directed to* the patient, and are *aimed at* the patient's possible futures as directly affected by the healer's actions. As such, these feelings are specifically moral in character: they are *concerns about and for* the patient in his or her present condition and possible futures. Hence, these feelings are *specific, moral*, orientations within which whatever goes on – medically, socially, etc. – has its specific contextural placements.

To repeat – this list is by no means exhaustive and certainly not definitively expressed. Even so, enough has been indicated for me to suggest certain themes characterizing ethical deliberations within the clinical situations of medical practice.

First, these clinical situations are inherently moral: the respective concerns of those whose situations they are make them so, as does the core phenomenon of affliction, damage or distress (the therapeutic dyad, as I have somewhat awkwardly termed this). As such, second, these moral issues are presented solely within the contexts of their actual occurrence: the "problems" if you will are first and foremost problems for those whose situations they are (physicians, patients, families, institutions, communities, etc.). Thus, each situation must be approached solely in its own terms, in the light of what each occasion itself demands.

As has been suggested, each of these is highly textured by prominent modes of feeling, as also by specific actions or conducts. People not only feel strongly on occasions of affliction, they also tend to be governed by a pronounced pragmatic motive: to "do" something about it. However, it has also become plain that although it happens nowadays that people are inclined to believe that "being moral" is mainly a matter of "feeling," it is rarely the case that they (physicians, patients, families, administrators, etc.) recognize these feelings evoked by affliction as moral in character. "Feelings," that is, are not merely outer

expressions of inner states, reports about how one feels "inside" and thus irrelevant to what is objectively the case. To the contrary, I've suggested, these modalities of feeling are occasioned by afflicted persons: as evoked by and directed to such persons, and aimed at helping them in their present distress and toward a restored future, such feelings are specific orientations, objective components of the clinical situation itself, organizing the perceptions, interpretations, concerns, and so on of those involved in them.

However, a third point emerges just insofar as these complex, contextually organizing modes of feeling and action are only rarely themselves recognized as specifically moral phenomena: what is situationally presented is then a form of what can only be called moral pathology. In simplest terms, not only are such feelings seldom seen as moral (conflicts, dilemmas, enigmas, etc.), but it not infrequently happens that they are misinterpreted as presenting something else (e.g. psycho-pathology), or are apparently deliberately ignored as extraneous to the problems of medical management, or regarded merely as expressions of common social mores. (see, e.g., Liddle, 1967) And, so far as these, or other forms of evasion, neglect, omission, or misinterpretation are presented in any specific case, one clearly confronts one or another sort of *a-pathos*: insensibility, indifference, or indolence regarding suffering, passion, or moral feeling. Of course, precisely because medical practice is centrally focused on assessing patients in terms of possible risks, harms, or benefits, and patients focused on being helped to become restored, the contexts of medical practice are inherently ripe for precisely such moral pathologies, and dealing with them is quite often a critical part of conscientious medical care. This is to say, fourth, that dealing with the moral issues presented in the contexts of their actual occurrence, that is in clinical situations, is a *clinical discipline having a distinctively therapeutic tenor.*

Lest this be received as too serious a flirtation with medicine, we might remind ourselves of our own typical teaching: this, after all purports to improve the learner in some specifiable way, and has its point therein, that is, it is a therapeutic undertaking which proceeds on the assumption that the student lacks or has not yet acquired something – something which will purportedly be acquired through our teaching, and that this will be good for the student. While it may be quite a difficult thing to specify that "good" with any exactness – which of course it is – this does not in the least belie the purported therapeutic aims of teaching.

In one sense, what I have come to call clinical ethics might be under-

stood as not unlike our typical teaching – but with a crucial difference, which may make all the difference but does not for all that belie the veracity of the analogy. First, though, the similarity: in a sense, the "students" who are the focus of clinical ethics – the patient and family, the physicians, residents, nurses, social workers, etc. – are in the position of "learners" not unlike students in the more usual sense. They, too, lack something or have not yet thoroughly and appropriately considered something – something which the "teacher," clinical ethicist, purports to provide – an understanding of their situations as intrinsically moral, and this in specifiable ways (the therapeutic dyad, and the rest of it). The clinical situations, like "classrooms," are occasions for enabling that "learning" to go on – and, like the usual classroom, situations can often go awry, just as they can also go well. And, just as there are real difficulties for all of us in determining just what it is about certain classes which makes them "successful," so, too, in clinical situations is this eminently difficult. But, there are differences, not only between the several sorts of students and teachers and classrooms, but also in the reasons for things going well or badly.

For in clinical situations, as we are wont to say, indulging in conundrums, "something critical is on the line"; "this is the real world," and not a mere, faint echo of it. Indeed, Siegler's accusation of philosophers in the BME – they have the luxury of mere "counterfeit courage" – has its precise point here. Not that he is correct; indeed, he may himself be accused of failing to appreciate the specific virtues, risks, and trials of intellectual struggles. It is true, nonetheless, that clinical situations are charged with urgencies, demands, responsibilities and consequences which are decisive in clear and immediate ways. And, in this, the luxuries of leisurely, semester-long discussions are simply not available. But this should not obscure the point: namely, that the insistent presence of moral conflicts, dilemmas, or enigmas in such situations presents us with the clear demand to address them, within the contexts of their occurrence. And, this clinical task, like that of clinical medicine, has its therapeutic significance: it is a positive benefit to people to enable them to understand the issues they in fact face in these contexts, as it is a positive harm to avoid, confuse, or obscure them.

Clearly, far more needs to be said about this issue, more than I have either time or wits to do here. What I must emphasize is that determining just what moral issues are presented, much less what sorts of considerations and/or actions might help to improve things, can be

accomplished only by respect for and careful attention to the demands of each particular situation in its own terms. This task, as I've suggested, is understandably complex, but the complexity can be specified, the tensions and anxieties generated by the necessary ambiguities and uncertainties of clinical situations can be eased, conflicts and disagreements settled. *How* this occurs is surely a critically important question; *that* it happens is perfectly clear in numerous cases. And, part of the task of clinical ethics is to engage the work of the first, while continuing to witness and hopefully contribute to the latter.

In this, clinical ethics is no different from moral life more generally. We do not, if you will, first know the good, then set about to "apply" it to practical situations, themselves thought to be "value-free" or morally neutral. Quite to the contrary, as clinical situations make wonderfully clear, our daily lives are "always-already" within the moral order. Precisely because, moreover, as Alfred Schutz has made marvelously lucid, the life-world "does not form a closed, unequivocally articulated, and clearly arranged province," so is the moral dimension of our daily lives "surrounded by uncertainty" (Schutz, 1973). We do not become better in a moral sense merely by learning the logical properties of the tricky words of moral discourse, nor by learning the canons of valid argument. Just as one becomes a more proficient clinical diagnostician only by actually performing clinical diagnoses; just as it is "by playing the harp that men become both good and bad harpists" (Aristotle, II,1); so "a man becomes just by performing just acts and self-controlled by performing acts of self-control," as Aristotle would put ut (II, 4). "Yet," he observed, "most men do not perform such acts, but by taking refuge in argument they think that they are engaged in philosophy and that they will become good in this way. In so doing, they act like sick men who listen attentively to what the doctor says, but fail to do any of the things he prescribed. That kind of philosophical activity will not bring health to the soul any more than this sort of treatment will produce a healthy body" (II, 4).

Medicine, with its therapeutic dyad and underlying moral resolve, is a venture into helping to correct, restore, or prevent the afflictions which people suffer; it seeks to improve their present condition by enabling them to become well again (to whatever extent this may be). Just because of this, moreover, medicine is subject to continuous critical inspection – by its practitioners, but also by patients, and the rest of us. In any event, it is in view of this, and in view of the moral character of affliction itself, that ethics is an inherent component of that venture. Although it would be an exaggeration to say, with Siegler,

that competent medicine and clinical ethics are the same thing, or that "good medicine is ethical medicine," it is surely the case that ethical considerations are an essential component of medical considerations: they are inseparable even though distinguishable parts of the same venture.

Thus, without the concrete clinical labors designed to find out and to interpret each specific case, there simply is no way for philosophy (ethics) to respond seriously to medicine's remarkable, if still somewhat puzzling, invitation to engage in this fascinating and historically significant cooperative enterprise. Whether it will eventually lead to a kind of "new Paideia," as Pellegrino believes, I cannot rightly say at this point. I can affirm vigorously that a clinically informed philosophy, and not only ethics, has a significance far beyond any I had initially suspected. What remains to be done, of course, is the *work*: and for that, I can only invite others to become engaged in this uncommon, but altogether rewarding, discipline.

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