PHILOSOPHY OF MEDICINE AND BIOETHICS

Philosophy and Medicine

VOLUME 50

PHILOSOPHY OF MEDICINE AND BIOETHICS

A TWENTY-YEAR RETROSPECTIVE AND CRITICAL APPRAISAL

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KLUWER ACADEMIC PUBLISHERS
NEW YORK, BOSTON, DORDRECHT, LONDON, MOSCOW

eBook ISBN: 0-306-48133-2
Print ISBN: 0-7923-3545-7

Created in the United States of America

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IN MEMORIAM

MARX W. WARTOFSKY
1928 - 1997

With the death of Marx Wartofsky, American philosophy has lost one of its most noble, generous, and energetic members.

The *Philosophy and Medicine* series would not have come into existence without the support of Marx Wartofsky and Robert Cohen, who, in 1974, approached D. Reidel Publishing Company prior to the First Trans-Disciplinary Symposium on Philosophy and Medicine.

The Editors are very fortunate to be able to publish Professor Wartofsky's contribution in this celebratory volume. The philosophy of medicine has its character due to his creative work. We deeply regret that he did not live to see its publication.

He will be sorely missed.

INTRODUCTION

The Institute for the Medical Humanities at the University of Texas Medical Branch co-sponsored the first Trans-Disciplinary Symposium on Philosophy and Medicine which was held in Galveston in May, 1974. The papers presented at that meeting inaugurated a philosophy and medicine book series edited by H. Tristram Engelhardt, Jr., and Stuart F. Spicker.

In their introduction to Volume 1 of this series, Engelhardt and Spicker emphasized that there are "few, if any areas of social concerns so pervasive as medicine and yet as underexamined by philosophy."[1] Participants in the first symposium contributed historical and philosophical assessments of concepts of health and disease, explorations of epistemological questions in the philosophy of science and medicine, and phenomenological analyses of the relation of body and self. There was also a lively exchange on "virtue ethics." The editors envisioned a continuing series of symposia that would provide opportunities for sustained transdisciplinary dialogues about philosophy and medicine.

To help celebrate more than twenty years of extraordinary success with this series, we convened another symposium in Galveston in February, 1995. We asked the participants (some of whom had attended the first symposium) to address the following questions: In what ways and to what ends have academic humanists and medical scientists and practitioners become serious conversation partners in recent decades? How have their dialogues been shaped by prevailing social views, political philosophies, academic habits, professional mores, and public pressures? What have been the key concepts and questions of these dialogues? Have they come and gone or remained with us, and why? Have the dialogues made any appreciable intellectual or social differences? Have they improved the care of the sick?

Philosophy of Medicine and Bioethics, Volume 50 in the series, contains a variety of distinctive responses to our questions. We have arranged these responses into three sections: History and Theory, Practice and Theory, and Policy.

The authors of the essays and commentaries in Section I develop a variety of theoretical perspectives from the humanities, and from philosophy of science and philosophy of medicine in particular.

Edmund Pellegrino perceives in the current evolution of bioethics a growing and troubling methodological imbalance between "disciplines of particularity" and philosophical ethics that reflects "the current trend from objectivity to subjectivity in ethical analysis . . . ." Against this trend Pellegrino argues for a place of prominence for philosophical ethics among the disciplines in dialogue about the proper shape of bioethics as an interdisciplinary enterprise. According to the ecumenical model he develops, philosophy is one discipline among others, but deserves pride of place because it remains "the fundamental discipline for analytic and normative ethics." Other disciplines can teach how it was and is with us but "only ethics as ethics seeks to discern what in the moral life is morally right and good."

In his conceptual survey of the recent involvement of the humanities with medicine, K. Danner Clouser articulates the view that the primary purpose of the medical humanities is service. Reflecting on his years of experience as a philosopher at work in the world of medicine, Clouser finds that world permeated by the kinds of considerations characteristic of humanistic deliberation. Furthermore, he sees a parallel between the relation of the medical humanities to the humanities and the relation of medicine to science. The former use the latter to accomplish a common goal by applying knowledge from their disciplines of origin for "the benefit and well-being of patients." Medicine teaches a narrowing of focus (as does education for the professions generally) with the result that, for all the depth of knowledge this approach makes possible, there is a distinct danger of becoming locked into only one perspective. An exclusive focus on a patient's pain may distract attention from his or her suffering, which may or may not be associated with the pain. "The ability to quickly and easily shift perspectives when appropriate, to see with 'new eyes,' is a valuable clinical skill," a trained capacity that, in Clouser's view, the medical humanities are particularly adept at providing.

In "The Primacy of Practice," Stephen Toulmin provides a historical framework for understanding the recent shift in the focus of philosophical ethics from definitional to substantive issues. By the end of the last century, he observes, a reaction had set in against historicism, motivated by "the hope of underpinning contingent knowledge by necessary principles." By the mid-twentieth century philosophical ethics, confronted, not least by medicine, with requests for help in

sorting out practical questions, discovered the wisdom of collectively accumulated and tested experience and "argumentation as a form of 'dialogical' exchange of opinion" to be more useful than prepositional knowledge. In Toulmin's view, such discoveries are bringing about a welcome reassessment of rhetoric and a revival of practical philosophy in the wake of the demise of foundationalism.

Marx Wartofsky is interested in the ways in which cognitive practices develop and change over time and in different circumstances. He is skeptical of epistemological claims about knowledge in general, and even of general claims regarding knowledge in particular domains of inquiry or practice, such as ethics or medicine. On Wartofsky's constructivist account of historical epistemology, "Knowledge is not simply reflection upon our experiences and our actions, but is constituent of and ingredient in our practices, and therefore is as various in its character and distinctive features as are these practices, and cannot be understood or appropriately studied apart from them." For purposes of analysis or comparison we may usefully abstract features held in common by particular forms of knowledge. But to mistake the abstraction for knowledge is to fall into the trap of reification. There is no such thing as knowledge in general. This is what the practitioners (Wartofsky's "endocrinologists") know and what the epistemologists can learn from them.

"Even if what 'works' is what 'counts,' how do we know that what works is good?" is the central question Pellegrino puts to Toulmin and Wartofsky in his commentary. Pellegrino rejects the idea that foundationalist accounts have been discredited in principle in the aftermath of the collapse of Cartesian foundationalism. He welcomes the turn from theory to practice taken by Toulmin and Wartofsky, but he sees no way in which practices can provide normative guidance. In his view, practice without metaphysical underpinnings is condemned to circularity and self-justification. "Even if praxis becomes the keystone, it must be set in a supporting arch."

H. Tristram Engelhardt, Jr., takes a different tack in his proposal for grounding secular bioethics. Appearances notwithstanding, Engelhardt doubts that secular bioethics has provided those whose lives are characterized by a radical pluralism "a neutral, but still content-full, vision of proper moral deportment that all could endorse . . . ." Apparent consensus on divisive issues (such as those dealt with by the National Commission for the Protection of Human Subjects) turns out, on closer examination, to have been "manufactured" by limiting participation to those of similar mind on the issues. Secular bioethics, Engelhardt argues, has been no more successful in achieving moral agreement than has any other master narrative. But, although it cannot deliver consensus, it can insist on the principle of permission as the bedrock of relations among moral strangers. "The authority to which persons can appeal when they do not share a common ideol-

ogy, moral vision, religion, or content-full political understanding is the authority of the consent of collaborators."

Bioethics seems largely to have displaced philosophy of medicine in recent decades, observes Henk ten Have. Or has it subsumed philosophy of medicine? For well over a century, prior to the emergence of contemporary bioethics, philosophy had occupied itself with medicine, but relations between the two disciplines were antagonistic. Around the turn of the century, this antagonism was ameliorated by a division of labor. Henceforth, the two disciplines would no longer compete in analyzing the human condition; rather, medicine would concentrate on accounting for and treating disease, and philosophy would analyze medicine's conceptual methods for doing that. In the course of pursuing its metamedical work, philosophy has discovered that "medicine is fundamentally embedded in culture . . . [and] cannot be understood without attention to cultural values." Bioethics, along with a broader-gauged philosophy of medicine that encompasses and extends earlier epistemological, anthropological, and ethical traditions are the upshot of this discovery.

Noting ten Have's regret that the chorus of concern over ethical issues in medicine threatens to drown out other voices speaking to important philosophical questions, Stuart Spicker asks what the likely continued hegemony of bioethics portends for the future of philosophy of medicine. And in his commentary on Engelhardt's paper, Spicker acknowledges the inadequacy of past attempts to ground morality in the claims of reason, but he is not persuaded by Engelhardt's argument that all such attempts must necessarily fail. "Is there nothing 'sacred' in the secular?" he asks. ". . . [P]erhaps moral authority can be located . . . in the integrity of the lived-body."

The authors in Section II bring various "practice" perspectives to bear in their reflections on philosophy of medicine and bioethics.

Larry Churchill critiques a methodological parochialism in bioethics that results from the urge to theorize moral experience in universal terms, an exercise that distorts experience by reducing its variety. He argues for reconceiving bioethics in the context of historically and culturally informed social inquiry that takes the particularity and complexity of moral experience as seriously as it takes the decisional aspects of moral reasoning. "What our experiences require is not *the* theory (or no theories), but several theories."

In her reflections on a week in the life of a practicing bioethicist, Judith Andre identifies three elements constitutive of bioethics as a practice—its interdisciplinarity, its practical orientation, and its eclectic approach to the acquisition and dissemination of knowledge. In that the practice of bioethics is in large measure about helping health-care professionals and the public "think more deeply and act more wisely about matters of health," bioethicists have a respon-

sibility to be cognizant of the ways in which their work may contribute to the valorization of health and medicine in our society, thereby drawing attention away from circumstances of social inequality that not only damage health but destroy hope.

Thomas Cole discerns in the papers by Churchill and Andre modes of reflective engagement reminiscent of the rhetorical humanism of the Renaissance. Cole believes that, in its deliberative form, rhetoric is well-suited to the task of entertaining and advancing multiple perspectives on varieties of moral experience, and to sustaining a vital connection between both feeling and thought, and personal integrity and social justice.

Remarking on the "poverty of proceduralism" characteristic of bioethics, Ronald Carson urges closer attention to the rich moral languages that patients, families, doctors, and nurses bring to their encounters. The practice of medical ethics, in the view he espouses, consists of reflective, interpretive work aimed at bridging the communication gap between conversation partners who often speak to each other in foreign moral accents. Carson looks to maxims, understood as illuminative of experience rather than prescriptive, as malleable but "steady guides" in the exercise of conscientious judgment.

In her commentary on Carson's paper, Anne Hudson Jones expresses doubt that the substitution of maxims for principles in moral reasoning will provide a true alternative to an impoverished proceduralism because it reinforces the privileged position of the doctor (or the ethicist). Jones identifies similarities between Carson's position and a radical strand of narrative ethics which she believes to be more promising in that it encourages a dialogue in which "everyone involved in a particular case . . . become[s] part of the chorus of voices that seeks its best resolution."

To make the case for a more culturally sophisticated bioethics, Carl Elliott scrutinizes the distinction between identity-altering therapies that aim to cure a condition, and those used to enhance the self. The former are commonly considered acceptable, whereas the latter are thought to be questionable. But, Elliott argues, because "cure" and "enhancement" derive their meaning from local understandings of identity and of life's purposes, a cultural appraisal of such concepts is necessary if the distinction is to be ethically useful. For this reason, "bioethics should look less like metaphysics and more like anthropology."

Gerald McKenny doesn't disagree but wants to revise and add a critical component to Elliott's proposal for an anthropological bioethics. McKenny insists that ideas about the self and the meaning of life not be disembodied but rather "formulated to include views about the place of the body in a morally worthy life." He argues further that a critical anthropological bioethics should not only describe and interpret the ways in which our identities are formed in

relation to cultural ideas and ideals but should also expose the self-deforming power of certain societal norms.

"On what basis do we rationally establish that another culture's practices should be stopped?" asks Loretta Kopelman. Kopelman argues that one should look to the claims made by defenders of such practices to determine what they claim to be the practice's purposes and benefits. These claims can then be assessed in light of relevant cross-cultural evidence. Advocates of female circumcision/genital mutilation, for example, claim that the practice prevents disease, promotes health, and contributes to the well-being of mothers and children. Evidence from interculturally valid studies of medical practices belies this claim. It is on the basis of such shared medical values and methods that rational criticism of the morally objectionable practices of another culture can be developed.

Grant Gillett is sympathetic to Kopelman's search for commonalities of conviction and belief sufficient to warrant one culture's criticism of another's practices. But he is skeptical about the prospect of finding common ground in the values and methods of Western medicine. Moreover, Gillett doubts that abstract reasoning of any kind will make much headway against entrenched moral views and cultural practices. In his view, a phenomenological approach is likely to be more promising. "It is plausible that if we examine some of the things that are basic to human life—the actual experiences of nurturing, being welcomed, having one's hurts tended, having one's greeting snubbed, pain, loneliness, and so on—we can erect a common ground in lived experience for some of our moral intuitions."

Courtney Campbell claims that medicine often responds ineffectively to patients' suffering because its grasp exceeds its reach. In his view, an untenable assumption of modern medical practice is that suffering is "an eliminable experience," when, in fact, "pain and suffering are inevitable features of the *human* condition" and "much suffering is medically intractable." In place of medical (or metaphysical) mastery of ineliminable suffering, Campbell commends empathy—"embodied presence," characterized by the patience to listen to, and the disposition to learn from, a suffering person.

Expressing appreciation for his explication of the personal nature of suffering and the healing power of empathy, David Barnard nonetheless finds that Campbell's notion of "presence" does not assume recognizable form. This, Barnard surmises, is because Campbell misconstrues a fundamental problem facing physicians when they try to respond to patients' suffering. "If medicine is to be faulted on this subject, it is for its failure to accomplish the possible, not for its arrogance in pursuing the impossible." What doctors should do is to manage the physical aspects of pain and suffering and, in Cicely Saunders' words, "persevere with the practical."

The contributors in Section III turn their critical attention to the contemporary policy arena where they raise important questions about the evolution and direction of research ethics, and the implications for medical practice of the radical reorganization of systems of health-care provision.

Baruch Brody notes the consensus regarding the ethics of research involving human subjects that had emerged by the early 1980s and explains why the bioethics community has evinced relatively little interest in these issues since that time. Biomedical research has continued apace, but research ethics has been limited to consideration of only a few issues, such as those arising in genetic, fetal, and animal studies. Brody proposes as a remedy for this situation the creation of relevant training opportunities in research ethics and the formation of new national societies and IRB networks.

By means of a review of recent publications and activities dealing with research ethics, Harold Vanderpool questions the degree to which this subject area has been neglected by bioethicists. Noting a number of formidable practical impediments to the development of the sorts of training programs and institutional structures advocated by Brody, Vanderpool nevertheless supports the call for a "return to basic concerns that were initially, but by no means fully, explored when bioethics emerged as disciplined inquiry regarding clinical medicine and research."

Haavi Morreim makes a case for the necessary interdisciplinarity of intellectual work at the intersection of medicine, law, economics, and ethics. Economic pressures are forcing changes in the way medicine is practiced. These changes are prompting a revaluation of the scope and limits of physicians' legal duties and ethical obligations. "Traditional moral expectations of virtually unlimited resources and unstinting loyalty are impugned by [these] newer realities. . . ." The determination of appropriate use of health-care resources should centrally involve physicians' views but also judgments that extend beyond medical expertise about what medical goals and health outcomes are worth pursuing.

In his response to Morreim's analysis, William Winslade concurs in the diagnosis of the moral and legal upheaval precipitated in medical practice by the adoption of "a business model in which patients are customers and consumers." He agrees with Morreim about a need for bioethicists to be intellectual cross-dressers, but he also strongly believes that both providers and patients must learn how to understand the intersections of ethics, law, and economics as they shape the polyadic and polyvalent relationships of emerging health-care organizations and systems.

Evident in the work presented in this volume is a continuing preoccupation with methodological questions, especially those having to do with the "right" relation between theory and practice in the philosophy and ethics of medicine.

Apparent as well is the critical attention presently being paid to "policy ethics" and to the fashioning of moral judgments across cultures.

We extend our gratitude to the authors of these essays and commentaries. Their responses to the questions we asked about the dialogues of recent decades indicate a continuing (and important) preoccupation with methodological questions, especially those having to do with the "right" relation between theory and practice in the philosophy and ethics of medicine, as well as the "best" way to adapt the insights of academic humanists to the needs of medical practitioners and patients. Apparent in their responses as well is recurring attention to the problems of transcultural morality in today's global cosmopolitanism and the need for carefully fashioned policies that address the pluralism and complexities of evolving public and professional cultures.

This, the third, symposium in Galveston was also convened to honor William Bennett Bean, M.D., the first director of the Institute for the Medical Humanities. We thank Thomas N. James, M.D., for providing financial support from the President's Office so that Dr. Bean could be remembered in this way.

We are especially grateful to those who provided considerable help in completing this project: Stuart F. Spicker and H. Tristram Engelhardt, Jr., for responding positively to the idea of an "anniversary volume" and for guidance as the series editors; Sharon Goodwin for coordinating the symposium; Deborah Cummins for a critical reading of the draft papers; Diane Pfeil for preparing the volume for publication; and Eleanor Porter for proofreading the manuscript.

NOTE

[1] Engelhardt Jr., H. T., and Spicker, S.F.: 1975, *Philosophy and Medicine,* Volume 1, D. Reidel, Dordrecht, The Netherlands, p. 1.