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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

of all—that is, that the issue of personhood is relevant to a decision made at a bedside. Since that truth has been present since physicians and patients first came together, it may seem self-evident, but that is not at all true. My contention that medicine is basically a moral profession—or moral-technical, if you wish, based on the fact that physicians are directly concerned with the immediate welfare of other humans—is probably not all that self-evident to most of my colleagues, and may even be argued here. That is, while the large problems of death and dying, transplantation and so forth are acknowledged by most to be moral-technical issues, it is not so clear to all that even in the treatment of trivial illnesses and human problems, moral difficulties constantly arise and are disposed of for better or worse by physicians and patients acting jointly or severally.

In a previous essay,(3) I discussed some of the reasons why the moral nature of medicine is so obscure but here I would like to touch on another reason. Often the abstraction of ethical issues, apparently so necessary for their dissection and understanding by philosophers, tends to remove them from the arena of their origin. That is, by concentrating on the frontiers of ethical thinking represented by organ scarcity in heart transplantation, the philosophers allow the physician who cares for patients as his daily job (none of whom may ever get close to a transplantation center) to continue in his belief that those intellectually interesting discussions have nothing to do with his routine concerns. He may even be thankful that he doesn't have to make such difficult decisions. Telling a particular asthmatic patient that moving to Arizona would be good for his asthma is not seen to be part of the same universe of discourse; it is merely a technical decision about asthma.

But here, in the reverse direction, is precisely what is so troubling about Fletcher's fifteen or even four indicators of humanness or Engelhardt's three(4) or anybody's whatever number of criteria for personhood. In searching for the essential predicates of personhood, it is necessary to refer to the properties of persons as they are found in this world. But it is self-evident that the properties of a person are not like the properties of a rectangle. The properties, whether they sound precise, like "cerebral function," or do not even pretend to

precision, like "awareness of self," are merely, to borrow from Robert Hartman,(5) metaphors. These property names, as metaphors, stand for the "totality of continuous transformations" of the root meaning of the word. We can never meet the person described by Fletcher's or anyone's indicators; he is merely the creature of the abstraction.

Physicians do not treat abstractions, they treat individual patients. They do not treat patients with the metaphor "self-awareness," they treat a person who, at that moment, contains one of the forms that self-awareness takes in the continuous transformation that is contained by the metaphor. And, further, the shape of self-awareness in that patient is itself undergoing continuous transformation, or at least so we believe. That may seem a complicated way of saying that physicians treat individuals–which we all knew anyway–but it leads to an important point about applied moral philosophy in contradistinction to applied physiology, for example. The point is that there is a basic difference between the nature of the properties of the body as shown in physiology and the nature of the properties of personhood.

The human body from time immemorial has contained all the physiology (at least that which is correct) that is described in modern textbooks of physiology. Further, astute physicians through the ages employed their experiential knowledge of that physiology in the care of patients. Its systematic discovery in the scientific era of medicine has vastly extended the practical utility of understanding human physiology largely through exact definition of phenomena. That is, it has become possible to correlate changes in physiology with disease states in a highly predictable manner only because the definitions of those aspects of physiology under study are sufficiently precise to allow reproducibility. But the definitions are in essence a consequence of the methods used to demonstrate the phenomenon. Thus, while it is possible to estimate blood pressure by feeling the pulse, such a method is not precise enough to allow duplication, and, in any case, is dependent on an awareness of blood pressure in the first place. The sphygmomanometer, however, measures blood pressure accurately enough to give the concept real clinical meaning. Clinical meaning implies that

something can be measured in a practical manner, has predictive and explanatory value, and can thus enter into decision-making. Even though a definition is often a complete abstraction of what occurs naturally, it remains extremely useful. For example, forced expiratory volume/one second (FEV_1) is merely the maximum amount of air that can be forcibly expelled from the lungs in one second. In other words, the definition is essentially the method.

This is not the place to explore the very real problems introduced into understanding physiologic processes by such artificial definitions; suffice it to say that at present the advantages seem to outweigh the disadvantages. All these definitions, to a greater or lesser degree, enjoy precision and reproducibility. I avoid using the word "objective" in reference to those measurements, since it is an overworked word in clinical medicine, which, I believe, often has more sentimental value than substance. While we are aware that these physiologic measurements are a static representation of a dynamic process and that variation is the rule in body functions, the measurements usefully stand for the thing they measure. While the variation may be considerable, the universe affected by the variation is usually small enough so that the predictive and explanatory value of the measurement is not destroyed.

Just as the patient has always been complete in physiology, from time immemorial, he or she has also contained all the properties of personhood considered by modern ethicists. And, equally, astute physicians through the ages have employed their experiential knowledge of those properties in patient care. There the similarity ends. A distinguished cardiologist once said that, because of advances in technology, the neophyte physician of today is in many respects the equal of the experienced physician of yesterday; the same cannot be said of the neophyte physician in the moral aspects of his profession. And, aside from the awareness of the problems created by our present discussion or its importance to philosophy, nothing in the attempts to distill the essence of personhood—that one quintessential factor—predicts a brighter future. One is reminded of the attempts by Boerhaave, a famous Dutch physician of the eighteenth century, to find the basic factor, the defining feature

of fever, something considered a disease at that time. He settled on an elevated pulse! Boerhaave was a brilliant physician and the apparent inanity of his conclusion suggests how muddy was the universe he was attempting to clarify. It took a century of observation and nosology to divide up the numerous, well-defined diseases that had previously been included in the rubric "fever." Precise definitions of the imprecise are not possible.

But in the nature of personhood, as opposed to physiology, because of the metaphorical nature of the names of the properties of person, attempts at precise definitions in the manner of the exact sciences would seem to me to lead away from, rather than closer to, understanding. Further, as I have noted, definitions useful in clinical medicine are dependent for their utility on the methodology that leads to the definition. For philosophy to develop a successful applied moral philosophy (and I will accept as the measure of success that the neophyte of the next generation be the equal of the present experienced practitioner) it would seem necessary to find methods by which the physician identifies the properties of personhood. In the light of the universal importance attached to the nature of person in moral decisions, those properties are moral data. Paul Ramsey objects to the word "data" used in conjunction with the word "moral" and I suspect that, in part, it is the implication of precision in the word "data" which offends him. It follows from Hartman's understanding of the metaphorical nature of the properties of personhood that no such precision is possible in the moral particulars of a person. Indeed, to seek precision in the physiologic sense, is, as I noted earlier, to move away from understanding in the moral. It may seem paradoxical to imply that greater understanding may come about by giving up the demand for preciseness. But there is a distinction between preciseness of thought and preciseness in the particulars on which the thought operates. To clarify that, it is necessary to refer to the differences between analytic thought and valuational thought as I have used those words in the discussion of thinking in medicine in "Preliminary Explorations of Thinking in Medicine".(6)

It follows from its reductionist nature that analytic thought can only be as exact as the definitions and data on which it is

based. That is, if I demonstrate to you the distinctness of the forced expiratory volume one second from forced vital capacity and how each reflects different functions of the lung, and if you are to understand me and use the concepts, it is essential that each word have the same precise meaning for both of us. (It is clear that the meanings do not have to reflect the "truth" about the lung—precision and accuracy are not the same.)

Exactness in valuational thought lies in another direction, particularly when it deals with conceptions of self. There I am being precise when I am able to delineate those particulars which are specific to *your* conceptions of self from those which are part of *my* similarly labeled conceptions—when I do not confuse what you say about you with what I say about you or about myself. Exactness is also lost when interpretation is confused with observation. That is, when you tell me about yourself, I leap from *what* you tell me to *why* you tell me, and why your conception takes that form. The interpretations may be correct, they may even add weight to your words, but they are not the conception itself as you displayed it. (Indeed, interpretation of that nature is analytic, not valuational.)

Both defects in valuational thought—confusion of hearers' thought for speakers, and mistaking interpretation for observation—are extremely difficult to avoid, the former because the hearer's conception serves an interpreter function in valuational thought. Shared knowledge of the world is essential if one person is to understand another. (Put another way, metaphors cannot work without some common understanding.)

The latter defect—substituting interpretation for observation—may be inherent in thought itself, but in reference to the particulars of person is particularly common in these days of widespread psychological sophistication. It seems necessary at this point to make a distinction between the particulars of personhood and the psychology of a person, since the term "psychology" is now used so widely as to have virtually lost all meaning. An example of the effect on medicine of a nearly universal psychologism among doctors and students may be useful. A twenty-five-year-old man developed pain in his throat of unusual character and duration which worried him greatly. He saw several physicians and was treated without effect. No

specific disease was found, but he could not be reassured. An adequate history revealed that his father had died six months earlier of cancer of the esophagus, and he felt his mother to be his primary responsibility since he was the only child still unmarried and at home. Armed with those facts and aware of the trivial nature of his symptoms, I was able to reassure him. I took his sense of responsibility toward his mother to be a particular in the moral sphere essential to a decision about his treatment.

When the case was related to some medical students, one of them noted that the patient probably had the symptoms because he felt guilty over the father's death and the fact that he had won the oedipal battle. Indeed, the student could have been correct. But she jumped over the patient's expressed sense of responsibility directly into the interpretation. I do not take the guilt to be a moral particular, since it is not known to me except by inference, but rather a psychological interpretation. And I certainly do not take the inferred oedipal conflict as a moral particular, but rather as a second-level psychological interpretation.

It is not my intention to belittle the interpretation that guilt secondary to oedipal conflicts underlay the patient's sense of responsibility. Indeed, I use this case with full awareness that the physical symptoms are most likely the result of psychological mechanisms—more probably pathological identification with the father than those suggested by the student—but that is irrelevant here. In fact, if the patient's illness was an inappropriate sense of responsibility (I am aware of the subjectivism implied in the word "inappropriate", but that, though important, is not my present topic), then understandings of "guilt" or "identification with father" might be essential to making the patient better. It is rather arbitrary to call the sense of responsibility a moral particular and relegate the guilt and oedipal conflict to the psychological, but it is important to the development of an applied moral philosophy, I believe, to make the distinction.

Another case may make the point more clearly. A woman with characteristic episodes of abdominal pain is found to have stones in her gallbladder; an operation is suggested. She says

that, if at all possible, she would like to delay her operation until her aged mother, presently ill, gets better, because her mother is her responsibility since her father's recent death. Here we have no difficulty separating the sense of responsibility from the symptoms or cause of the illness. We recognize our need to accept the sense of responsibility apart from her gallbladder disease. And, if her life were to be threatened by a delay in operation, we acknowledge the necessity to help her balance her needs against those of her mother, in acceptance of the natural existence of such a sense of responsibility in daughters.

I take the sense of responsibility to be a part of the anatomy of the person just as the gallbladder is part of the anatomy of the body. A sense of responsibility, the ability to form relationships, curiosity, the need for control, the need for love, the need to be needed, the desire not to be a burden are all universally found among persons. The list is not meant to be complete; many other properties could be, and perhaps should be, listed. Here there may be a need for a list in order that those looking for the metaphorical meaning of those properties for an individual patient might know what to seek. No psychological system of which I am aware explains their presence in persons. A psychology may tell us how they develop, why one hypertrophies and another atrophies, or even the pathology that results when one of those factors is absent. Psychologies may even tell us why they are present in the sense (anthropomorphic or teleologic) that it is good for persons to have these factors—but nothing explains why they are there; they are simply part of the moral biology of mankind. It seems strange to me as I write this because I, too, am used to psychological interpretations. Odd, because I have no trouble distinguishing between an acknowledgment of the anatomical presence of the gallbladder and its evolution, embryology, physiology, and pathology.

In an applied moral philosophy, the particulars germane to moral decisions reside in the anatomy of the person as well as the body. A critical examination of such a particular (in the first case above, the sense of responsibility) may be benefited by knowledge of its pathology—inappropriately great, inappropriately small, or just an inappropriate sense of responsibility—

but the essential knowledge on which such a critical valuation is based is the appreciation of its existence in the person in the first place.

To return to the first example, one might wonder how the physician knew that the patient felt so responsible for his mother. Quite simply, the doctor asked the patient. The actual train of questions first established that the patient was unmarried, the youngest child, that his sister and brother were both married with children of their own, and that he lived with his mother. Just as the fact, time, and cause of the father's death were elicited as part of a routine initial medical history, so was his marital status. The remainder of the questions were part of a specific inquiry into that aspect of the nature of the patient that applied to the problem at hand. In short, the particulars germane to the moral case were elicited by communication between the two, more specifically, through intentional speech acts.

The basic method for finding particulars essential to ethical decision-making in medicine that is suggested by this case, indeed by me in general terms, is the use of language. It seems reasonable in searching for the shape of an applied moral philosophy and, in particular, for a systematic or disciplined manner by which the moral particulars of the person are to be found by the applied practitioner, to start with the analysis of medical conversation. For the inquiry by the physician to have taken place in the first place and for it to have been successful—that is, produce information relevant to the patient's problem (more precisely the physician's perception of the patient's problem) much is assumed about the nature of speech acts. The work of Searle,(7) Fraser,(8) and Grice(9) is pertinent. (Much is also assumed about the relationship between doctors and patients, but that is not our present problem.)

Certainly we expect the conversations between the doctor and patient to have had intelligible meaning to both of them. While we intuitively know that to be true, Grice has summarized the argument in favor of its truth in a manner sufficiently serviceable for us to expect that both participants are cooperating and that cooperation implies certain characteristics of conversation. That which is implied in normal (as opposed to

pathological) conversation allows us to suppose that the content has reliability in context. That is, we do not expect the speaker either to lie, to be inappropriate, to say too much or too little, or to say it in an incomprehensible manner. What is more, we can expect that the hearer will often have to work (to infer) to determine what it is that the speaker means; it is often the case that we do not say in precise words what we mean.

While Grice's comments may not satisfy those searching for pure meaning in words, and there are definitely situations where his maxims of conversational implicature are flouted, or where they are inadequate, it is in the nature of any applied discipline, linguistics and philosophy included, that the discipline will be usefully employed if it is successful in the usual instance; it is not necessary that the logic of the discipline never fail.

But even if we accept that the conversation between doctor and patient is comprehensible, it is not at all clear (except intuitively) how the physician evoked the moral particular inherent in the patient's sense of responsibility. Here Searle (and Fraser on Searle) are helpful. Further conditions for successful conversational interaction on the part of the physician include his personal body of information; his background of knowledge, both technical and experiential; his knowledge of the culture of the patient; social conventions, how patients act; as well as the fact that he and the patient have shared knowledge of the world, that is, conceptions that they hold in common. Also important is his knowledge of the particular patient, from whatever source it may have come. Then there is the specific history of the previous aspects of the conversation in question. Also contributing to successful speech performance are the identity of both speakers and how they perceive each other's role in the interaction, how the patient sees physicians in general, and how the physician perceives patients in general.

In other words, to understand how the physician arrived at the particular of person, knew it for what it was, and was then able to use it, one cannot conceive of both arriving at the conversation like two *tabulae rasae*. But since we know that already, it is equally important to point out that a successful and disciplined applied moral philosophy cannot be based only on the untutored intuition of the applied moral philosopher.

The gentleman who found out he was writing prose did not have his prose improved because of that knowledge. In like manner, to point out to physicians that, when they have a conversation with a patient that leads them to make a decision based on both knowledge of person and knowledge of disease, they are applied moral philosophers, will not, by itself, improve the quality of their performance. There could be no performance if Grice's maxims and Searle's conditions did not hold to at least some degree, and it is equally true that increasing experience would very likely improve performance without any knowledge of the nature of speech.

But for the development and teaching of an applied moral philosophy, a systematic and disciplined approach to understanding speech would seem essential if we are to meet the criteria of success suggested initially: that is, the neophyte practitioner of the next generation is as good (at least in respect to the applied discipline) as the experienced practitioner of the present generation.

In this discussion, I have devoted myself to examining the particulars on which moral decisions are based rather than the mechanics of those decisions. In so doing, I have concluded that the basic source of information about the personhood of the patient is the patient's words. I am not saying only that one find out the details of personhood important to a particular patient by asking, for that seems at least partially self-evident (the degree that it is not self-evident is not my concern at this moment). Rather, I am saying that the patient will tell about himself, including particulars germane to moral choice without being asked. That such particulars, as part of ordinary clinical conversation, are there to be heard. The patient will, to some degree, display the particulars of his conceptions of self in the course of providing information about his illness.

But now we have come to a testable hypothesis. It seems to me, as I listen to the conversation between doctor and patient, that the facts of the patient's illness—the symptoms—are intertwined with the particulars of the patient's person. The physician, to make his diagnosis, is unraveling that fabric and is or is not discarding the particulars of person. If that is true, and can be demonstrated, as I think it can, we can begin to arrive at

a methodology for obtaining the information on which moral decisions are based. Such a methodology or even the information derived from it does not tell us how decisions are made nor allow us to teach others how to make decisions. It does not, in other words, define or teach wisdom. But surely it satisfies the first step toward wisdom, which must be an awareness that judgment is necessary and an awareness of the information on which judgment is based. Finding such a methodology—teaching how to listen for the particulars of person—does not even ensure that it will be employed, but it satisfies the first requirement for an applied discipline—a method that allows the application of the insights of the pure field to the applied.

NOTES

1. Joseph Fletcher, "Indicators of Humanhood: A Tentative Profile of Man," *Hastings Center Report* 2 (1972), 1-4.
2. Joseph Fletcher, "Four Indicators of Humanhood—The Inquiry Matures," *Hastings Center Report* 4 (1974), 4-7.
3. Eric J. Cassell, "Making and Escaping Moral Decisions," *Hastings Center Studies* 1 (1973), 53-62.
4. H. Tristram Engelhardt, quoted by Fletcher, "Four Indicators of Humanhood," p. 6.
5. Robert Hartman, "The Axiomatic Structure of Intrinsic Value," *Journal of Value Inquiry* 8 (1974), 81-101.
6. Eric J. Cassell, "Preliminary Explorations of Thinking in Medicine," *Ethics in Science and Medicine* 2 (1975), 1-12.
7. John R. Searle, *Speech Acts* (Cambridge: Cambridge University Press, 1969), esp. pp. 64-71.
8. Bruce Fraser, "Review of John Searle's *Speech Acts*," *Foundations of Language* 4 (1974), 433-46.
9. H. P. Grice, "Logic and Conversation," unpublished mimeo.