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Moral Thought in Clinical Practice: Applying the Abstract to the Usual

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RECENT DISCUSSIONS OF ETHICS in medicine have concerned themselves with large problems in the care of the dying, transplantation, abortion, genetic manipulation, behavior control, and so forth. Each of these areas provides substantial questions for rigorous exercises in moral philosophy. Yet it is axiomatic that they are drawn from, and are, to one degree or another, the day-to-day concern of clinical medicine. This fact creates a sense of unease because of a belief that physicians have neither special competence nor training to make such moral decisions. That same disquiet should infuse discussions of medical ethicists with a certain urgency, but even more, with a desire to see the results of their work return to clinical practice. Yet, we are not at all certain how newly developed understandings in moral philosophy are brought back to the practice of medicine. We need, then, a better comprehension of what an applied moral philosophy would look, or, better, sound like. What more fitting place to examine such a question than clinical medicine, where there already exists applied anatomy, applied biochemistry, applied pathology, and so on.

One similarity that is already apparent between applied moral philosophy and applied anatomy or biochemistry, for example, is the impatience with physicians shared by philosophers, anatomists, biochemists, and others from pure disciplines. It is worth a few moments' reflection on why the philosopher or scientist might be irritated with the physician. In any intellectual pursuit the challenges lie in the large problems, at the blurred edge of the field, not at its established center, in the unusual, not the ordinary. The moral philosopher may struggle with the meaning of "the good" but is entirely able to say and hear the word "good" in everyday life—understanding and being understood without much difficulty. But that day-to-day life is the concern of the applied worker whose challenge may lie in applying the abstract to the usual. Similarly, the physician may struggle with problems such as where to use actinomycin-D (an antitumor agent), chlorpromazine (a tranquilizer) or imipramine hydrochloride (an antidepressant) without any awareness or even interest in the fact that, as different as are their effects on patients, they share certain similarities in structure which are intriguing in their specific relationship to the structure of DNA in the helix.

Thus, I ask, as an applied moral philosopher, a measure of tolerance for dealing with what may appear trivial, and tolerance for having plunged into the world of value thought apparently without regard to the keen fights over certain words and concepts that do not seem even to give me pause. But I think that we shall see that the trivial aspects of the nature of person that emerge in this discussion are very interesting, and that the need for plunging on toward a disciplined applied moral philosophy is great.

A second obstacle in the path of creating an applied moral thought lies in the failure to distinguish between the problems inherent in certain moral decisions—such as when to turn off the respirator—and the information from which those problems are formed and on which the decisions are based. Again, a similarity can be found in the sciences. If the biochemist is challenged by the chemistry of DNA and its relationship to the function of DNA, then he needs DNA to work with; and, except as it interferes with his experiments, he doesn't care if it

comes from a man or a mouse, but the physician trying to use the results of those studies must be concerned because he works with men, not mice.

At a recent meeting of philosophers, a finely constructed argument was presented that dealt with population problems. One of the examples from which the argument was drawn was biologically impossible. That impossibility was not relevant to doing philosophy, but it was crucial to medicine. Medicine is not done, it is practiced. So I ask tolerance again, because I am going to deal primarily with how the physician acquires the moral particulars of day-to-day clinical problems, rather than how he operates on those particulars in making a decision.

Perhaps by definition, and almost certainly by general agreement, the nature of person is central to ethical problems in medicine. Agreement begins to evaporate with attempts to enumerate and characterize the predicates of the concept of "person." The correspondence in the *Hastings Center Report* in reply to Joseph Fletcher's "Tentative Profile of Man"(1) is informative in this regard. One writer states that Fletcher is too abstract, and not based in the biology of man, another that Fletcher is behavioristically biased, confusing a characteristic of personhood with measurement. I was not privy to the whole correspondence, but if I were, I could find, I am sure, many other disagreements and perhaps as many agreements. Nonetheless, we understand the drive behind Fletcher's attempt to set some standards—provide some guides to measurement in order that we might get down to the daily business of *making* the decisions rather than constantly discussing *how* the decisions are to be made. In his second essay in the *Report*,(2) Fletcher is trying to distill his list of fifteen positive and five negative indicators down to four more basic indicators of personhood. The many reasons for and against the criteria are argued and cited in his discussion which could, of course, have gone on to encyclopedic length without providing much more guidance to a physician at a bedside. The discussion is the business of moral philosophers, and, I presume, moves their field forward.

While the substance of the discussion at this point may not provide physicians with the guidance desired, the very *fact* of the discussion provides the most basic and important direction