Philosophical Medical Ethics

Conscience, good character, integrity, and to hell with philosophical medical ethics?

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One of the recurring themes at the time of the Arthur case was what a good man and doctor Dr Arthur was, a man of integrity. A recurring theme throughout medical discussion of medical ethics, typified by the British Medical Association's *Handbook of Medical Ethics*,¹ is the importance of recourse to conscience.

In addition to this positive attitude to the importance of good conscience, good character, and integrity, doctors often have a distinctly negative attitude to philosophical discussion, argument, and criticism concerning medical ethics. They agree with Dr Watt that too often it leads "to abstract and inconclusive intellectual argument—neither conducive to postprandial reflection nor necessarily relevant to the insistent demands on the busy practitioner throughout his day."² As for the possible role of medical ethics in medical education, many no doubt agree with Professor Swales that, "... ethical philosophy is qualitatively different from and irrelevant to clinical teaching."³

The argument against philosophical medical ethics

Often in conversation, though not often in print, clinicians can be heard to combine these two positions in the way summarised in the title. Slightly more fully the argument goes something like this:

There is something wrong with medical education if it has to go in for all this discussion and argument about medical ethics. (In my day) we learnt about medical ethics by learning to become good doctors, in all senses of good. We had had, I hope, good moral education, starting well before we came to medical school, at home, at church, and at school. Our consciences had been formed early on, and when we got to medical school the process continued. We learnt what was done and what was not done, mostly from the example of our teachers but also by firm reproof if we behaved badly or inappropriately, and perhaps we might even have been rewarded by a faint smile or a nod of approval when we did the right thing. At the heart of our medical education was an emphasis on character development, on personal integrity, on obeying our consciences—in short, on being a good chap. We never heard about utilitarianism and deontological theories of ethics or even about the virtues; we just learned what was appropriate in which circumstances.

I cannot pretend that this is a verbatim quotation from any particular doctor but I think it easily could have been and I should be surprised if it does not set many readers nodding vigorously and wondering if this will not have to be the last article in my series about philosophical medical ethics.

Why good conscience, integrity, and good character are not enough

My first and most important response is that I have never heard of any moral philosopher, and especially of any moral philosopher particularly interested in medical ethics, who is in any way opposed to the encouragement of good character, integrity, and a well developed conscience. What many philosophers are opposed to is any assumption that these features can be sufficient even for moral development let alone for medical or any other sorts of ethics. Personally I have no doubt that it is a necessary part of medical, and indeed premedical, education that students and doctors are educated to have a good conscience, a good character, and integrity, but as soon as attempts are made to explain what is meant by these qualities the need for some sort of additional critical philosophical analysis becomes apparent.

CONSCIENCE

Conscience, for example, turns out to be an ambiguous concept. On the one hand is a concept of an unthinking but morally controlling force within us telling us what we should and should not do. This is the concept corresponding to the Oxford English Dictionary's "internal conviction . . . the faculty or principle which pronounces upon the moral quality of one's actions or motives, approving the right and condemning the wrong,"⁴ and corresponding to Freud's account of the "ego-ideal" or (later) "superego"—that is, the faculty of the mind in which the injunctions and prohibitions of "father . . . masters and others in authority . . . continues in the form of conscience to exercise the censorship of morals. The tension between the demands of conscience and the actual attainments of the ego is experienced as a sense of guilt."⁵

On the other hand is the concept of conscience corresponding to the Oxford English Dictionary's "inward knowledge . . . inmost thought . . . internal recognition of the moral quality of one's motives and actions."⁶ This second concept also corresponds to many theological and philosophical analyses in which conscience is described as an essentially rational faculty; Father Gerard Hughes SJ, for example, wrote that conscience "is not the name of some privileged insight with which we were all endowed at birth and which functions quite happily ever afterwards. It is simply the name of our ability to reflect intelligently on moral matters,"⁷ and in their textbook on medical ethics Beauchamp and Childress write, "In general, conscience is a mode of thought about one's acts and their rightness or wrongness, goodness or badness."⁸

It is thus immediately apparent that claims for the adequacy of a good conscience for medical ethics must make clear which of these two concepts of conscience is intended. If the non-thinking, non-rational faculty of conscience is intended the problem of conflict of conscience, whether intrapersonal or interpersonal, is left unamenable to reason. For example, if Dr A's conscience tells him to

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transfuse a Jehovah's Witness regardless of her own views and Dr B's conscience tells him not to transfuse such a patient, where stands medical ethics? Which position is right and why? Are both right? Why? Is no resolution or even attempt at resolution possible or desirable? Perhaps, it might be argued, a resolution could be attempted by appealing to good character and integrity, the two other members of the trio. They are considered below, but it seems difficult to deny the possibility, at least, that Drs A and B are both of good character and integrity. (Were there not in fact doctors of good character, integrity, and good conscience on both sides of the Arthur dispute?)

The obvious way out of such an impasse is to choose the second concept of conscience, in which the exercise of reason is an essential element, but if that concept of conscience is chosen the original claim that moral philosophy can be dispensed with and medical ethics allowed to rest on conscience, good character, and integrity becomes vacuous, for "making reasoned judgments about moral questions" and "thought about one's acts and their rightness or wrongness" are the main constituents of the activity of moral philosophy.

INTEGRITY

With the concept of integrity there is again a preliminary problem of ambiguity: integrity can mean some morally specified and admirable condition such as "sinlessness . . . soundness of moral principle . . . uprightness, honesty, sincerity"; alternatively and quite differently it can mean completeness or wholeness. (Dictionary definitions such as these are rarely if ever of any substantive value in philosophical discussion but are often exceedingly valuable for showing that a word has more than one meaning.)

The usual sense of integrity relied on in moral philosophy leans on the second more literal concept of (moral) wholeness or of being one's own person. It requires identifying oneself with a particular moral stance and sticking to it in the face of temptation to abandon it; it also entails a sense of what one can and cannot live with and is thus a fundamental part of one's moral character and identity. This sense of integrity does not, however, seem to obviate the need for moral criticism, reflection, and argument any more than does reliance on one's (unreflective) conscience, for people notoriously vary in what they morally speaking can and cannot live with, and if impasse or war is to be avoided some sort of rational reflection is required. Furthermore, how is one properly to decide what sort of moral agent one ought to be, where one must say "enough, no further" without such reflection and criticism? Should one, on the other hand, do merely what one was brought up and taught to do, without such reflection and criticism?

Surely even if the answer to that last question is yes it should only be given after such reflection and criticism. Iris Murdoch argues persuasively against the adequacy of such rational reflection and criticism, equating a Kantian rational agent with Milton's Lucifer⁸; MacIntyre argues powerfully for the importance of Aristotelian virtue theory⁹; but both of course recognise the need to provide philosophical justification and argument for their positions.

The philosopher Bernard Williams wrote, "One who displays integrity acts from those dispositions and motives which are most deeply his, and has also the virtues that enable him to do that."¹⁰ Here we have a concept of integrity that seems to use both the sense of wholeness and also some specific virtues akin to the first definition of integrity.

GOOD CHARACTER

The discussion thus shifts to the third member of the triad under consideration, good character or "virtuous" character. Can reliance on good or virtuous character (in association with good conscience and integrity) be sufficient for medical ethics and obviate the need for philosophical medical ethics? There seems to be two ways in which an affirmative answer might be plausible. The first is to claim that moral philosophy is primarily concerned with the virtues and therefore that study of different sorts of moral philosophy (for

instance, deontological and utilitarian theories of ethics), is inappropriate. The second is to claim that doctors do not have to understand the philosophical underpinnings of their morality; they simply have to be of good or virtuous character.

Questions about the centrality or otherwise of the virtues are, however, philosophical questions. Thus even if it were agreed that moral philosophy is primarily about the virtues (a resurgent theme in contemporary philosophy) it would be absurd to suggest that this made it possible for medical ethics to do without moral philosophy; unless of course the claim is that, while *someone* may properly be concerned with critical study of the virtues, doctors need not be; they need only to be of good character.

Once again the problems of such a claim are unpacked along with the contents. What are the virtues of a good doctor? This is a question recurrently discussed by medical educators, and disagreement, as well as a wide variety of proposed answers, is characteristic of such discussions.¹¹⁻¹⁴ The idea that this question is not a proper concern of the medical profession is hardly likely to appeal to the sorts of doctors who claim that doctors need not be concerned with the critical study of the virtues, yet to answer it without such study—that is, without critical philosophical study of the moral assumptions and objectives of medical practice—is somewhat like specifying the syllabus for therapeutics while claiming that neither the medical students nor the doctors laying down the syllabus need know any pharmacology. Of course, such ignorance used of necessity to be the case in medical training, and we look back at those times with some regret. Shall we not equally look back with regret at our contemporary readiness voluntarily to eschew critical moral philosophy?

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Three women have varying degrees of neck instability which causes pain in the neck radiating to the side of the head and aggravated by any form of exertion involving neck motions. During the attacks the hearing of the affected side becomes distorted, resulting in hyperacusis or tinnitus. Relief of the neck problem seems to coincide with relief of the ear complaints. Has this condition been previously described and if so what anatomical pathway would mediate such a symptom?

There is a history of reports of cervical deafness stemming largely from some German work, together with many anecdotal reports. The evidence, however, is somewhat insubstantial and a well documented report could add considerably to our knowledge and understanding. The general view would appear to be that the effects on hearing are related to temporary or semipermanent occlusion of the vertebral artery passing through the cervical spine rather than to direct cervical reflexes.—S D G STEPHENS, consultant in audiological medicine, London.