

IDEALISM IN MEDICAL ETHICS:  
THE PROBLEM OF THE MORAL INVERSION

by

Allen Ralph Dyer

Department of Religion  
Duke University

Date: 10/6/80

Approved:



William H. Poteat, Supervisor

Thomas A. Langford  
[Signature]  
[Signature]  
Robert T. Olson

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of Philosophy in the Department of  
Religion in the Graduate School  
of Duke University

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ABSTRACT  
(Religion)

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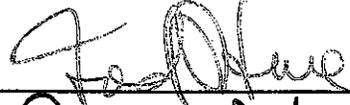
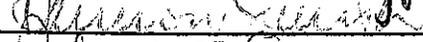
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## ABSTRACT

This dissertation examines conflicting ideals in contemporary society regarding modern medicine by focusing on the efforts of biomedical ethics to call medicine back to its humanistic roots. These efforts often fail, it is argued, because they rely on the same epistemological assumptions which have led medicine to focus too much on the physical aspects of disease and not enough on the patient's experience of illness. For ethics an account of knowing which holds complete explicitness as its goal lends itself more to matters of public policy than to reflection on the ambiguities of personal responsibility. It is the thesis of this dissertation that our culture has come to hold its ideals as moral imperatives, which no person in reality can live up to, rather than recognizing them as standards toward which one should strive, and furthermore that ruthless adherence to the demand for such moral perfectionism may inadvertently result in immorality justified on moral grounds.

The reasons for this approach to ethics may be understood by contrasting the approach to knowledge epitomized by René Descartes with Michael Polanyi's reflections on how

a scientist comes to know. Descartes sought to guard knowledge against religious dogmatism by basing it on doubt, rather than belief. Polanyi reminds us that the scientist must always believe his findings and convince others before they are accredited as "facts". Even physical science, held to be the most objective form of knowing, relies on tacit factors and antecedent belief, even if not acknowledged as such.

The problem Polanyi saw in contemporary society was not so much a problem for physical science, which largely ignores the tenets of objectivist philosophy, but a problem for ethics, which may precede by an appeal to purported facts rather than acknowledging the moral values which underlie personal commitments. Polanyi saw in our inability to acknowledge our moral commitments as our own the possibility of moral inversion, in which immoral ends, selfishness, even violence, might come to be justified on supposedly objective grounds.

Moral inversion is a phenomenon in which moral passions are repudiated in face of the demand for strict scientific objectivity. What happens in the repudiation is often a reversal in which the individual, unable to meet the demands for moral perfection and, seeing such perfectionism as hypocritical, repudiates it in the name of a scientifically justifiable reality. Yet such explicit repudiation does not do away with the force of moral claims, which continue to influence personal conduct whether actually acknowledged or not.

A number of issues in medical ethics are examined in light of the interplay between the values which may be in conflict in our society and the facts which are used to explain these conflicts. In each of several issues--physician advertising, use of placebos, opposition to involuntary psychiatric commitment to protect the civil liberties of patients, abortion argued as a definition of the origin of life, definitions of death, and informed consent--noble ideals held as imperatives may become immoral if the needs of individual persons are subsumed in the interest of maintaining abstract principles. In each of the examples so discussed, it is held that a problem arises in medical practice from the Cartesian mind-body dualism, which either identifies the body as a machine or views the mind in a disembodied way.

In order to better appreciate the responsibilities of physicians in light of these difficulties the concept of self is reviewed in philosophical and psychoanalytic perspectives. The self is identified as a moral agent by the values one holds, whether regulated by the superego and a sense of guilt, by the ego ideal and a sense of shame, or by a mature interaction with another person, unique by virtue of unique historical experiences. For the physician, it is concluded, medicine cannot be responsibly practiced without an assessment of the unique needs and desires of each individual patient.

## PREFACE

This dissertation is dedicated to my parents, Dr. John Dyer and Avis Dyer, and to the memory of Dr. George Ham, who prepared me for this work.

A number of foundations have contributed to my teaching and research activities over the past several years, and because this work has drawn so heavily on that teaching and research, as well as on my practice, they all deserve to be mentioned: The National Fund for Medical Education provided a fellowship, which enabled me to devote most of my time for the past year to the actual writing of the dissertation. Its president Dr. John G. Freymann and vice-president, Robert Stone, have offered numerous helpful suggestions on matters of medical education. The Hunt Foundation and the Roy A. Hunt Foundation have supported my teaching efforts in medical ethics; I am indebted to members of the Hunt family, particularly Alfred M. Hunt, Torrence M. Hunt, and Dr. Christopher M. Hunt, not only for their generosity, but for the close personal interest they have shown in my work. I am indebted to the Mary Duke Biddle Foundation and to Dr. James Semans and Mary D. B. T. Semans for support and encouragement. The Institute for Human Values in Medicine

provided a fellowship, which supported some of the preliminary research for this dissertation and provides a congenial forum for those engaged in teaching humanities in medical environments. Dr. Ewald Busse arranged a fellowship from the William W. Halstead Foundation to assist him in teaching Psychiatric Aspects of Middle and Late Life; this experience as much as any has taught me the importance of temporing the theoretical with the practical. Additional support has come from the Commonwealth Foundation through its grant to Duke University to strengthen health sciences education and from the Macy Foundation to support a research project on the doctor-patient relationship. The Danforth Foundation provided a Kent Fellowship, which supported graduate school coursework.

I would like to thank the members of my committee, who have stimulated many of the reflections on these pages by raising questions over the years in their own scholarship and in conversations. They are Professors Harmon Smith, Robert Osborn, Thomas Langford, Frederick Hine, Robert Coles, and William Poteat, director. To Poteat goes a special debt of gratitude for inspiration in the earliest consideration of the possibility of undertaking this work and for very specific diagnoses of its ills and prescriptions for treatment as it neared completion.

My secretary, Phyllis Thomas, has patiently and efficiently ushered these pages through uncountable revisions while at the same time attending to the myriad details of a busy office and contributing to a pleasant work atmosphere.

My family deserves special mention for appreciations which defy specification. My wife Sue has provided encouragement, support, scholarly example, as well as constructive criticism. Our sons, Will and Cliff, have provided numerous cheery interruptions, which have kept the developmental and historical perspective ever before me.

A. R. D.

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## INTRODUCTION

The purpose of this study is to examine the impact of traditional epistemology on ethics and medical ethics. An objectivist approach desiccates the sense of personal responsibility by analyzing moral issues apart from the actual life situation of a deciding agent. This approach obscures rather than clarifies the very existence of ethical dilemmas and hence impersonalizes, by conceptually separating, the making of choices and the practice of medicine. The work will draw heavily on the epistemological revisions of Michael Polanyi, which prove heuristically useful in demonstrating the dynamic mutuality of scientific pursuit and human values and the fallacy of the scientist/humanist dichotomy, to which modern medicine is heir.

For modern medicine, its practitioners and beneficiaries alike, a tension has arisen between a humanistic view of patient care and a technological view of medicine. Objectivist epistemology has encompassed human being in a technological ethos, in which man has become an object to be understood and controlled. Physicians and patients remain epistemological peers: physicians know no more about

their patients than they know about themselves.<sup>1</sup> But technological ethos expects a discarnate physician, functioning like a computer with no feelings, to manipulate the body of a mindless patient, thereby dehumanizing not only the patient, but the physician as well.

The charge of "dehumanization" in medicine warrants serious consideration but with an approach which would be truly radical, going beyond mere itemization of medicine's shortcomings, and thereby providing approaches for fundamental conceptual revision and reconstruction. It is an interesting testimony of the pervasive power of objectivist epistemology on the popular imagination that the physician--almost as anthropomorphic god--is held responsible and capable of being responsible for this state of affairs when the locus of difficulty lies in fact in a cultural outlook and expectation shared by physician and patient alike.

Part of the tension in medicine stems from a "two cultures" dichotomy in our society in which there is open conflict between the commitments of the "sciences" camp, with an emphasis on objectivity, fact, abstraction, and certainty, and the cause of

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<sup>1</sup>I am indebted to Dr. Otto Guttentag for this aphorism.

of the "humanities" with an emphasis on subjectivity, value, emotion, and experience. This dichotomy is itself epistemologically spurious, even though it has dominated the reflection upon the doings and knowings of this culture since the seventeenth century. Ideally medicine in its actual practice, were it independent of these reflections and unencumbered by these spurious dichotomies, should be in a good position to bridge this cultural gap with its dual epistemological heritage, the art and science of medicine. However, medical science in its very successes and prodigious accomplishment has been peculiarly liable to the enticements of the regnant objectivist--and false--account of all scientific knowing and doing. This account has not caused the complete disappearance of both physician and patient as persons, which an exhaustive and explicit obedience to this account would accomplish, because the unspecifiable elements of every actual practice elude the account. Both medical practitioners and the public have been led to misperceive the nature and larger human setting of medical technology, to misvalue it and thus to be led by it to grandiose expectations. The result is a highly technologized approach to medical practice.

Modern medicine is facing a crisis of confidence. It is simultaneously the hope of our civilization and suspect as the perpetrator of grave evils. The physician simultaneously enjoys great respect as a confidant with whom one might share all ills and at the same time is seen as the bearer of a brusque, impersonal medical technology. Encompassing not only life and death, birth, procreation and the possibility of genetic manipulation, public health, world health, population, allocation of scarce resources including food, as well as such mundane considerations as quality of life, problems of living such as marital happiness, there is hardly a political or social issue that is not related directly or indirectly to the concerns of modern medicine. Indeed modern medicine is caught in the vortex of a civilization rethinking itself. It has even been suggested that medical institutions have achieved a "religious" status in modern society, dealing with our "ultimate concerns" to use Tillich's conceptualization of religion. Pejoratively cast, this phenomenon is sometimes called the "medicalization of society."

It is this crisis of public confidence, which occasions the recent vigorous interest in medical ethics, and ethics quite generally. And ethics is embroiled in the controversies

surrounding modern medicine. Ethics is at once the vehicle for questioning and challenging medical practice and, at the same time, the bearer of medical tradition. Ethics is thus a multi-duty word, reflecting multi-duty tasks, which need clarification before it can be pressed into service for any of its manifold purposes. It is the purpose of this dissertation to reflect on the values underlying medical practice and the society in which medicine is practiced by reflecting on the approaches to ethics and medical ethics.

Even the phrase "medical ethics" is passing from currency in recent years, being replaced by "biomedical ethics" and more recently by "bioethics." This movement may be taken on the one hand as a recognition that the problems seen a decade ago as medical problems really involve the most fundamental values of society and not just the concerns of physicians and patients. The elimination of a medical focus may also represent a shift of confidence, an erosion of public trust.

An explicit attention to ethics might be seen as a corrective humanizing force in medical education. In fact, however, medical ethics and "bioethics" often have their own paradoxically dehumanizing effect on medical practice. By removing ethical reflection from the clinical arena--from the

setting of actual practice where those inalienable unspecifiable elements of the humane physician's attention to his patient continue to appear--to the arena of public policy and attempting to establish ethics as a rival rather than a coordinate discipline, one in which the physician is said to have no "expertise", even thinking about ethics is estranged from actual decision-making.

The irony of this development lies in its circularity. The charge which can legitimately be leveled against the technocrat is that of shortsightedness, in which decisions are based on private expertise, unconscious of value conflicts, rather than on socially reflective judgments. The ethicist may rightly repudiate this arrogation of power, but cannot at the same time lay claim to the same prerogatives as the true expert in ethical reasoning. It is often true that physicians are poorly trained in ethics and may assume that the warrants of their judgments lie in their special training or "expertise". As unfortunate as this misunderstanding may be philosophically, it is largely mitigated by the personal concern most physicians still demonstrate for their patients; however the same arrogance in a philosopher may have devastating consequences. Physicians and philosophers may thus seem naive to each other; physicians for

deciding with a paucity of ethical reflection; philosophers for arguing at a level of abstraction or criticism so far removed from the complexity of real-life situations as to appear ultimately hollow.

This could only happen in a culture where the specialization of forms of knowing has been accompanied by a systematic conceptual estrangement of the person and his responsibility from any accounts of our acts of knowing. In such a situation the physician, day-in and day-out, goes about, willy nilly, making his (sometimes bad, usually unreflected) life and death ethical choices--for they are no less ethical nor less choices for being unreflected--while the philosopher achieves an abstract clarity upon abstractly formulated questions, equally forgetting that only an actually existent responsible self in the context of a particular ethical dilemma can be a moral agent. Only by casting ethical problems in an epistemological framework is it possible to establish intellectual contact among the practitioners of various specializations by disclosing to them that all forms of human knowing are necessarily grounded in the self-accrediting decisions of responsible selves within a convivial order.

As a brief but sobering example of this challenge to medicine, played out so many ways in the "who decides?" discussions: a prominent ethicist from the Hastings Center, seeking experience in medicine, went onto an orthopedics ward and asked the residents if they had any ethical problems. Thinking he meant terminal patients on respirators or some of the usual headline issues often spoken of as ethical dilemmas, the residents replied that they currently had no ethical problems. He then examined the charts of two patients with similar fractures and found that one patient had received Demerol for pain and the other had received only Darvon. He then smugly concluded that these were not medical decisions but ethical decisions instead.<sup>2</sup>

The physicians acted on their values unreflectively; the philosopher abstracted ethical reflection from the context in which an action was to be taken. In attempting to demonstrate the centrality of ethics in clinical judgment, he regrettably separated thought from action.— A valid point could be made that choice of analgesic involves human values, attitudes toward pain and suffering, and compassion for the patient. To say that these concerns are not medical reinforces the prejudice that medicine is merely

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<sup>2</sup> Anecdote supplied by Willard Gaylin, personal communication.

a technical enterprise and that science is value neutral and further implies that a physician may or must defer ethical reflection to a specialist in ethics. This view is nothing short of scandalous and literally de-personalizes both reflection on the practice of medicine and reflection on ethics as well. Indeed a cogent case could be made for saying that physicians do not need courses in ethics or consultations with so-called ethical experts; they need instead to be shown how to appreciate and accredit their own personal, humane judgment in face of the ubiquitous threat of its impeachment by the regnant objectivist account of knowing and doing, which denies them any personal participation in both their medical scientific knowings and their therapeutic doings.

The point which needs to be stressed is that the domain of "clinical judgment" very much involves ethical choices even in mundane examples. This is an important realization in medical education because there is a real tendency for medical students and physicians, confronted by the hostile critics amongst ethical specialists, to attempt the strictly impossible: to limit their concern to technical matters, which can be carefully defended.

A reaffirmation that the individual is responsible for his or her actions should be obvious to anyone reflecting on ethics and might even seem trivial were it not for the devastating credibility we have come unreflectively to accord to the objectivist account of knowing and doing. We have so thoroughly come to expect an exhaustive and explicit account of behavior (we once might have said "conduct") that we become suspect of any attempts to wrestle with the personal ambiguities involved in the decision-making process. When an ethicist such as Robert Veatch argues that physicians have little training in ethics, but are much involved in making ethical decisions, we are easily led to his conclusion that this is a "generalization of expertise," the translation of expertise from a technical area to a moral area.<sup>3</sup> We are too ready to accept that the physician should refrain from making moral judgments because we accept the specialization of forms of knowing and accept that there could be such a thing as a value-free technical judgment independent of moral considerations. Physicians and laymen both participate in this folie à deux because it is part of our common cultural heritage. We ask for a precise clarification of the issues, when we know that is not possible. Yet neither physician nor patient would dare say very much

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<sup>3</sup>Robert Veatch, "The Generalization of Expertise," Hastings Center Studies 1 (1973):29-40.

about the personal ingredients that might bear on a particular decision when such personal disclosures might be subject to critical scrutiny.

Thus matters of personal ethics very quickly get translated into matters of public policy. We are relatively more comfortable analyzing issues than we are in looking at the ingredients of personal decisions, indeed looking at ourselves and our sometimes conflicted motives for action. Medical ethics provides a fruitful area for investigation since the decisions of the physician are of such obvious consequence, but self-scrutiny for the physician may be particularly difficult because the physicians' decisions are made so publicly and because they are so often made in the company of strangers. We should not conclude, however, that because the decisions of the physician are of such obvious consequence that they are inherently different from the decisions of any of the citizens of our culture, a used car salesman, a "homemaker", or a college professor, for all involve the living of lives, the making of choices, and the interaction of individuals with others who may not share our commitments and values.

Our culture inhibits moral reflection at a personal level. It encourages us to alienate our moral authority to an expert

or system of rules. In a culture both skeptical and (morally) perfectionistic, ideals are confused with imperatives.

Legitimate moral ideals are not recognized as goals toward which one might strive, but rather are held as imperatives to which one must adhere.

I believe that it may be shown that such alienation stems from the epistemological tradition of critical thought, best focused for us by Descartes and given shape by logical positivism. Although critical objectivity has become for several centuries a social criterion for valid knowledge, it has, by estranging the concept of the responsible self from its accounts of knowing and doing, destroyed the only conceivable ground for the action of a moral agent. From the perspectives of the decision-maker, the critical tradition has left two very divergent approaches to ethics, neither one entirely complete or satisfactory in itself: (1) the systematic articulation of belief or values, such things as creeds, catechisms, rules and laws; and (2) the critical analysis of such beliefs, either as they are articulated or as the articulation is implied in action (roughly speaking, deontological and teleological approaches). This regnant account of ethics (what Stanley Hauerwas calls the "standard account")<sup>4</sup> holds in the utilitarian

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<sup>4</sup>Stanley Hauerwas, Truthfulness and Tragedy: Further Investigation into Christian Ethics. (Notre Dame: University of Notre Dame Press, 1977).

and Kantian formulation that the purpose of ethical theory is the analysis of moral rules. This insistence derives from the modern demand for and interpretation of objectivity in which standards must invariably be explicit, atemporal, acultural, impersonal, and universal. Any reference to the agent or person who might make decisions is systematically eliminated. Medicine in such a view becomes a tragic profession (in Hegel's sense of the tragic) facing inescapable choices, not between a clearly defined good and an evil, but between conflicting "goods" or conflicting "evils," depending on one's perspective.

Polanyi's epistemology is truly radical, attacking the problem at its roots. It is not like Descartes' philosophy an attempt to come up with a revision of the old ways de nouveau, but rather it looks at the workings of the scientific method as practiced by scientists in pursuit of discovery to show that the Cartesian account is false (1) because it demands complete explicitness, something no scientist could live with, and (2) because the Cartesian account posits a dyadic relationship between the knower and the known and does not account for the community of knowers who must understand and accept or reject the discoveries of a particular scientist (Indeed now the discoveries are made by communities of interdependent

scientists). Descartes' system is based on skepticism and doubt; Polanyi corrects the Cartesian error by reminding us that knowledge rests on belief and trust established in a convivial order of a community of knowers committed to the pursuit of truth. Science does not proceed according to the dictates of the Cartesian account or method, Polanyi carefully demonstrates, because scientists largely ignore its tenets in actual practice, but ethics can be seriously misled.

Polanyi's notion of the moral inversion provides a useful conceptual framework for understanding how ethics can go awry in an age whose habits of thought have become abstracted from personal experience, an age whose habits of thought are both scientifically skeptical and morally perfectionistic. Moral inversion is a phenomenon in which moral passions are repudiated in the face of the demand for strict scientific objectivity. What happens in the repudiation is often a reversal or inversion in which quite immoral ends are justified scientifically. The inversion occurs when an individual is unable to meet the demands of moral perfection and, seeing such perfectionism as hypocritical (literally less than critical), repudiates it in the name of something "honest," "authentic," or "real."

Even gratuitous violence may be preferable to mindless conformity to hypocritical social convention. The ideal of critical objectivity causes such a person to repudiate exclusively the validity of any moral passions or value judgments whatsoever. However such repudiation on an explicit level does not do away with moral passion, nor does it do away with the force of moral claims. What has been repudiated at an explicit level has a life of its own, undomesticated by reflection, which will assert itself in some disguised form.

Modernity has been inspired simultaneously by a high moral dynamism and a stern critical passion for an objectivist perspective upon human affairs. The objectivist view seeks ruthlessly to discredit as merely subjective--and therefore spurious and thus essentially hypocritical--all of those values which have been sought and are embodied in the traditions of society and which must be replaced by a new order based entirely upon a value-free rationality. Since in such a scheme there is no longer a natural and legitimate setting for the embodiment and exercise of our moral passions (which do not simply disappear because they have been denied in an objectivist philosophy), no longer able to do their work in accrediting and upholding moral judgments, they masquerade as the engine

of a morally passionate denial of morality. As Polanyi has demonstrated,

Moral passions are thereby cast in the form of a scientific affirmation. . . These supposedly scientific assertions are, of course, accepted only because they satisfy certain moral passions. Unfortunately, moral passions undergo a fateful change when decked out as scientific statements. Legitimate moral motives stripped from their moral context, become isolated and inaccessible to ethical reflection.<sup>5</sup>

When moral passion is thus philosophically dispossessed and disappears from view and hence from all criticism, it is displaced as the moral passion which underlies the demand for objectivity, in which view it has no undisguised place. This is a moral inversion.

Medicine and medical ethics offer numerous examples of the moral inversion, and I will attempt to show that many of the well-intentioned arguments in medical ethics function in fact as moral inversions, setting forth impossibly abstract ideals, which are not recognized as ideals toward which one might strive, but rather as imperatives, which can only be compromised in the pluralistic social order that confronts the physician. Beyond that goal, however, I will attempt to delineate the even broader implications for ethical theory of the dynamic interplay of moral forces as regulators of

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<sup>5</sup>Michael Polanyi, Personal Knowledge: Towards a Post-Critical Philosophy, (New York: Harper Torchbook, 1964), pp. 230-231.

individual and social behavior, demonstrating the deleterious effects of the critical tradition for both individual and social ethics.

Chapter One, "The Tasks and Methods of Ethics," will review philosophical approaches to ethics particularly as they apply to the ethics of the medical profession. Specific examples from medical practice and from political debate will highlight the limits of theory. Deontological and teleological approaches will be critiqued for being merely theoretical and too abstract to adequately deal with many of the problems facing medicine in our culture. Appendices to Chapter One include the text of various ethical codes and a further note on the function of ethical codes.

Chapter Two, "The Self as a Moral Agent," discusses what is involved in making a moral decision. It reaffirms a view of personhood which is historically and culturally grounded and stresses the importance of tacit and sometimes unconscious factors in the decision-making process.

An appendix to Chapter Two, "The Impeachment of Altruism," further documents the moral inversion in modern culture by examining the set of values which have been identified by the term "altruism." The unarticulated ethic of the medical

profession might be called "altruistic," and altruism is the ideal which has been inverted in our objectivistic, skeptical and perfectionistic culture. Altruism has been rendered totally unbelievable as a possible human motive by the force of the critical tradition. Existentialism stresses instead "authenticity," and certain Christian traditions stress the ideal character of ethics, which no one can in reality fulfill. "Altruism," however, is again of focal concern because of the sociobiological suggestion of its genetic adaptability. This is a particularly revealing demonstration of the interworkings of ethics and a scientific view of reality in which the scientific view is falsely held to be a "better justification of inhibitory moral traditions than psychiatry or religion can provide."

Chapter Three, "The Cartesian Legacy," looks at Descartes' biography as well as his philosophy to understand how he could develop a system of thought which is at once so universally satisfying and at the same time so frustrating and inadequate. Descartes' philosophy separates the cognitive and affective realms and enables us to function in more or less purely cognitive realms for most of our adult lives, thus giving us a way of avoiding unpleasant affects. Though almost no one ever

really accomplishes this, it has become widely accepted as a social convention of how one publicly conducts intellectual affairs.

Chapter Four, "The Post-Critical Alternative," contrasts Polanyi's epistemology with that of Descartes for the purpose of demonstrating the utter falsification of ethics which may occur by rigidly adhering to the Cartesian account. Cartesianism leads us to suppose that we make decisions by rendering everything explicit. What happens when we believe this (regnant) false account is that our trust in our tacit powers (abilities, skills) is undermined. Since we are never able to give an explicit account of our actions/judgments/decisions/motives, we feel compelled to abandon them (the tacit, historical, cultural, dynamic, unconscious grounding for our actions). This may become moral inversion if we substitute an immorality which is easier to justify and to achieve.

Chapter Five, "Mind-Body Dualisms in Medical Ethics," focuses on selected problems in medical ethics to demonstrate how the Cartesian legacy inclines us to accept dualistic formulations of the problems we face. The examples from medicine and psychiatry detail two basic kinds of moral inversions, following the remnants of Cartesian dualism: (1) the

body treated as a machine (res extensa) and (2) discarnate mentality (res cogitans). The former is overly materialistic; the latter is overly rationalistic. As an example of an overly materialistic approach, the abortion debate is fought on grounds which identify life in mechanical physiological terms. If one were to accept the received forms of the argument, it would seem one were either pro-life or pro-choice. But such dichotomies make it difficult to identify the values which are held or to discuss the meaning of life in other than metabolic terms. As an example of an overly rationalistic approach, the ethics of placebos is often discussed as a matter of truth-telling without really probing how truth is known, particularly in those situations where placebos are most likely to be used, with the psychosomatic patients who experience symptoms for which no physiologic basis can be found. As an example based on a confusion of mind and body, involuntary psychiatric commitment is condemned by Thomas Szasz and others, but often because it is assumed that all persons are "autonomous," which some people are not, or because medicine should be limited to dealing with physical problems. In neither of these circumstances is any credibility held for the possibility of dealing with whole persons in relationship with others.

The concluding chapter, entitled, "The Responsible Physician" examines the responsibilities of the physician in relationship to the patient. The paradigm of responsibility for the physician is that of the parent for the child, not in the paternalistic sense that the patient is a child to the physician, but with full recognition that at a time of illness, the patient is temporarily dependent on the physician, just as the child is temporarily dependent on the responsible parent, who helps the child grow toward independence and autonomy.

A final note on methodology is in order. A post-critical epistemology implies self-understanding at the level of personal decision-making, which philosophy cannot accomplish, but merely make possible. From the brief sketches I have just outlined, it will be evident that I intend to rely on my experiences as a physician and as a teacher to contribute to the elucidation of certain philosophic problems. It is not my intention to revert to a merely abstract analysis of alternatives to settle these accounts once and for all. Rather, I propose to take my cues from Polanyi himself, who once charmingly described his work as "scandal-mongering," which in his case meant discrediting accounts in the history of science which falsely ignored the process of discovery.

Similarly I have a repertoire of such scandals in medical ethics, which I believe will demonstrate the crypto-Cartesian legacy of critical thought in medicine and the destructive effect it has on a holistic or personal approach to medical ethics and medical care, but perhaps more importantly I hope to open these issues to a process of ethical reflection which will reaccredit the active, responsible, and responsive judgment of those who make decisions. One sees in the way I have juxtaposed these issues and questions a precarious oscillation between the political and the theoretical, which I would like to highlight at the outset as a roadmap of what is to follow. As we proceed down the paths and avenues open to us by the practical considerations of medical practice and the theoretical reflections of ethics, I believe we will find these issues intertwined: the impersonal and grandiose ambitions of man to control nature, the scientific legacy of medicine, and the human desire to trust and be trusted, the humanistic legacy of medicine. Both these human inclinations are so deeply rooted in our philosophical traditions and so rigidly split in our minds and psyches that it is hard not to think of them as separate, mutually exclusive and irreconcilable. The tension is as current as modern medical ethical dilemmas, and as old as the difference between a Platonic and an Aristotelean world-view, Plato

emphasizing an ideal conception of society and Aristotle calling attention to the musings of a man of practical wisdom. Yet insofar as we are integral, whole human beings, i.e. persons of any moral integrity at all, not hopelessly fragmented, these dichotomous tensions are daily reconciled and integrated in all of us insofar as we do act responsibly under sometimes trying circumstances. I therefore take medical practice and the ethical reflection on that practice as an opportunity to review the philosophical traditions which shape the way in which we customarily view the world, and at the same time propose that a clarification of that world-view, seen as a reflection on the nature of ethics, and the nature of science, or perhaps more specifically, the nature of ethics in a scientific age, will help illuminate the problems which issue from medical practice.

CHAPTER ONE  
THE TASKS AND METHODS OF ETHICS

I.

In a homogeneous culture, tribe, or community, morality is tacitly understood with little need for formal reflection or articulation. One learns the rules of culture by living in that culture and not by being taught abstract and explicitly formulated rules to which one then adheres. In a heterogeneous group, what we call a "pluralistic society," insofar as it is a society, there is at least a modicum and perhaps even widespread tacit adhesion to shared principles; but insofar as it is pluralistic there is considerable and often articulated divergence as to the appropriate modes of interaction. Explicit attention to matters of ethics then becomes necessary.

In a stable culture, moral norms are internalized, and we think of ethics in terms of matters of conscience; in a changing culture, the internalized morality of a particular subgroup or individual may be in conflict with other mores,

and we may not trust that the dictates of individual conscience will be an adequate safeguard of right or correct conduct. Increasingly in this society we are moving away from informal standards of both personal and professional ethics, from broad and tacitly indwelt general principles developed over centuries, toward a civilly enforced body of law and administrative regulations. This change has been interpreted as one based on a deep current mistrust of all "assumed relationships," the breakdown of Gemeinschaft (a community of feeling that results from likeness and shared life experience) into Gesellschaft (a more rational, more mechanistic way of life, with greater structure and more written and explicit rules and regulations.)<sup>1</sup> Broad ethical principles no longer serve as shared values, and there is an attempt to make moral principles explicit as behavioral guidelines.

## II.

What then is ethics? It is more than morality, the values of a particular culture. In fact ethics may be said to be the process of reflecting on a given set of values, particularly as they are translated into action, often in a preconscious, prearticulate fashion. A working definition of ethics varies considerably depending on one's perspective, and this should be no

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<sup>1</sup>Daniel X. Freedman, cited in J. Romano, "Reflections on Informed Consent." Archives of General Psychiatry, 30 (1974): 192-235. This distinction is originally attributable to the German sociologist Toennies.

surprise. Medical ethics are related to but not limited to the norms of medical practice. Medical ethics also reflect the values of the culture in which medicine is practiced. Chauncey Leake, a pharmacologist and early commentator on medical ethics, notes that what is usually referred to as medical ethics is really more a matter of professional etiquette. He writes in the preface to his edition of Percival's Medical Ethics, which served as exemplar for the early AMA codes:

The term "medical ethics" introduced by Percival is a misnomer. Based on Greek traditions of good taste. . .it refers chiefly to the rules of etiquette developed in the profession to regulate the professional contacts of its members with each other. . .Medical etiquette is concerned with the conduct of physicians toward each other and embodies the tenets of professional courtesy. Medical ethics should be concerned with the ultimate consequences of the conduct of physicians toward their individual patients, and toward society as a whole, and it should include consideration of the will and motive behind this conduct.<sup>2</sup>

Dan Clouser, a philosopher teaching in a medical center, notes that "Medical morality is no different than normal, everyday morality. . .It is just that in medical ethics these familiar moral rules are being applied to situations and relationships."<sup>3</sup> Charles Moore, a practicing physician who spent a year at the Hastings Center studying medical ethics, wrote his reflections of his experiences there in an article entitled, "This is medical

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<sup>2</sup>Chauncey Leake, Percival's Medical Ethics. (Baltimore: Williams and Williams, 1927), pp. 1-2.

<sup>3</sup>K. Danner Clouser, "What is Medical Ethics?" Annals of Internal Medicine 80 (May 1974):657-660.

ethics?" He noted that, "Most of the conversations I have had with ethicists have tended to anger me, producing a feeling of deep frustration." He identified the reason for this frustration as the fact that most ethicists dealt with research issues and not with the issues facing the practicing physician.<sup>4</sup> I suspect there may have been deeper reasons as well, such as the gulf between their respective worlds of discourse. At the very least these vignettes suggest that there is considerable difference of opinion as to what medical ethics is or should be.

What the word "ethics" connotes may be very different to a member of a profession, a physician, reflecting on daily practice, and a philosopher, criticizing those practices from without. What I am suggesting is not just a mutual antagonism, though that may be an ingredient, but a difference of perspective, a difference involving the distinction of self and other. Both approaches are legitimate and relevant, yet confusion often arises when one speaks about "ethics" as to whether one intends to be self-reflective or critical. If one adopts a self-reflective stance, one opens oneself to the scrutiny of others. If one takes a critical stance, one runs the risk of making others defensive. A common connotation of ethics is often that of the critic of the moral behavior of others, of even sometimes

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<sup>4</sup>Charles B. Moore, "This is Medical Ethics?" The Hastings Center Report (November 1974):1-3. The Hastings Center is the Institute of Society, Ethics and the Life Sciences in Hastings, New York.

the scold; therefore it is important to keep sharply in focus the nature of the ethical enterprise one is undertaking.

The ethical orientation of the modern practitioner of medicine is particularly problematic. The contemporary physician is caught between the Gemeinschaft of traditional medical ideals and the Gesellschaft of regulatory guidelines. Traditions at least as old as the cults of Aesculapius and the Oath of Hippocrates stress the fiduciary character of medical practice: the fundamental warrant of medical practice is the trust placed in the physician, based on the physician's competence and intention to help or benefit the patient. But being traditional these ideals are largely unarticulated and inherently ambiguous. In recent years ever more explicit codification has supplemented the received traditions.<sup>5</sup>

An important distinction for "medical ethics" hinges on the notion of a profession. It has been suggested that self-

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<sup>5</sup>Prior to World War II one could cite religious texts such as the Decalogue, the Oath of Hippocrates, and Thomas Percival's "Code of Medical Ethics" (1803), but basically medical ethics derived from tacitly understood religious and cultural traditions. While many of these traditions are still valid and valued, the list of guidelines with which a physician now must be familiar is extensive and includes the following: The Principles of Medical Ethics of the American Medical Association, Opinions and Reports of the Judicial Council (AMA); "The Nuremburg Code (1947)"; the Declaration of Helsinki, adopted in 1964 by the World Medical Association; "The Institutional Guide to DHEW Policy on Protection of Human Subjects" (NIH) 72-102, published in 1971; and the American Hospital Association's 12-point Patient's Bill of Rights. The rate of increase in the number of federal and state statutes and the trend of recent judicial decisions really necessitate specialized legal consultation for a current appraisal of acceptable conduct in particular situations.

conscious reflection on standards of conduct is one of the defining characteristics of a profession.<sup>6</sup> Ethical reflection for a profession consists of setting standards, often articulated as ethical codes, then judging its members for inclusion or exclusion by those standards. Here the concern is as much with the moral reputation of the profession as a group as with the moral integrity of a particular member.<sup>7</sup>

Often there is no explicit statement as to the expected behavior of the professional, but through "socialization" or "professionalization," the physician comes nonetheless to

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<sup>6</sup>Stanley Joel Reiser, Arthur J. Dyck, and William J. Curran, eds., Ethics in Medicine; Historical Perspectives and Contemporary Concerns. (Cambridge: MIT Press, 1977), p. 1.

<sup>7</sup>It is interesting to realize that when we think today of a profession as being defined by the knowledge of a learned science, originally a profession was the verbal profession of vows upon entering a religious order. I wish to stress this point because I do not believe things have really changed that much if one considers what knowledge is in the continuity of human ideas. In medieval times knowledge was the province of religious orders, but modern science had its origins in religious belief, and even in modern time there is, as Polanyi stresses, an ingredient of personal commitment to the things known or believed, which is generally ignored in our contemporary accounts of science. I therefore submit, again in anticipation of what is to come, that a look at epistemology will be relevant to the understanding of ethics. This point will be considered further in subsequent chapters and in the appendix to this chapter.

understand what is expected. I often ask medical colleagues from other countries how ethics was taught to them. Almost invariably the reply is that there was little or no formal teaching of ethics. But then a curious anecdote will emerge, which will suggest something about the kind of standards to which physicians somehow learn to conform. In Belgium, for example, physicians are expected not to get drunk in public; even in non-medical situations, physicians are expected to maintain different standards of conduct. In Ghana, a physician was censored by the medical society for getting into an altercation with a taxi driver about the fee, suggesting that physicians should be so dedicated to service of others that any attempt to stand up for one's own interests reflects badly on the profession. In this country, the owner of a riding stable complained that a physician was "unethical" (understand "unprofessional"), because of rudeness in a dispute about riding time, and the physician was reprimanded by the professional society, not for standing up for his rights, but for identifying himself as a physician in the dispute.

These examples may sound quixotic, but they serve to illustrate the range of issues that may be considered under

the heading of "medical ethics." It may therefore be useful to keep in mind the differing tasks of ethics, which may lead to different methods of ethical reflection, depending on the purposes one assumes. The maintaining of clear distinctions about the tasks of ethics may help to eliminate some of the confusion that arises when the various approaches to ethics seem to be at cross-purposes. In the interest of maintaining that clarity, I offer the following comparisons:

Figure 1

## THE TASKS OF ETHICS

<u>Upwards perspective</u>	<u>Downwards perspective</u>
self-reflective	critical
moral inspiration	regulation of abuse
affective	cognitive
post-critical	analytical
teleological (end-based, goal-based)	deontological (rule-based)
fiduciary relationship (based on trust)	adversary relationship (based on control)
tacit	explicit

The upwards perspective is that of the individual agent in relation to the larger culture. The downwards perspective is the view on the individual from the perspective of the norms of the culture or group. In what I call the "upwards perspective," we are talking about the very highest standards of ethical conduct to which anyone might aspire, ethical ideals, not moral imperatives. The task of ethics in the downwards perspective is regulation of abuse. In terms of a profession, this would be the profession "policing itself," if viewed from within the profession, or subjecting the profession to scrutiny, if viewed from without. The upwards perspective is that of the individual (practitioner) seeking to insure that his own conduct is the highest possible. The upwards perspective presupposes the mutual trust of the physician and patient in their collaboration. There is no maximal limit on mutual responsibility of the patient and physician in their partnership. But there are minimal limits. The downwards perspective is that of the regulatory agency or professional society seeking to insure that the behavior of a particular individual does not fall below certain minimal standards. No trust is assumed, and in the downwards perspective, ambiguity is reduced through an adversarial procedure such as peer review, Institutional Review Board (IRB), or actual

judicial process.

These two approaches to ethics are not mutually exclusive, nor do they demand that one choose between them. Rather they serve very different purposes, operating at times simultaneously in the minds of a given person or group as a way of getting beyond the habits of modern thought which would have us choose either one or the other when we need to understand both, and.

The recognition of multiple tasks of ethics as disclosed by considering the operative norms of special groups such as the medical profession raises questions as to the methods of the ethical enterprise, not just in terms of choosing among conflicting allegiances, but also in terms of understanding what one is about when "doing" ethics. When is a question or issue to be understood as an ethical question or issue? Does it depend on one's perspective? If so, is this to suggest that different conclusions could be reached in different situations? If not, could one hope for an absolute guideline as a point of reference in making decisions? Our task will be not only to look at specific decisions from the perspective of the physician nor at specific rules from the perspective of the philosopher, but rather what we can learn about our culture from the ways in which we are inclined to apply moral principles to particular situations.

## III.

One of the features of our culture that has a bearing on ethics is its demand for conceptual explicitness. Another is its difficulty in addressing matters of value as ethical issues in their own right, the tendency being to translate matters of value into matters of fact, which are more convenient to deal with, often in a legal as distinct from a strictly moral context. In subsequent chapters it will be possible to analyze why this is the case. Here it will only be possible to illustrate the phenomenon. . . .

As an example of the deep-seated cultural confusion about how to deal with matters of ethics, we may consider the suit of the Federal Trade Commission against the American Medical Association. In 1975, the FTC sued the AMA, the Connecticut State Medical Society and the New Haven County Medical Association for being in restraint of trade under the Sherman Anti-Trust Act on the grounds that the AMA's code of ethics prohibited advertising. The charge borders on being preposterous but cannot easily be dismissed because of the general acknowledgment that high medical costs must somehow be brought under control and the general bewilderment about how best that might be accomplished.

What makes such matters particularly confusing is the number of issues which are dealt with simultaneously without clear delineation as to the conceptual levels that might be requisite for clear understanding and effective action. We are concerned with moral ideals, how ought things to be, but at the same time with pragmatic questions, how might such ideals best be accomplished. The traditional philosophical is/ought controversy has practical application where facts are confused with values and their relationship is not made clear. Analysis of this situation will demonstrate that what may have appeared to be a legally straightforward move has many ambiguous dimensions, the consideration of which may be informative of the manner in which this culture attempts to deal with value conflicts.

First of all is the perception that medical costs are extraordinarily high and that they should be reduced. That is a (value) judgment which is fairly non-controversial. The reason medical costs are so high is a matter of fact and is obviously complicated. It is often held that medical costs are high because of the things that physicians do, not only charging high fees, but also in ordering expensive tests and procedures. This is a seductive argument, because

it is obviously true, at least in part, but it is misleading because it ignores the role of the patient, i.e. the public, in the determination of costs through the expectations placed on the health care delivery system. The localization of responsibility solely with the physician may obscure an even more pervasive folie à deux, namely that physicians and patients in this culture share grandiose and expensive expectations of the medical system.

The assumption of the FTC is that the reason costs are high is because doctors have a monopoly on health care delivery and can thus maintain artificially high costs for their own profit. If doctors were not prohibited from advertising, it is held, prices would come down because patients could shop for the best deals. In June 1977, Michael B. Pertschuk, a lawyer and chairman of the FTC, stated the case as follows: "One possible way to control the seemingly uncontrollable health sector could be to treat it as a business and make it respond to the same market place influences as other American businesses and industries."<sup>8</sup> In other words, medicine could better be controlled if it were understood as a trade and not as a profession. Such assumptions are held as facts and are used to justify the

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<sup>8</sup>H. Thomas Ballantine, Jr. "Annual Discourse--The Crisis in Ethics, Anno Domini 1979," New England Journal of Medicine 301 (September 21, 1979):634.

administrative actions taken by the FTC even though there is little economic data to warrant the conclusion that medical care could function as a "free market" commodity<sup>9</sup> or if it could, that advertising would stimulate competition and reduce costs. Though the "facts" are dubious, they are believed, and because they are believed, the values which undergird the actions taken are removed from the realm of moral debate. What makes this a disturbing commentary on American society, the relative virtues and vices of both the AMA and the FTC notwithstanding, is that there seems to be no conviction that it would make any difference to voice moral concerns as moral concerns and expect that it might have any force to change the way people would act. What it would mean to deal with this issue as a moral issue is that cost containment would be sanctioned as a matter of personal and professional conscience, and physicians, if not patients as well, would look for ways of reducing costs.

The attack on the code of ethics of the AMA is itself a curious move involving some mistaken assumptions. If the FTC were to make its case in a strictly logical fashion, it should demonstrate not only that the reason medical costs are high is because physicians don't advertise, and the

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<sup>9</sup>For extensive discussion of the facts and values in this matter, see Carol Levine, "Ethics and Health Cost Containment," Hastings Center Report 9 (February 1979):9-13.

reason physicians don't advertise is because the code of ethics prohibits it. Whether or not the first assumption is true would require a sophisticated economic analysis to demonstrate, but it is clearly not the case that the reason physicians don't advertise is because the code of ethics prohibits it. The code of ethics doesn't serve as a regulatory document in a voluntary organization to which not all physicians belong anyway, and furthermore, even if it did, it does not in fact prohibit advertising. What the Principles of Medical Ethics do say is that the physician should not solicit patients. (Principle 5)<sup>10</sup> The Opinions and Reports of the Judician Council of the AMA, a document which periodically comments on the interpretation of the principles in light of particular case situations, makes it quite clear that what is meant by "solicitation" is "obtaining patients by deception."

Thus it is no surprise that the AMA, as part of the more than \$500,000 in legal fees spent in its defense, based its position on this point of fact, rather than attempting to articulate the moral grounds for its code of ethics and its status as a profession. The point that the code ("principles") does not prohibit advertising is a moot technicality and a concession to the FTC that the AMA shares with the FTC the same

<sup>10</sup> See appendix to this chapter for text of the AMA Principles (Preamble and Section 5) and for further discussion about the functions of ethical codes.

epistemological outlook and the same approach to dealing with matters of values. In fact most scrupulous physicians would find it unthinkable to advertise, no matter what the AMA code or the FTC said. (It would not similarly be considered unethical to discuss one's fees or even to publish one's fees even though too few physicians possess the skill to be significantly candid with patients about matters of money.)

One of the paradoxical effects of the FTC action has been to focus attention on an almost forgotten ethical document and to stimulate thought and discussion about the meaning and nature of a profession as distinct from a trade. Had some of this understanding been available to the AMA, it might have been better advised to articulate the moral warrants of professional life, the ethical justification for its prohibition against solicitation and the function of a code of ethics in maintaining ethical standards, rather than rest its defense on a fact which was not really at issue in the first place. Professional ethics presuppose Gemeinschaft, whereas a government regulatory agency presupposes its goals must be accomplished by a Gesellschaft.

When the AMA first introduced its code of ethics in 1847, it represented but one of several rival approaches to health

care; many physicians were poorly trained if at all. One of the unquestionably significant contributions of the AMA has been to establish uniform standards of training and practice, so that if one has appendicitis, for example, one can trust that the care one will receive in an accredited rural hospital will be very similar to that in a sophisticated urban center. The approach to the treatment for strep throat will not vary from practitioner to practitioner; it will be treated with antibiotics, and antibiotics should be refused if the infection is viral. With such rigorous uniformity of standards, a well-trained physician does not seek to establish a practice by direct public appeal through the media, but rather by establishing a reputation based on competence, as the following example illustrates:

An ophthalmologist practicing in a small city in upstate New York developed a new procedure, which helped restore the vision of children with congenital defects of the extra-ocular muscles. The success of his operation was reported in the local newspapers. He was concerned that this account might be seen as an improper attempt to solicit patients and that he should have reported his findings only to the medical community, who would then refer appropriate cases.

The FTC was successful in reclassifying medicine from a profession to a trade. On November 13, 1978, a decision and

order was issued by FTC administrative court which barred the AMA from making any reference to advertising and the solicitation of patients, and further prohibited the AMA from "formulating, adopting and disseminating" any ethical guidelines without first obtaining "permission from and approval of the guidelines by the Federal Trade Commission."<sup>11</sup>

One might say, depending on one's beliefs, that the FTC action was long overdue and represents a creative effort to bring organized medicine into line or that it represents an unfortunate intrusion of the government into the moral life ("freedom") of its citizens. The point I wish to stress is not that the FTC action was right or wrong, but that it was done in the wrong way for the wrong reasons from the standpoint of ethics. Matters of value were camouflaged as matters of fact and the very real moral controversy was shortcircuited by translating value considerations into a debate about economic facts. Nonetheless the act whereby medical care is determined to be a commodity is an appraisal, a value judgment. It is a choice even though the grounds for making that choice are not subjected to ethical reflection.

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<sup>11</sup>Ballantine, Ibid., p. 635. The saga will continue, for of course there will be appeals taking many years. Meanwhile Congress temporarily clipped the wings of the FTC by refusing to authorize its fundings. Some physicians and clinics have begun to advertise, and many have been sued by the FTC for making false claims. For several years now the rate of increase of hospital and physicians costs have been held to a rate much lower than the general inflation rate, and this has been accomplished without significant advertising.

Furthermore it is an appraisal that runs counter to a very different appraisal, namely the judgment of the physician that medical care cannot be reduced to an impersonal and strictly economic transaction, for all that we recognize that physicians do not make as much of the personal encounter as might be desirable. Indeed the most trenchant criticism of the AMA's code of ethics might be that it does not adequately spell out the fundamental importance of the concern for the patient and the partnership with the patient in the doctor-patient relationship so thoroughly is this taken for granted.

#### IV.

Cases of such complexity raise numerous questions, many of which might properly be considered ethical questions, and many of which suggest the relationship of ethics to other disciplines such as law and politics. Analysis of the details of these various questions could be virtually interminable with not only rival disciplines having much to say on the matter, but also rival ethical theories. We are faced with the perception of a very real problem, but with no clearly defined approach for its resolution. It becomes important to reflect not only on the particular approaches to ethics, but to the various methods of going about ethical reflection

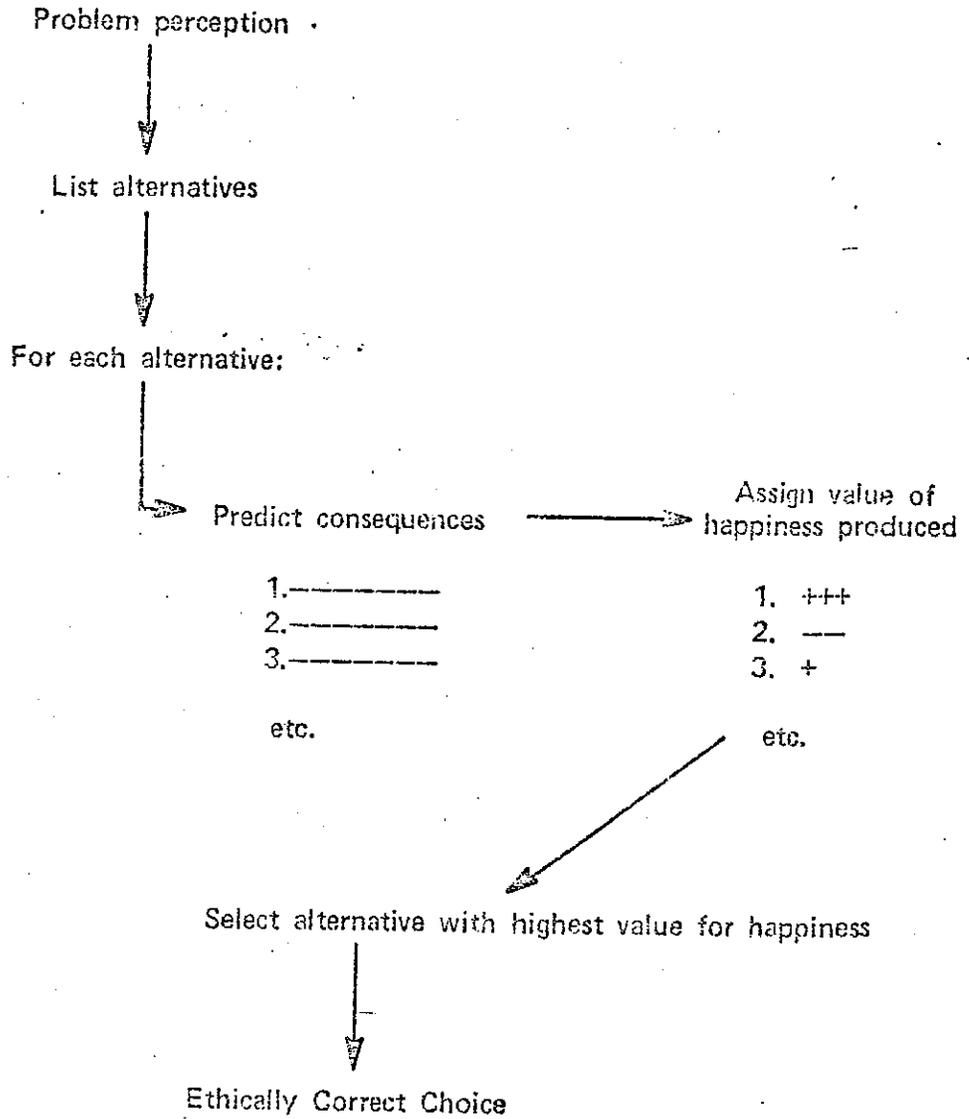
in general.

William Frankena, in his practical and popular text, Ethics, distinguishes two types of theory of moral obligation in philosophical theory, teleological and deontological ethical theories. Teleological ethical theories (from the Greek telos = end or goal) hold that the ultimate or basic criterion or standard by which an act is judged morally right, wrong, obligatory, or correct is the general happiness of all people concerned, or the greatest net balance of good over evil. This is the principle of utility or beneficence, which implies that good and bad are capable of being measured and balanced against each other in some quantitative or mathematical way. Thus teleological theories often go by the name of utilitarianism. They are represented by such philosophers as Jeremy Bentham, John Stuart Mill, G. E. Moore, and most recently by Joseph Fletcher, whose situation ethics employs as its central principle, "agape," the love for humanity, or general goodwill.<sup>12</sup>

Act-utilitarians judge each action individually according to whether it will promote the general happiness, whereas rule-utilitarians select rules of conduct which are judged to promote the general happiness, and then act in accordance with those rules. Figure 2 illustrates in a schematic algorithm

<sup>12</sup> Joseph Fletcher, Situation Ethics. (Philadelphia: Westminister Press, 1966); Morals and Medicine. (Princeton: Princeton University Press, 1954).

Act-Utilitarian Ethical Method



Method fails if:

- 1) Unable to predict consequences accurately
- 2) Unable to estimate accurate happiness values

(decision tree) the steps involved in the act-utilitarian form of the teleological ethical method.<sup>13</sup> By appeal to this visual schema one notices the variable dimension of time as well as the necessity for mathematical quantification. The decision-making process starts with a perception of a problem, proceeds with a listing of all the conceivable alternatives, for which consequences are predicted and values of happiness assigned. The limitations of this method are noted in that the method fails if one is unable to predict the consequences accurately or if one is unable to estimate accurate happiness values. In medical ethical dilemmas it is often difficult to predict consequences accurately. For example, it was generally assumed Karen Quinlan would die if her respirator were turned off; she did not. Furthermore there is often such a disparity between the individual happiness or suffering and the general social welfare that it makes it very difficult to calculate happiness values in individual situations. What and whose happiness is being considered when a respirator is turned off? Our awesome ambivalence in face of death makes it difficult even to acknowledge consciously the full range of alternatives and their possible consequences. What might be the real impact of such things as elective death, suicide, euthanasia, active and passive, and how

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<sup>13</sup>The decision trees are taken from Howard Brody's excellent "programmed" text, Ethical Decisions in Medicine. (Boston: Little Brown, 1976).

close are they psychologically to murder?

Deontological ethical theories maintain that there are rules or principles of action which have moral validity independent of the consequences and that one must act in accordance with these rules or principles. Deontological theories assert that there are considerations other than goodness or badness on which decisions are to be based, things such as keeping a promise, maintaining justice, or adhering to a commandment of God or the state, which are important regardless of the consequences of the action. One finds deontological theories in well-defined communities, such as religious communities, where one of the ethical considerations is preservation of the social order. Professional standards of ethics have such deontological features, where the rule or principle may be applied to exclude or coerce the deviant member in order to maintain the reputation of the group. Duty, obligation, obedience and loyalty are the values which define deontological functioning. Because of the specificity of the application of ethical principles and the possibility of conflict among principles, there tends to be an elaboration of principles or laws to apply to various situations. Thus one sees the development of a complex corpus of law and devoted study as in Talmudic scholarship or in American constitutional

law. This problem can be avoided in ethical theory if one can claim that there is only one basic principle. The best example of this kind of pure rule-deontology is Immanuel Kant's categorical imperative, which in its first form states, "Act only on that maxim which you can at the same time will to be a universal law,"<sup>14</sup> or alternatively stated, "Act always so as to treat people as ends and not merely as means only."<sup>15</sup>

Figure 3 delineates the steps in decision-making following the deontological ethical method. The alternative actions arising from a perceived problem are compared with a list of rules or principles looking for consistency. If there is no consistency, one may appeal to a higher authority in search for a right action, but is left unguided if the rule or principle (or authority) does not specify action in a particular situation or if the application of rules or principles result in conflict.

An example of a case in which Kant's principle might be illuminating is the question of removing an organ from a "brain-dead" person on a respirator for transplantation. By the notion that brain function is necessary for "personhood," the body is not a person, and we are free to use it as a means toward some other value: saving someone else's life. But we are similarly not free to remove an organ from a living person with-

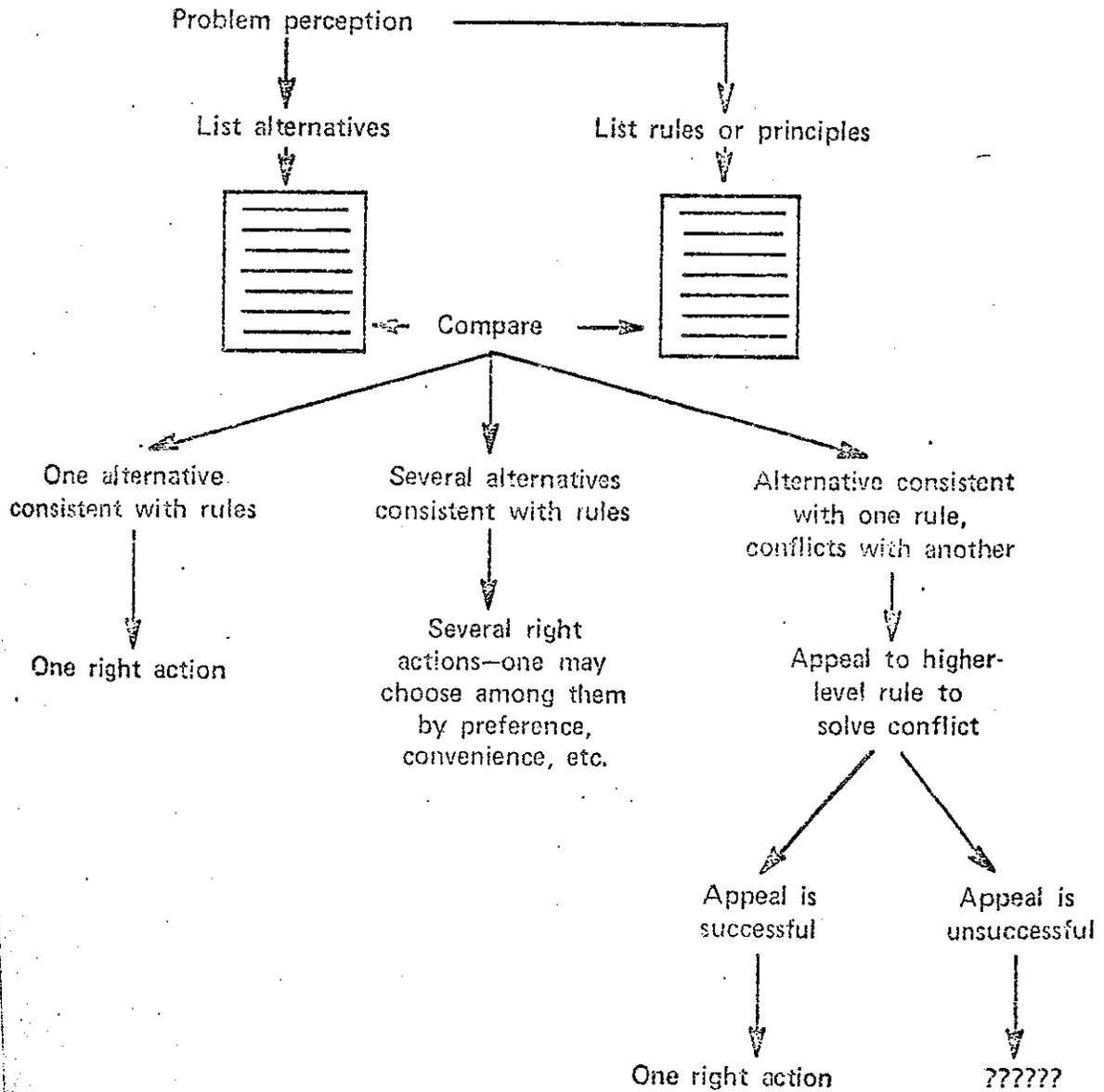
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<sup>14</sup> Immanuel Kant, Fundamental Principles of the Metaphysics of Morals. (Indianapolis: The Library of Liberal Arts, Bobbs-Merill, 1949), p. 38;

<sup>15</sup> *Ibid.*, p. 46.

Figure 3

Deontological Ethical Method



out his consent to save another's life: that would be using the person as a means and not as an end in himself. Under strict utilitarian guidelines, we could do so if the general happiness would be increased--say the person needing the organ was a great scientist and the involuntary donor was a depraved criminal. Here the Kantian deontologist could claim his method to be superior to utilitarianism, because it attributes to the individual not just value, which is relative, but the dignity of being regarded as an end in himself.

The teleological and deontological ethical methods share as liabilities the abstractness of their application. By attempting to dissect for analysis the ingredients involved in decision-making, many considerations which cannot be easily articulated or brought to consciousness fail to receive sufficient attention. Cognitive elements are stressed while affective elements may be suppressed.

Another method of ethical reasoning is the consequentialist approach, a method in which an action is judged to be morally right or wrong by judging the consequences of the action. Utilitarianism is in fact a form of consequentialist ethics inasmuch as it specifies criteria, such as general happiness, by

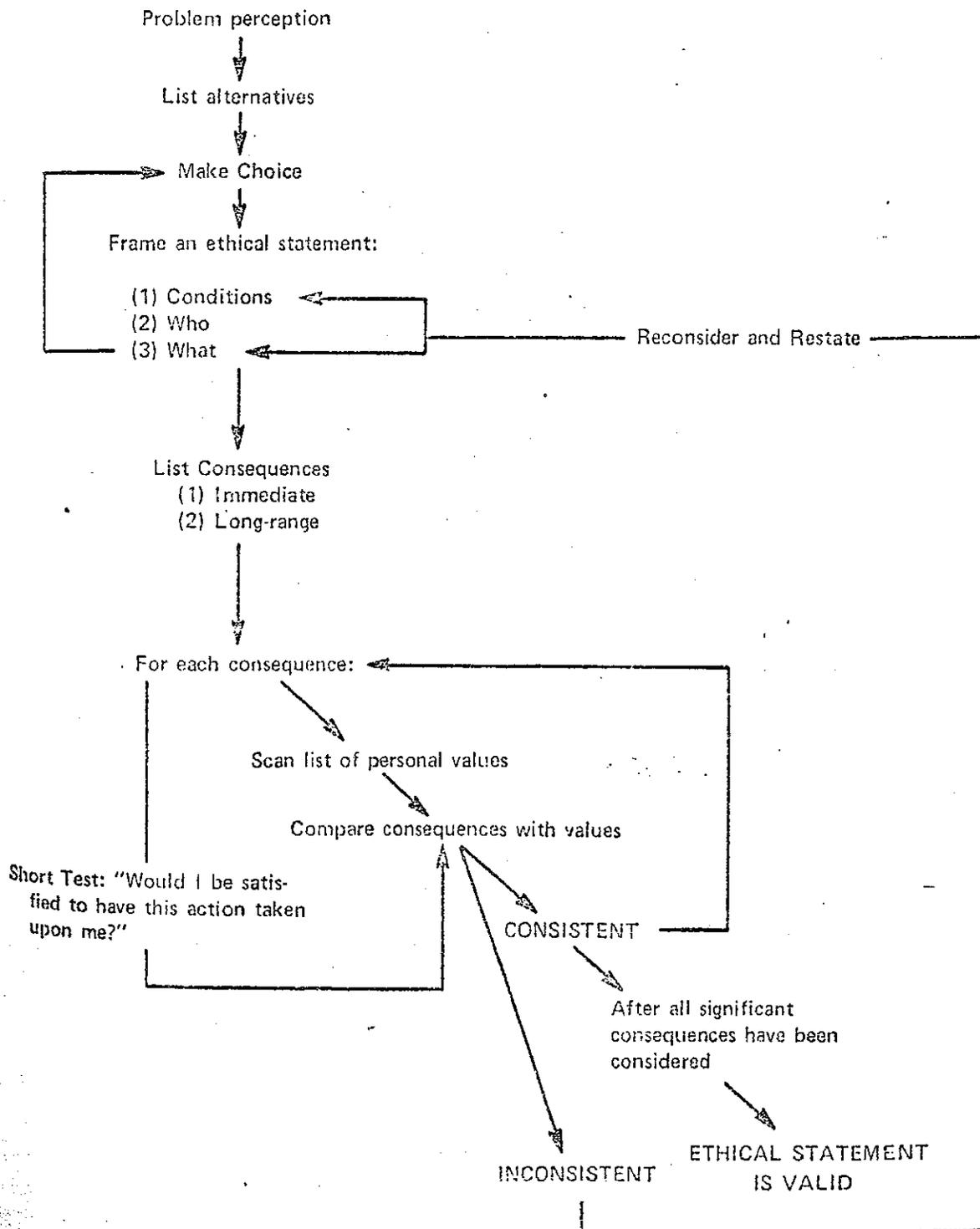
which moral actions are to be judged. It is a common point of distinction in ethical theory to differentiate those who hold that certain types of action ought to be done or not done irrespective of circumstances and consequences and those who deny this; or to differentiate the consequentialists, to use G. E. M. Anscombe's term, (including Betham, Mill, G. E. Moore, Fletcher) and those Alasdair MacIntyre labels as consequentialism's absolutist critics (including not only Kant and his latter day followers, but also such diverse predecessors as Aristotle, St. Paul, and Aquinas).<sup>16</sup>

The consequentialist ethical method is diagrammed in Figure 4. Several features immediately distinguish this method from the teleological and deontological methods. First it will be noticed that one of the first steps is to make a choice among the alternatives--before reflection and analysis. This accounts for the human tendency to favor a particular course of action at a "gut level," which is not necessarily wrong so long as those inclinations are carefully scrutinized. The feedback loops in Figure 4 account for that process of consideration and reconsideration. The consequentialist method accounts for cognitive factors in its demand for consistency as a test of validity of that statement. What is striking is that it also recognizes the

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<sup>16</sup> Alasdair MacIntyre, "Why is the Search for the Foundations of Ethics so Frustrating?" Hastings Center Report (August 1979):16-22.

Figure 4



affective components and insists that they too be considered. The short test might be paraphrased "Is this an action I could be comfortable with?" and properly gives attention to affective as well as cognitive considerations.

## V

The striking contrast between the consequentialist method and the absolutist approaches is the focus on the personal issues for the deciding agent in the consequentialist method and the focus on the issues, independent of a person who might act, in the absolutist approaches. One might immediately say "Of course, these are not mutually exclusive alternatives; one needs consider both the deciding agent and the issue." The matter would be simple were it not for the altogether too familiar experience we have all had in ethical argument, bull-sessions, or political debate of seeing relevant personal issues discounted as meaninglessly subjective and therefore unworthy of consideration in an argument tacitly governed by the demand for total explicitness and impersonality. This experience of impotent frustration suggests some of the sources of social discontent of the poor, the weak, the powerless in calling moral attention to their situation. What kinds of arguments can be

advanced that have suasion over the social order? Though such dynamics are complex, we must at least consider their implications for ethical theory.

Stanley Hauerwas attacks the absolutist view of ethics, what he calls the "standard account" and what I prefer to call the "regnant account," the view which holds that ethics should deduce by reason a truth which could be applied in a particular dilemma. This view, Hauerwas points out, would hold that ethics should be universal, impersonal, atemporal and a-cultural. Hauerwas contrasts this standard account with an approach based on "story" or narrative to re-emphasize the centrality of the moral agent in moral action. His critique hinges on a view of "objectivity" at work in modern culture which contaminates thinking about ethics by requiring a dissociation between the issue and the agent, the truth and the knower of the truth, the decision and the decider. About this notion of objectivity and its deleterious consequences for our moral life, I will have more to say in the following chapters, but Hauerwas very deftly sets the tone in the context of our consideration of ethical theory.

I am not trying to supplement the Kantian paradigm that appears to many today to be the only intelligible form of moral objectivity; rather I am trying to provide a new way to conceive of moral rationality and objectivity. It is not the demand for "objective moral judgments" that has misled us, but rather the theories of "objectivity" that have dominated the modern period."<sup>17</sup>

<sup>17</sup> Stanley Hauerwas, Truthfulness and Tragedy. (Notre Dame: University of Notre Dame Press, 1977), p. 2.

Hauerwas specifically takes exception to Frankena's approach to ethics, which attempts to explain ethical behavior in terms of a theory of obligation, rather than adequately accounting for the notion of "virtue" in explaining why people are moral. The critique is an important one because among the moral philosophers, Frankena does recognize the importance of the concept of virtue for moral life, but seems unable sufficiently to divorce himself from the standard account to give an adequately developed moral psychology. He notes, for example, with Pritchard that when one turns from the "vivid accounts of human life and action" found in Shakespeare to moral philosophy, the latter seems remote and abstract from the facts of life.<sup>18</sup> This confession may be telling of the predicament of the moral philosopher, who in his account of moral theory in a rigorously objective fashion is reluctant to mess with the uncertainties and ambiguities that accompany subjectivity. This realization is not to depreciate the importance of a well grounded theory of moral obligation, but rather to open up for consideration the more personal, but less precisely specifiable, elements of moral life. Put starkly in Hauerwas's words, "Integrity, not obligation, is the hallmark of the moral life."<sup>19</sup> That integrity is literally an integration:

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<sup>18</sup>William Frankena, "Pritchard and the Ethics of Virtue," *Monist*, 54:17, quoted in Hauerwas, *Ibid.*, p. 40.

<sup>19</sup>*Ibid.*, p. 41.

of our beliefs about the world in which we live and our beliefs about the values and purposes by which we should conduct our lives. That integrity includes but is not limited to obligation to externally conceived imperatives. More fundamentally it issues from internal commitments, which we honor in order to maintain our sense of who we are, our identities as persons. It is a psychosomatic integrity of mind (thoughts) and bodily feelings (affects).

This approach to ethics may seem so obvious as to be trivial and at the same time so threatening as to require strenuous denunciation. To consider an approach to ethics that is not universal, but rather an approach that is personal, temporal and cultural raises the spectre of ethical relativism. To admit psychological considerations into ethical reflection raises the possibility of pluralism and individualism, which might threaten the social stability. To consider personal motives, intentions, and emotions may seem tantamount to opening Pandora's Box to come what may. Nietzsche's observation that "If God is dead, anything is permitted," may be paraphrased, "If science is not heeded in ethics, anything may be permitted." Abraham Edel in considering the uses of science in ethics notes that "Traditionally morality rested on supernaturalist or non-naturalist bases," meaning "an absolute moral order founded on

a religious framework." However, "The growth of science and technology in modern times, with their vast accompanying changes in mode of life, ushered in a secular atmosphere."<sup>20</sup> Recognizing the possibility of a relativity of values (that is, recognizing the possibility that someone might counter an absolutist approach with "It all depends. . .") Edel turns to the "human sciences," biology, psychology, anthropology, sociology, and history in search of a "common ethic." Science then is asked to provide what religion no longer can, viz. a compelling basis for ethics. Michael Scriven also appeals to a scientific approach to ethics and is equally distraught at the possibility of irrationality in ethics: "It is stupefying to realize that a generation of philosophers was content to accept the idea that there could not be good reasons for morality."<sup>21</sup>

Scriven's outburst has an intimidating quality to it. For anyone schooled in the dominant modes of Western philosophy and modern thought who cannot immediately articulate these "good reasons for morality," Scriven's remark evokes almost shameful defensiveness. It matters not that careful reflection does not in fact yield good prescriptive norms or suggest their application in practice, one gets the feeling that one should

<sup>20</sup> Abraham Edel, Ethical Judgment; The Use of Science in Ethics, (New York: The Free Press, 1964), p. 15.

<sup>21</sup> Michael Scriven, The Science of Ethics, p. 39, quoted in Donald Campbell, "Response to Dyer," American Psychologist (August 1968):770-72. See Appendix to Chapter Two for the context of this debate.

seek this sort of articulation. Indeed it would seem almost heretical--should one say unscientific?--to suggest that moral actions do not in fact issue from reflected, abstracted, conscious, philosophical positions, but rather issue from the considered judgment of moral agents reflecting values formed over a lifetime of commitments.

Thus in questioning the methods of ethics, no less a question than the methods of science and their relationship to ethics must be considered. Furthermore no less a question than the relationship of religion and science must be considered, for it is an oversimplification to say scientific thinking has supplanted religious thinking in the modern age. Modern scientific thought had its origins in religious philosophy and it is the way in which these two modes of thought came to be separated which characterizes the modern age. The crisis for ethics and more particularly the crisis of confidence faced by modern medicine must be understood by appreciating the outlook which requires us to choose between either matters of fact or matters of value.

It is precisely the question as to what ethics is all about which characterizes the modern age. In some fields, but not ethics, it is fashionable to speak of one period or another as

an age, characterized by certain values, a certain style, a certain world-view. In ethics, one searches for timeless values, which should transcend the whims of a particular generation. Our time is often considered unique because of the special problems it presents for ethics by virtue of its manifold technological innovations. The modern age does pose some special challenges for ethics, not just in locating the eternal verities in a maze of technological innovations, but in the very process of doing ethics at a time when moral argument not only is not fashionable but is almost alien to the characteristic modes of intellectual thought and social discourse--and at a time which, though we may be reluctant to admit it, is intensely moral, perfectionistically moral.

## APPENDIX I

## A FURTHER NOTE ON ETHICAL CODES

Ethical codes are deontological in form, but in application their function is much more teleological. The AMA's Principles of Medical Ethics (1957), for example, states that "They are not laws but standards by which a physician may determine the propriety of his conduct. . ." The Hippocratic Oath, which has survived approximately 2400 years, no longer serves much of an administrative purpose, if it ever did, but rather is a symbol of the highest aspirations of the profession, ideals of honor, trust, and moral obligation.

It is interesting to note that many medical students today refuse to swear by the Oath of Hippocrates even as a symbol, objecting to some of its antiquated tenets such as not cutting the stone, not performing abortions or euthanasia and objecting to the idea of indebtedness to teachers, perhaps feeling that indebtedness to the loan officers is sufficient.

Another objection to the Hippocratic Oath code recurs in many contexts. It is the paternalistic outlook and fraternal nature of the medical profession, reflected in the oath. The oath requires the student to care for his teachers even as his own parents, and to teach the art of medicine to the teacher's sons and only the teacher's sons and others who have sworn by the physicians' oath but to no others. This strikes a note of professional elitism, which is dissonant in our egalitarian

society, but we must suspect that such paternalism and fraternalism have deep psychological significance which warrants further consideration.

When we consider ethics at the personal level of doing right as well as thinking the right thoughts and articulating principles for ethical behavior, there is a fundamental human insecurity about being judged and criticized. A (medical) student may be able to articulate ideal principles, but what does that student in fact do when making decisions? There may be things one would feel comfortable discussing with others while some inclinations or uncertainties one may be aware of but prefer not to discuss with people one does not trust. Still there may be determinants of one's conduct which are out of conscious awareness. An ethic which demands idealistic perfectionism may miss some of those aspects of decision-making which are prereflective or unconscious. Alternatively the paternalistic and fraternalistic trends in the medical and other professions may well serve the function of providing what Polanyi calls the "convivial order," an environment in which one can feel comfortable with colleagues of more or less similar concerns and ideals, so that a process of reflecting really can occur. This is the context in which

it makes sense to understand a profession in terms of its self-conscious reflection on its ethical standards.

This convivial function and the literal paternalism is particularly evident in Thomas Percival's Medical Ethics, which was written in 1794 as a set of instructions to Dr. Percival's son upon entering the medical profession. The motivating force for setting down principles was to communicate to a son what it meant to practice medicine. Secrecy (confidentiality), compassion and proper care of patients, as well as upholding the dignity of the profession, continued from the ancient oaths.

In 1847, the fledgling American Medical Association adopted a code of ethics that was largely derived from Percival's. A certain protectionism was given emphasis, however, that remains today in techniques of consultation, solicitation of patients, patient stealing, etc. Though it is claimed that such strictures are really more matters of etiquette than morals, it is important to consider the historical roots of that emphasis. At that time, licensing of physicians had been discontinued, and quackery by mail-order "physicians" was rampant. Thus, the apparent "etiquette" can be argued as a proper ethical principle to protect patients

from exploitation and harm. The AMA principles have undergone numerous revisions over the years attending to the dual functions of ethics in both the upwards and downwards perspectives.

Codes of ethics in the popular perception have a rather timeless quality as if carved in stone like the Decalogue. In fact they reflect a rather dynamic and continuously renewing interplay of concerns. Graduating medical students will occasionally undertake to articulate their own principles in lieu of the Hippocratic Oath, which, though it may suggest a departure from the traditions of a unified profession, discloses a discipline to think seriously about principles a group could agree upon and articulate. The AMA periodically revises its code. The American Psychiatric Association around 1970 began to take more seriously the investigation of ethics complaints against its members and drafted "Annotations (to the AMA principles) Applicable to Psychiatry," a task which initially took two years and has been continuous ever since. In 1977 the World Psychiatric Association attempted to draft a "Declaration of Hawaii," to state among other things that political use of psychiatry was against the principles held in common by the psychiatrists of the world. The document underwent about a dozen drafts which were circulated to the national associations

of the WPA. By the time a document was forged that was more or less acceptable "in principle" to the world's psychiatric associations, including the Soviet Union, it was not clear exactly what lines might be drawn against the political abuse of psychiatry.

As more and more groups attempt to claim professional status, there is more attention given to the ethical standards which might be definitive of social workers, nurse clinicians, and others. The American Hospital Association has drafted a patient's "Bill of Rights" to focus the centrality of the patient in the decisions which occur in hospitals. There is even talk of need of codes of ethics or professional standards for groups such as teachers, which have traditionally enjoyed the security of institutional Gemeinschaft, but whom some would hold have too much autonomy and too little accountability in matters of course content, grading of students, and an imbalance of power with the ability to jeopardize, possibly unfairly, a student's chances of future success including ability to earn money. The American Association of Medical Colleges (already) requires medical schools to state that due process is a fundamental right, which students possess. This transition to Gesellschaft may be a cause for celebration or lament, but seems to be giving matters of ethics attention which is well-deserved.

## APPENDIX II

PRINCIPLES OF MEDICAL ETHICS,  
AMERICAN MEDICAL ASSOCIATION, 1957 version (italics added)

## PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

## SECTION 1

The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

## SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

## SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

## SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

## SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

## SECTION 6

A physician should not dispose of his services under terms of conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

## SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

## SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

## SECTION 9

A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

## SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

AMERICAN MEDICAL ASSOCIATION  
PRINCIPLES OF MEDICAL ETHICS

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the right of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

ADOPTED JULY 22, 1980

## APPENDIX V. PATIENT'S BILL OF RIGHTS

(American Hospital Association, November, 1972)

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or delegate of the physician of the patient's continuing health care requirements following discharge.
11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

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- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

ADOPTED JULY 22, 1980

## CHAPTER TWO

### THE SELF AS MORAL AGENT

#### I.

There is an equivocation in modern philosophy, which makes ethics a problematic undertaking. It stems from our ability to give impersonal accounts of human behavior, the things people do, while at the same time experiencing ourselves as participants in history. So accustomed have we become to looking at ourselves from an imaginary point outside ourselves and outside our world, that we often forget who we are; we forget that thread of history that makes us uniquely ourselves. We could never tolerate a complete dissociation from the circumstances of our existence and maintain our sanity, yet a selective surrender to the forces of impersonality can from time to time be a convenient escape from the awesome responsibilities of human being.

It is to this equivocation that a theory of ethics must speak. One may look at ethics from the perspective of the self, the person, the agent, who must decide and act in a social

context (upwards perspective) or one may look at ethics from the perspective of the social order into which the individual must fit (downwards perspective). The questions that one formulates for ethics may be very different in these two perspectives. It is even possible to divert one's attention away from that person by abstractly formulating the questions for the ethical undertaking, yet that person never disappears no matter how impersonal the considerations become. "What is right or wrong?" is a question of a very different sort from the question "What ought I to do?" Yet both are properly considered ethical questions. What is not a proper approach is to consider one approach exclusive of the other. The distinction between an absolutist and a relativistic ethics is itself specious, suggesting that it may be possible and appropriate to ignore either the person or the context. This tension, which has plagued modern philosophy since the Enlightenment, leaves us believing that we must make a choice, adherence to ourselves or to an objective reality, when in fact we need to understand how to locate ourselves in a reality which is beyond ourselves.

The recognition of multiple tasks for ethical reflection, which are inclusive and not exclusive, raises questions about

the methods of thought which may be appropriate and helpful in doing ethics. When is a question or issue understood to be an ethical question or issue? By saying it must be personal, does this mean that it depends on one's perspective? If so, is this to suggest that different conclusions could be reached in different situations? If not, could one hope for an absolute guideline as a point of reference in making decisions?

But after all, what is goodness? Answer me that, Alexey. Goodness is one thing with me and another with a Chinaman, so it's a relative thing. Or isn't it? Is it not relative? A treacherous question! You won't laugh if I tell you it's kept me awake two nights. I only wonder now how people can live and think nothing of it. .  
Vanity!<sup>1</sup>

This abstractly formulated question, "What is goodness?" is not the way ethical dilemmas are usually experienced. They emerge from the context of the lives we lead, and it is an attempt to get away from the immediacy of the decisions we must make that we abstractly formulate our question, so that we may act with less turmoil than an Ivan Karamazov experienced. People can live and think nothing of the question because action is often taken without the intense reflection that perplexes Dostoevsky's characters. At the one extreme are those impulsive characters who reflect not at all on their actions; at the other extreme are those obsessional Hamlets whose actions are almost

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<sup>1</sup> Fyodor Dostoevsky, The Brothers Karamazov, cited in Abraham Edel, *Ibid.*, p. 2.

completely inhibited by their thoughts. Descartes even based his existence on his thinking: Cogito ergo sum. At least he thought this was what he was doing.

This chapter attempts to get a bearing on the problem of doing ethics in our highly scientific and philosophically abstract culture by looking in some depth at the person who must make moral decisions and then act. By looking at the decision-making process, we realize that as important as abstract thought and cognition are, there are other ingredients as well. So thoroughly have thought and action come to be separated in the modern imagination, we have become accustomed to asking the epistemological question, "How do we know?" independent of the ethical question, "What shall we do?" So thoroughly do we allow ourselves to maintain this split in our minds that often we do not even know who or what we are. We are not only confused, but depersonalized by the impersonalization of philosophy and ethics. Thus when we say that ethics is more than morality--that it is the process of reflecting on values as values are translated into action--we are identifying the person by the actions that person chooses. One is not what one thinks but what one does--or more precisely, one is known by what one does. This is what Hauerwas means when he claims that integrity, not obligation, is the hallmark of moral life.

One's wholeness is constituted by one's consistency in meeting obligations over a period of time, a lifetime, not in proclaiming what one considers to be virtuous. When Hauerwas faults the standard account of ethics for its attempt to be universal, impersonal, atemporal, and acultural, he is reminding us of what we already know, but are inclined to forget, namely that ethics is contextual (arises from particular life situations), and it is personal, historical and cultural. We are inclined to forget this because of the demand that such awareness places upon us. We are obligated to follow the admonition "Know thyself" because our sense of identity depends upon it, and our moral reputation rests upon what we choose to do.

## II.

Hauerwas' critique of the standard account may be summarized and contrasted with its alternative by means of the following chart.

Figure 5

<u>Standard (regnant) account</u>	<u>Alternative (post-critical) account</u>
universal	contextual
impersonal	personal
atemporal	historical
acultural	cultural
based on obligation	based on integrity
enforced by control, suasion, or sanction	enforced by willing assent, trust in a convivial order or community

Each of these features will be examined in some detail in the discussions which follow. We may start by looking at what at first may appear to be a rather mundane clinical situation. If ethics is to be understood as a process of reflecting on the value judgments one makes, it is very much like clinical judgment for the physician. Does clinical judgment include ethical ingredients even if not recognized as such? Again consider the decision involved in choosing an analgesic:

A 54-year-old engineer is now in his eighth post-op day following abdominal surgery for ulcer repair. While a likeable person, this engineer gives the impression of being a chronic complainer, a hypochondriac. And he requests his Demerol for pain always half an hour before it is ordered, once every four hours for pain: his surgeon comes in and talks to him a little bit about it. The surgeon says, "Most of my patients are better by the eighth day. Demerol is a highly addictive medication." The engineer says, "I understand all of that. Just give me a few more days of medication." After some discussion along these lines, the surgeon says, "Well, I think what I will do is switch you to Talwin for pain. You'll still have<sup>2</sup> your pain medication but with a less addictive drug."

This example has the virtue of illustrating a real conflict, which involves more than just technical criteria and facts, and which, though of no apparent controversy, is of grave importance to the people involved. The physician might not recognize this as a matter for ethical reflection, thinking it to be merely a matter of clinical judgment. The philosopher/ethicist is quick

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<sup>2</sup>This case is adapted from Howard Brody's book Ethical Decisions in Medicine.

to spot the value dimensions of this kind of decision and raise in an ethical context the kind of questions the physician might well also be raising without identifying them as ethical questions per se. Is depriving the engineer of the narcotic he requests causing him undue suffering, or conversely, would acceding to his request/demand mean irresponsibly addicting him? The matter might in fact become quite controversial if it is recognized that the surgeon is making a judgment about what might be called the engineer's "character," even if that character judgment were camouflaged as a "psychiatric assessment" of addictive potential.

Physicians make numerous such choices every day. When are these decisions to be identified as ethical choices? I submit that a mundane choice is considered an ethical matter when there is an element of conflict involved. This conflict may be a conflict within oneself: a given individual faces a dilemma between two courses of action, each having some merit; we call this intrapsychic conflict. Or the conflict may be between two or more persons, committed to different courses of action, which we may call interpersonal conflict.

We could hope that where such conflicts arise they might be resolved peacefully, but we can easily imagine that such conflicts might generate friction, heat, antagonism, anger. . .

Where there is conflict there is likely to be affect. Ethical discussion often becomes difficult because of the unpleasantness of the affect it generates. Indeed it is such conflict that often occasions ethical reflection. It is a task of ethics to resolve or mediate such conflicts, and many approaches to ethics will try to minimize the affect. Objectivity and equanimity are seen as desirable. Analysis of alternatives, it is sometimes suggested, should be rational, cool, dispassionate, and logically rigorous. While this may be desirable, abstract analysis can often miss the point of real conflict and be too remote from the genuine concerns. It is also a task of ethics to identify real concerns, which may have lain dormant because it would be uncomfortable to deal with them.

Thus as a starting point and point of orientation when ethical reflection seems to be getting abstract and remote, I often find it useful to ask, "Where is the affect?" as a way of locating ethical conflict.

At a panel discussion of the Karen Quinlan situation, the problem of when to turn off an artificial respirator was addressed by a physician, a lawyer, and a philosopher, from the perspectives of their varied disciplines. Each in turn gave a talk outlining the issues from his point of view. The talks were very abstract with qualifications and requalifications about possible definitions of death and how a decision to turn off her respirator might be reached. The

comments made had a very detached quality as if the speakers were indifferent to the situation, yet there was an undercurrent of tension, anxiety, perhaps as everyone present imagined being in such a situation and how to deal with it. Where was the affect? Finally a point was raised which seemed initially to be tangential to the substance of the discussion. How much was it costing and who was paying? At that time Karen Quinlan's hospitalization had cost some \$130,000 at public expense. Perhaps that should not have mattered, but it did. It was mentioned that Mr. Wrigley, the Chicago chewing gum magnate, had kept his wife alive on a respirator for a number of years at personal expense. The lawyer argued that as long as it was done at personal expense, there was no matter of ethical concern. A political science professor objected very strenuously that who paid was an irrelevant issue, and that there was a real ethical conflict involved. At this point the discussion became very heated and everyone got drawn in. It seemed that one of the key affective issues involved was the issue of money. Who was spending money and how the money was being spent was something about which people had very strong feelings. An issue which started out as a concern with definitions of death, turned out to involve "allocation of scarce resources," distributive justice, and free economy as well.

These two examples in particular and any of a number of situations we might choose to examine, several of which we will later have occasion to consider, illustrate a problem in ethics, which John Macmurray terms "the crisis of the personal" in philosophy, which Polanyi writes about as a consideration of "Personal Knowledge", and which I am considering here by

examining the self as a moral agent. In the example of choosing an analgesic, we see that it is possible for a person (the physician) to act (to choose an analgesic) without necessarily reflecting on that action. In the extreme of this impersonality the action could become almost reflexive: "I act this way because that's what I always do," or because "that's what is always done, standard procedure." In consideration of the Karen Quinlan panel discussion, we see reflection either with a paucity of affect or an almost uncontrollable excess of affect.<sup>3</sup> The equivocation in these situations comes from an uncertainty about where to locate the person or how to identify the person. Does one indwell the situation (mind and body, thought and affect)? Or is the person removed from the situation, reflecting from the Archimedian point outside the world? Our first instinct might say both or either, so accustomed have we become to moving back and forth by acts of mental distancing. It is this ability that we have acquired that makes imperative a closer look at what we mean by the personal.

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<sup>3</sup>The task of the ethicist is in at least one very important regard similar to that of the psychotherapist or psychoanalyst, viz. in the attempt to achieve the right titration or balance of affect so that learning about human experience may take place and so an integrity of mind and body may be achieved. When confronted by a hyper-rational elaboration of detail and an isolation of affect, it is necessary to raise the titre of emotion. On the other hand when confronted with hysterical over-emotionality, the task is to lower the level of affect, so that reason may have an opportunity.

What is a self, a person? We may easily be misled if we follow a philosophy based on understanding the physical universe; we are not merely atoms, which mean nothing more to one another than an occasional bump in a vast emptiness. The word "person" was in its earliest forms the Latin "persona," the mask worn by actors in a drama. The linguistic clue suggests an awareness of the equivocation in selfhood, for the mask that one presented publicly was not necessarily the private self. Indeed there is the inherent possibility for self-deception in assuming a public role to disclose one's conscious intentions, for if one holds up a mirror to oneself, it may be the mask that looks back.

But the mask cannot be worn at all times, so one must look again and again to know a self. A self is dynamic, not static; it changes and develops over time. This is what it means to have a history and to live and act in history. When one is identified by a variety of the predicates that one might choose, e.g. I am a . . . carpenter, father, Christian, male, diabetic, Democratic, teenager, or whatever, these are but partial identities, chosen for the sake of expediency to attempt to convey something more complex than language can easily disclose. One's self must encompass all that one is and has been, a totality of life history and its memories, not all of which are accessible to conscious memory at any

one time, many of which one might wish to delete and may do so by selective amnesia. Somerset Maugham recognized this when he said,

What makes old age hard to bear is not a failing of one's faculties, mental and physical, but the burden of one's memories.<sup>4</sup>

The view of history Maugham is reflecting is not the view of history that is so often held, the chronicle of time, the march of events, but a very personal view of history, a view which Merleau-Ponty has called "temporal thickness."<sup>5</sup> History is not just the public and recorded events, but each person has a unique history of one's own. Furthermore it must be emphatically emphasized that this history extends back to childhood, to birth, though the earliest memories may be obliterated. This point is important to keep in mind as we reconsider the meaning of the personal, the historical, the temporal and the cultural in relation to ethics, for the early antecedents of rationality have some forms which are very different from the adult thought process that are usually meant when one refers to "rationality". History is not just the chronicle of events of successive generations of rational adults, as we might find in the textbooks, but each person starts as an irrational child and carries into

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<sup>4</sup> Somerset Maugham, Points of View, quoted in Pietro Castelnuovo-Tedesco, "'The Mind as a Stage'. Some Comments on Reminiscence and Internal Objects," International Journal of Psychoanalysis 59 (1978):19.

<sup>5</sup> Maurice Merleau-Ponty, Phenomenology of Perception (London: Routledge and Kegan Paul, 1962), p. 410ff.

adult life the childhood antecedents of pre-rational thought, what psychiatrists call "primary process" thinking.

According to Piaget's studies of cognitive development, there is a disjunction in cognitive processes which occurs around the onset of adolescence. At this time

the child achieves the [Cartesian] cogito and reaches the truths of rationalism. At this stage. . . he discovers himself both as a point of view on the world and also as called upon to transcend that point of view and to construct an objectivity at the level of judgment.<sup>6</sup>

The cogito thus becomes the child's passport to adult society. As he learns the rules of his culture by living them, he develops a critical sense. Thus supported by the norms of his group, he acquires a sure standard for judgment. And as a self-assured judge, one of course is less vulnerable himself. Yet, even while recognizing this developmental transition, Piaget brings to the child a mature outlook as if the thoughts of the adult were self-sufficient and devoid of all contradiction when in reality, as Merleau-Ponty reminds us,

it must be the case that the child's outlook is in some way vindicated against the adult's and against Piaget, and that the unsophisticated thinking of our earliest years remains as an indispensable acquisition underlying that of maturity.<sup>7</sup>

<sup>6</sup> Jean Piaget, La Représentation du monde chez l'enfant, p. 21, cited in Merleau-Ponty, Ibid, p. 355.

<sup>7</sup> Ibid. For further discussion, see my article "R.D. Laing in Post-Critical Perspective," British Journal of Psychiatry, (March 1974):252-259.

Philosophy is an undertaking of the rational mind. As a branch of philosophy, ethics is a rational undertaking. Yet people do not always behave in rational ways, and ethics must account for this irrationality in human behavior. Therefore I am proposing that, as a way of getting beyond the limitations imposed on ethics by an impersonal view of objectivity, a look at the childhood antecedents of rationality will be a useful undertaking. There are several avenues to this understanding, which converge to broaden the conceptions of what it may be possible to accomplish in ethical reflection. One is psychoanalysis, which emerges historically at the time when critical thought is gaining its greatest incisiveness, indeed at a time when logical positivism is emerging in Vienna and elsewhere. Another useful approach is the ethical revisions offered by such philosophers as Stanley Hauerwas, who suggest that narrative accounts of the life stories of those involved in making decisions offers clues to the ethical issues at stake. John Macmurray offers a critique of traditional philosophy, which suggests possible reorientations, and Michael Polanyi's epistemology similarly offers new possibilities for ethics. Although my main task in this project is to document the limitations objectivist epistemology poses for ethics, I will not resist opportunities to suggest alternatives which may be more productive.

## IV.

John Macmurray in his Gifford Lectures of 1953, given under the title, "The Form of the Personal" and published under the title, The Self as Agent, identifies what he calls "the crisis of the personal." Macmurray is concerned that modern philosophy has led to a situation in which man is seen impersonally, thus impeding the possibility of accounting for man in relation either to other persons or to God. ("always an 'I,' never a 'Thou'") He levels two charges against philosophy, (1) that it is merely theoretical and (2) that it is egocentric. Of the first charge he notes,

Philosophy aims at a complete rationality. But the rationality of our conclusions does not depend alone upon the correctness of our thinking. It depends even more upon the propriety of the questions with which we concern ourselves. The primary and the critical task is the discovery of the problem. If we ask the wrong question the logical correctness of our answer is of little consequence.

He further notes that "Common tradition conceives the philosopher as a man of a balanced temper, who meets fortune or disaster with equanimity."<sup>9</sup> The theory with which philosophy deals must be rooted in the practical questions which man experiences or risk being trivial or misleading.

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<sup>8</sup> John Macmurray, The Self as Agent, (London: Faber, 1957), p. 21.

<sup>9</sup> Ibid., p. 23.

Of the second charge that modern philosophy is egocentric, he notes that "It takes the Self as its starting-point, and not God, or the world or the community; and that the Self is seen as an individual in isolation, withdrawn from active relations with other selves." About this solipsistic outlook, there will be much more to be said in the following chapter, but for the time being we must note the distortion in the notion of a self, of a person.

Macmurray proposes to redress this imbalance by transferring the center of gravity in philosophy from thought to action. It is in this sense that he defines the self as an agent, and attempts to substitute the 'I do' for the 'I think' as the defining characteristic of personhood.

Considerations of thought are static; they do not move. Considerations of action are dynamic, and we may inquire into the forces which cause motion. In so doing we rely metaphorically on the mechanical images of physical forces moving bodies through space and time in order to grasp something of mental life and experience, which so elude our understanding. Gilbert Ryle speaks of the mind as the "ghost in the machine"<sup>10</sup> as a way of helping us through the familiar layers of philosophical thought to an understanding of mental life. His rebellion is not destructive, but an acknowledgment of the habitual ways we have come to understand ourselves.

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<sup>10</sup>Gilbert Ryle, The Concept of Mind. (London: Hutchison, 1949).

## V.

Freud similarly relied on mechanical metaphors in his attempt to elucidate the unconscious realms of mental life. When he spoke of psychodynamics, he was casting in scientific language the mythologies of the ages and returning us to the histories of persons. In order to understand ethics, that is in order to understand persons who act and make decisions in history, it is necessary to understand the forces which move people. We do not really want a passionless philosophy, but want to understand the emotions which underlie philosophical deliberation, even though we constantly fear that sanctioning a recognition of these forces will unleash uncivilized demons which might better remain contained.<sup>11</sup>

What forces underlie morality? What emotions or affects provide the dynamos which move people to action? By asking these questions, what are we able to accomplish that a merely theoretical and egocentric philosophy cannot accomplish? What is the self that acts in history and how does knowledge of this self, ourself, help us in making decisions in relation both to the situations in which we find ourselves and also in relation to those principles which we are able abstractly to adduce?

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<sup>11</sup> Etymologically "emotion" derives from the Old French, esmouvoir, to excite, and from the Latin, ēmovēre, to move out, stir up, excite.

This nest of questions is complex, and might correctly be answered by saying that all emotions in one way or another at some time or another influence the way people act. Therefore we must quickly limit our focus to specific emotions and situations by way of example or remain forever on a theoretical level. The clues from the psychoanalytic study of problems in self-esteem and the devices by which a person regulates self-esteem through morality will therefore be illuminating.

The psychoanalytic study of the self derives from Freud's early observations "On Narcissism" (1914)<sup>12</sup> in which he introduced the concept of the ego ideal, also sometimes referred to as the ideal self, which later (1923)<sup>13</sup> gave origin to the concept of the superego in Freud's topographic (id, ego, super-ego) theory of personality development. The term narcissism is

<sup>12</sup>Sigmund Freud, The Complete Psychological Works of Sigmund Freud (Standard Edition), trans. and ed. James Strachey, vol. 14: "On Narcissism: An Introduction." (London: The Hogarth Press and the Institute of Psychoanalysis, 1957), pp. 203-204. One of the best and most succinct discussions of narcissism appears in my wife's Ph.D. dissertation: Susan K. Dyer, Plinlimmon's Theme: The Aspirations and Limitations of Man in the Novels of Herman Melville, (Durham: Duke University, 1977). Also the writings of Heinz Kohut, particularly The Analysis of the Self (New York: International Universities Press, 1971) and Otto Kernberg, particularly Borderline Conditions and Pathological Narcissism (New York: Jason Aronson, 1971) have stimulated much interest and rethinking of the psychoanalytic theories of narcissism.

<sup>13</sup>S. Freud, *Ibid.*, "The Ego and the Id," vol. 14, pp. 3-66.

derived from clinical description and was chosen by Paul Nacke in 1899 to denote the attitude of a person who treats his own body in the same way in which the body of a sexual object is ordinarily treated. Freud at that time was developing his libido theory, which derived support from the studies of children and from primitive peoples. Totem and Taboo (1921)<sup>14</sup> preceded Freud's work on narcissism, and Jung's departure from psychoanalysis occurred about this time in protest of Freud's insistence on infantile sexuality. Autoeroticism was clearly evident in the normal development of children, a pleasurable "instinct" from the start, but the ego, that mental agency which mediates and regulates the impulses, had to be developed over time.

The study of primitive cultures' abhorrence of incest and the function of taboos against it demonstrated the dynamic forces which enabled these forces to be suppressed, and the unacceptable (hostile, murderous, even sexual) impulses of children in civilized Vienna followed the patterns of the primitives. Libidinal instinctual impulses undergo pathologic repression if they come into conflict with the person's cultural and ethical ideas. The formation of an ego ideal and later a superego are the devices by which the young child can learn to

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S. Freud, Ibid., "Totem and Taboo," vol. 13, pp. 1-165.

live harmoniously in a family and in a culture. They are pleasurable deceptions, which the child can unconsciously maintain, while the ego gradually learns how to cope with reality.

Freud declared the ego ideal to be the "heir of the original narcissism"<sup>15</sup> and Hartman and Lowenstein say, "the ego ideal can be considered a rescue operation for narcissism,"<sup>16</sup> --in other words it is born of an effort to restore the lost Shangri-La of the symbiosis with an all-giving mother. In this blissful state the human infant lies securely at the center of his universe. His every need is met by a mother (or sometimes another) who needs him almost as much as he needs her. He is omnipotent. If he is hungry or in some other way uncomfortable, he cries, and mother comes to meet the need. This state is referred to as primary narcissism, but it is a precarious condition.

The enemy of primary narcissism is the reality principle. The symbiosis is ruptured too soon after the infant is expelled from the womb. He is hungry and cries, but the mother does not immediately appear. The universe is not perfect as he had imagined, and it is not under his control. The result is rage; possibly despair, if he is abandoned or

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<sup>15</sup>S. Freud., *Ibid.*, "Group Psychology and the Analysis of the Ego," (1921), p. 110.

<sup>16</sup>Heinz Hartmann and Rudolph Lowenstein, "Notes on the Superego." Psychoanalytic Study of the Child, 17 (1962):01.

if his mother is not dependable. The original sense of omnipotence has received the first of many "narcissistic injuries." Reality has entered in.

The infant copes with this intrusion by shifting focus to an idealized parent; it is not he but the parent that is perfect. As the infant's physical and mental abilities, particularly locomotion, develop, it is less necessary to be completely dependent on the mother and the infant becomes aware of his separateness from her. The small, helpless infant forms an ideal of what he would like to be like, viz. omnipotent like the parents. But even under the best of circumstances, the idealized parents prove fallible, incapable of providing the total gratification remembered from earliest infancy, and the infant develops a new and better possibility for the self, the ego ideal. The love which was originally invested in the self, then in the idealized parent, is now invested in the ideal self that he desires to become. This state is called secondary narcissism. Freud observed that man creates ideals for himself in order to restore the lost narcissism of childhood, to restore that state of contentment in which one's needs are passively met. It is the ego ideal, Freud claimed, "by which the ego measures itself, towards which it strives, and whose demands for ever-increasing perfection it is always striving

to fulfill."<sup>17</sup> But the grandiose aspirations for perfection can never in reality be fulfilled. A person's sense of self-esteem is determined by the distance between his actual self, his strengths, talents, abilities, and accomplishments, and his ego ideal.

The superego, thought by many psychoanalysts to be distinct from the ego ideal, is a developmentally later acquisition. In contrast to the ego ideal, which lures the person on to higher and often impossible standards of perfection, the superego is restrictive. It is the superego which is the internalized representation of the parents and of the culture's standards for conduct. The superego is the unconscious conscience that criticizes the id impulses and keeps the ego in line. Instinctual gratification (whether sexual or aggressive) is renounced either out of fear of loss of love by the ego ideal or by fear of punishment by the superego. This is why Freud suggests in Civilization and its Discontents<sup>18</sup> that neurosis is the price we must pay for the harmony of civilized culture, a verdict which is only reluctantly accepted.

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<sup>17</sup>S. Freud, *Ibid.*, "Neurosis and Psychosis," (1924), vol. 19, pp. 92-93.

<sup>18</sup>*Ibid.*, vol. 21 (1930).

Earlier I contrasted upwards and downwards perspectives on tasks of ethics. Considered not only in terms of the function of ethical theory, but also of the development of an individual, it may now be said that ethics in the upwards perspective functions by means of the ego ideal, and ethics in the downwards perspective functions by means of the super-ego. One is beckoned upwards by the highest standards of moral perfection, but restricted from falling below certain minimal standards by means of superego strictures if internalized, and by the possibility of external punishment if necessary. Teleological ethical theories appeal to goals that all might be expected to hold. Deontological ethical theories set standards by which one may know what limitations are expected. To our criticism of the standard account of ethics being inadequate because it attempts to be universal, impersonal, acultural and ahistorical, we may now add that teleological and deontological accounts are inadequate not only because they are too abstract but also because they rest on immature developmental forms, the ego ideal and the super-ego. Having said this, we may now explore in greater depth the affects associated with the ego ideal and the superego and why they are inadequate as a basis for morality.

## VI.

Morality in any given culture is enforced by the affects of shame and guilt. Shame is the primary affect which mediates the functioning of the ego ideal in a given person, and guilt is the affect by which the superego exerts its force. Shame consists of feelings of inferiority, humiliation, embarrassment, inadequacy, incompetence, weakness, dishonor, disgrace, "loss of face"; the feeling of being vulnerable to, or actually experiencing ridicule, contempt, insult, derision, scorn, rejection, or other "narcissistic wounds"; the feeling of not being able to take care of oneself, and of being dependent on others. Jealousy and envy are members of this family of feelings. Guilt refers to the feeling of having committed a sin, a crime, an evil or an injustice; the feeling of culpability; the feeling of obligation; the feeling of being dangerous or harmful to others; and the feeling of needing expiation and deserving punishment.

James Gilligan in a very provocative analysis, "Beyond Morality: Psychoanalytic Reflections on Shame, Guilt, and Love"<sup>19</sup> sees morality as a "force antagonistic to love, a force causing illness and death--neurosis and psychosis, homicide and suicide." He views morality as a "necessary but immature stage of affective and cognitive development, so that

<sup>19</sup>James Gilligan, "Beyond Morality: Psychoanalytic Reflections on Shame, Guilt and Love," in Thomas Likona, ed., Moral Development and Behavior: Theory, Research, and Social Issues, (New York: Holt, Rinehart and Winston, 1976), pp. 144-158.

fixation at the moral stage represents developmental retardation, or immaturity, and regression to it represents psychopathology, or neurosis.<sup>20</sup> He claims that morality is dead, that it killed itself. Citing the self-criticism moral philosophy has subjected itself to over the past two centuries (e.g. Hume, Kant, Nietzsche, and Wittgenstein), he believes that the only knowledge possible is of scientific facts, not moral value.

As evidence for this, he draws on demonstrations of the effects of shame and guilt in various cultures. An example of a pure shame culture is the Kwakiutl Indians of Vancouver Island, described by Ruth Benedict:

Behavior. . . was dominated at every point by the need to demonstrate the greatness of the individual and the inferiority of his rivals. It was carried out with uncensored self-glorification and with gibes and insults poured upon the opponents. . . The Kwakiutl stressed equally the fear of ridicule, and the interpretation of experience in terms of insults. They recognized only one gamut of emotion, that which swings between victory and shame.<sup>21</sup>

An example of a pure guilt culture is the Hutterites, a Protestant sect scattered through the northern Middle West and southern Canada on communal farms and colonies, where they consciously attempt to adhere strictly and literally to the ethic of the New Testament. They are described by Kaplan and Plaut:

<sup>20</sup> Ibid., p. 145.

<sup>21</sup> R. Benedict, Patterns of Culture, (New York: New American Library, 1958), p. 198, cited in Gilligan, Ibid., p. 146.

Religion is the major cohesive force in this folk culture. The Hutterites consider themselves to . . . live the only true form of Christianity, one which entails communal sharing of property and cooperative production and distribution of goods. The values of brotherliness, self-renunciation and passivity in the face of aggression are emphasized. The Hutterites speak often of their past martyrs and of their willingness to suffer for their faith at the present time.<sup>22</sup>

In these extreme forms shame cultures display a maximum of hostility toward others in order to maintain a maximum of love for the self; the guilt cultures display a minimum of love for the self in order to check hostility toward others and maintain nonviolence and pacifism.

I am in fundamental agreement with Gilligan's contention that morality can be a destructive force if it inadequately relies on shame and guilt. I disagree that morality must necessarily be destructive, however. Considered in historical perspective, that is in developmental perspective, morality serves the growing person well by providing an orientation to one's culture, to those others with whom one lives, and an identity, that is a sense of self by which one is known and to which one can refer in making decisions. This sense of agency, however, is achieved gradually over time and emerges from the immature forms of the ego ideal and superego. The mature sense of agency carries with it

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<sup>22</sup>J. Kaplan and T. Plaut, Personality in a Communal Society, (Lawrence: University of Kansas, 1956), p. 12, cited in Gilligan, *Ibid.*

the sense of competence, empowerment, potency, internal force, confidence in initiating charge or control<sup>23</sup> and a realistic appraisal of what it may be possible and appropriate to accomplish. The mature agent has more or less successfully resolved his narcissism: his expectations for himself, his (ego) ideals, are more or less in line with his abilities, and his goals, though perhaps ambitious, are not grandiose nor striving for omnipotent perfection. Given the vicissitudes of human development, this state of mature agency is not usually achieved. Even when it is achieved, it is in precarious balance with those stresses in life which would precipitate helplessness and dependency: the various life crises, loss of loved ones, aging, and especially the loss of one's health through unexpected illness. These stresses may bring forth a yearning for an ideal world, a return to a state of blissful dependency, and that yearning may include the idealized wish for the physician to be an omnipotent god, a wish the physician may be seduced into sharing. Such dependency, however, engenders much ambivalence, especially in a culture which so values independence, self-reliance and autonomy. When reflecting ethically on the possibilities for such an ideal world, we must be mindful of our own narcissistic temptations and keep reality firmly in view.

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<sup>23</sup> For an excellent analysis of the concept of agency see William R. Rogers, "Helplessness and Agency in the Healing Process," in William R. Rogers and David Bernard, Eds., Nourishing the Humanistic in Medicine; Interactions with the Social Sciences, (Pittsburgh: University of Pittsburgh Press, 1979), pp. 25-52.

There is nothing wrong with maintaining perfectionistic ideals unless they are used destructively to clobber mortal humans who cannot live up to their standards. It is these immature and grandiose forms of morality that can be destructive.

## VII.

In Chapter Four, "The Post-Critical Alternative," I will explore the destructive force of excesses of morality and the demand for moral perfection. In the appendix to this chapter, we will have an opportunity to further consider some of the positive, life-sustaining characteristics of morality. The thesis advanced here is that values form the core of the identity of a person, and thus regulate self-esteem. If viewed from the perspective of the regnant epistemology, which defines a person in terms of thought not action, morality becomes a destructive force. In its abstract forms morality insists on moral perfection, which no person can achieve. Gilligan is right insofar as he views morality in the context of the standard epistemological accounts of morality. Morality has killed itself, or rather, it has failed to give an adequate account of itself. However we may carry Gilligan's use of the psychoanalytic approach, and Polanyi's use of the post-critical approach beyond the limitations of the standard/regnant account to demonstrate that love or trust as the most fundamental and earliest developmental issue is the correct basis for morality, not shame or guilt, which represent pathological aberrations,

if not properly resolved. This stands in staunch opposition to the view which holds (solipsistically) that the autonomy of persons is the basis for ethics. This cannot be the case because persons are in no real way autonomous; they exist in relationship with others, whom they may or may not trust, but upon whom they are unquestionably dependent and interdependent. It will take careful consideration of these issues in the following chapters to make this point fully comprehensible. In Chapter III we turn to Descartes, whose dualistic philosophy bases knowledge on doubt rather than belief (trust) because, I believe it may be shown, of his own insecurity in trusting, an insecurity which touches all of us fundamentally because of the developmental traumas we must face in early childhood. In Chapter IV we turn to Polanyi, who corrects the Cartesian mistake, by reminding us that we have never been able to base knowledge on doubt, but rather that knowledge rests, in modern science as it always has, on a fiduciary enterprise of a community of knowers rather than on the isolated efforts of individuals who bear no relationship to one another. Having done this we may turn again in Chapter V to a look at our own culture, and the way morality and ethics function for us moderns by looking specifically at medical ethics and the problems of our culture in medical practice.

APPENDIX TO CHAPTER TWO  
THE IMPEACHMENT OF ALTRUISM

Altruism is an endangered species. It is on the verge of extinction. We may not have seen the end of altruism, of concern for the well-being of others, and of some of the nobler forms of human conduct, but the word "altruism," has lost its usefulness. It has lost its ability to serve as a vehicle of moral inspiration. Altruism, however, is in good company. Other words of our moral vocabulary have similarly been rendered antique. Sin, for example, restitution, virtue, chastity, and guilt (except in a therapeutic sense) have all but disappeared from ordinary language, leaving us handicapped in talking about moral issues.

Narcissism, on the other hand, is just coming into its own. The word "narcissism," which is in many ways the opposite of altruism, serves an increasingly useful function in calling attention to the shape and contours of the culture in which we live. Does this mean that selfishness, or narcissism, has gained the upper hand over selflessness, or altruism? I think not. What I am suggesting instead is that in contemporary culture the ideals suggested by the word "altruism" are so difficult to fulfill that they seem incredible, literally not believable. Anyone professing to be altruistic is suspect, whereas anyone professing self-interest is hailed as honest if not admirable.

The word "altruism" is only about 125 years old, having been coined by Auguste Comte<sup>1</sup> who also gave us "sociology." But the idea of sacrificing oneself for the welfare of others goes back to the foundations of our philosophical heritage, to Plato and to early Christian traditions. Western thought is so habitually ethical that most of the people never suspect that it could be otherwise.

The United States in particular offered a fertile ground for the concept of altruism in the late 19th century. It was a time of laissez-faire capitalism and the heyday of the "work ethic." A candid look at the ethics of the time might suggest a world dominated by self-interest, by greed and by opportunism. Yet it was also a time of intense religiosity in which ethical justification was sought for human conduct, perhaps defensively and rationalistically. "Altruism" provided a rallying point as the banner for reforms that collided head-on with the premise of man's selfishness. It was celebrated in magazines, novels and altruistic societies of a utopian sort.<sup>2</sup>

Nineteenth century altruists preached that Progress was the object of Nature, and that Altruism was the object of Progress. They extolled altruism as the instinct that had equalized and thus healthily intensified the competitive

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<sup>1</sup>In his System of Public Policy, 1851-54.

<sup>2</sup>For an excellent review of this epoch of American history see Louis Budd, "Altruism Arrives in America," American Quarterly VIII (Spring 1956):40-52.

struggle, making in other words for more of a fair fight. This was a time of Social Darwinism, in which "the survival of the fittest" provided natural justification for those who got ahead at the expense of others. "Nature red with tooth and claw"--this not only explained the origin of species, but also provided a justification for the accumulation of capital.

Indeed altruism embraced the major ethical and scientific positions of the day. It appealed to the ethics of Jesus, particularly as expressed in the Sermon on the Mount; to the socialists' drive for mutual welfare, thus flirting with both Marxism and capitalism; and to evolutionists concern for the social or racial unit.

It may be difficult to imagine what it was like to live in those turbulent times and to see man from his special place in nature and tossed among the brutes by the theory of evolution. Altruism may have served to preserve a sense of the nobility of our own species, but not all views of human nature are optimistic. Consider this analysis of "The Antisocial Contract."

The evolution of society fits the Darwinian paradigm in its most individualistic form. Nothing in it cries out to be explained otherwise. The economy of nature is competitive from beginning to end. . . . No hint of genuine charity ameliorates our vision of

society, once sentimentalism has been laid aside. What passes for cooperation turns out to be a mixture of opportunism and exploitation. . . . Where it is in his own interest, every organism may reasonably be expected to aid his fellows. Where he has no alternative he submits to the yoke of communal servitude. Yet given a full chance to act in his own interest, nothing but expediency will restrain him from brutalizing, from maiming, from murdering--his brother, his mate, his parent, or his child. Scratch<sup>3</sup> an "altruist," and watch a "hypocrite" bleed.

Altruism is hardly credible as a pure explanation of human motivation, given what we now know about human dynamics. It now seems obvious that the altruists of the 1890's saw personality too unitarily, as either benign or vicious. We now recognize that kindly (or hostile) behavior can have mixed, ambivalent motives which can also differ from one person to the next and from time to time in a given individual. Recall that Freud published The Interpretation of Dreams in 1900, and it is only in this century that depth psychology has become part of our intellectual baggage and habitual way of looking at things, and even today there is great resistance in looking too deeply.

The altruists of the nineteenth century underestimated the strength of the ego's self-serving drive and thought they could soothe it away. They had limitless faith in moral suasion.

<sup>3</sup>M. T. Ghiselin, The Economy of Nature and the Evolution of Sex. (Berkeley: University of California Press, 1974). (This is the very sentiment to which Polanyi calls attention in his discussion of the moral inversion. It is the ideals which have been called altruistic which are inverted.)

Today the magnitude and the velocity of the social change make gentle moral appeals sound quixotic, while the anonymity of urbanism mocks any dream of promoting altruism by personal example.

In spite of all its shortcomings altruism has an amazing buoyancy. Moral inclinations, of course, live on even though moral perfection is not possible. The word "altruism" after years of dormancy is now making a comeback. The new altruism, however, has a special meaning and this is potentially a source of confusion. For biologists, and particularly for the new discipline known as sociobiology,<sup>4</sup> altruism involves self-sacrifice for the welfare of the group of genetically related others. The biological implications of altruism are long term and concerned with behavior that would likely continue the species, whereas the familiar use of altruism refers to unselfish regard for the welfare of others in a day-to-day manner. The Good Samaritan is an example of an old-fashioned altruist. His actions were not in response to social pressures or moral obligations; he acted gratuitously, and in a way that was costly to himself. These are tenets of altruism as we generally think of it. The behavior of the social insects, ants, bees and termites, are examples of the new altruism. The sacrifices of the worker bees, ensure the furtherance of the

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<sup>4</sup>E.O. Wilson, Sociobiology; The New Synthesis (Cambridge: Belknap/Harvard University Press, 1975); David P. Barsch, Sociobiology and Behavior, (New York: Elsevier, 1977); Gerald Dawkins, The Selfish Gene, (New York: Oxford, 1976).

species by enabling the queen to reproduce. Thus it becomes necessary to distinguish the new altruism, which refers to species-maintaining behavior, from traditional altruism, which refers to individual non-reciprocal giving.

For our purposes in understanding the dynamics of moral life, we could largely ignore the specialized use of the term altruism by the sociobiologists except for the irresistible temptation to draw parallels between the evolution of behavior of the social insects and that of humans. Admittedly one can see analogies between army ants and human beings. Both have an urban social order, stored food-stuffs, full-time division of labor and apartment living. It is not difficult to see the ways in which self-sacrifice in social insects serves to further reproduction of genes. The confusion arises when too facile an analogy is drawn with human behavior. We forget what we are trying to understand when we use the two altruisms interchangeably and also when animal traits are given familiar names like coyness, spite, jealousy, selfishness, deceitfulness, greediness, and cooperativeness, with the explicit assumption that there are specific genes determining these traits. Polanyi calls this mental process a pseudo-substitution.<sup>5</sup>

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<sup>5</sup>M. Polanyi, Personal Knowledge, p. 16.

The new discipline of sociobiology and in particular the genetics of altruism issue are causing a lot of debate these days. It may be useful to focus on social evolution to understand the place of moral tradition in contemporary society. As I suggested earlier, we have become almost embarrassed to speak of moral tradition although the inclination to morality is not quite so alien to us. We are asked by the sociobiologists to believe that the presence of altruism in insects and other non-humans in some way provides justification--indeed scientific justification--for altruistic behavior which seems to have lost its moral compulsion.

I believe the analogies between the two kinds of altruism, let's now call them moral altruism and behavioral altruism, are too tenuous to use them interchangeably. Furthermore the so-called scientific justification of altruism on genetic-adaptive grounds obscures the very essence of moral considerations, which deserve consideration in their own right. Nonetheless the interesting development of sociobiology and the sketching of its implications for moral tradition tells us something very important about moral life in an age which is both habitually ethical and habitually scientific in its manner of thinking.

Let me give an example, an important example I believe, of the issues at stake. Donald Campbell, who is Professor of Psychology at Northwestern University, and recent president of the American Psychological Association, has written a major paper entitled "On the Conflicts Between Biological and Social Evolution and Between Psychology and Moral Tradition."<sup>6</sup> In it he argues that "present-day psychology and psychiatry in all their major forms are more hostile to the inhibitory messages of traditional religious moralizing than is scientifically justified."<sup>7</sup> He further argues on the basis of the genetics of altruism that basic biological human nature is in agreement with traditional religious moral teachings. He notes that "the religions of all ancient urban civilization (as independently developed in China, India, Mesopotamia, Egypt, Mexico, and Peru) taught that many aspects of human nature need to be curbed if optimal coordination is to be achieved, for example, selfishness, pride, greed, dishonesty, covetousness, cowardice, lust, wrath." "Psychology and psychiatry," according to Campbell, "not only describe man as selfishly motivated, but implicitly or explicitly teach that he ought to be so."

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<sup>6</sup> Donald Campbell, "On the Conflicts Between Biological and Social Evolution and Between Psychology and Moral Tradition," American Psychologist, 30 (December 1975):1103-1126.

<sup>7</sup> Ibid., p. 1103.

They tend to see repression and inhibition of individual impulse as undesirable, and see all guilt as a dysfunctional neurotic blight created by cruel child rearing and a needlessly repressive society. They further recommend that we accept our biological and psychological impulses as good and seek pleasure rather than enchain ourselves with duty."<sup>8</sup>

Campbell's characterization of psychology and psychiatry is obviously overly general, but he does make an important point. It is in fact a point made by the famous psychiatrist Karl Menninger in his book Whatever Became of Sin?<sup>9</sup>

Menninger notes that sin, that is the concept of sin, seems to have disappeared from our society, having been translated into other considerations, such as a new social morality, crime, symptoms, or collective irresponsibility, but is no longer used as a term for the abdication of personal responsibility. This was the point I started out with and this is a point that Campbell also makes in reference to Menninger:

I am indeed asserting a social functionality and psychological validity to concepts such as temptation and original sin due to human carnal, animal nature. This orientation makes me sympathetic to psychotherapists such as Mowrer and Menninger who have come to regard much human sin with an almost traditional disapproval, and who are recommending that guilt feelings often should

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<sup>8</sup>Ibid., p. 1104.

<sup>9</sup>Karl Menninger, Whatever Became of Sin? (New York: Hawthorn, 1973).

be cured by confession, expiation, restitution, and cessation of guilt-producing behavior, rather than by always removing the demands of conscience, interpreting away feelings of guilt as neurotic symptoms. I can only hope that by raising this conclusion in the context of modern scientific concerns about the problems of complex social coordination and the population genetics of altruistic traits, I can make the point more convincing to psychologists and psychiatrists than Mowrer and Menninger have been able to do.<sup>10</sup>

I would suggest instead that we need to reaccredit our moral vocabulary and acknowledge the place of valuing in our lives. We need to speak about moral issues as moral issues. This enterprise may require some hard self-scrutiny. What are the resistances within ourselves to making value judgments and acknowledging them publicly?

To answer this question it may be useful to take a look at adolescent development,<sup>11</sup> a time when values and a sense of identity are being formed and a time in which our manner of dealing with value issues takes shape. The adolescent reworks and hopefully "re-solves" many of life's earlier conflicts, but with greater intellectual capabilities. During adolescence we may witness the force of the critical tradition of intellectual thought on personal cognitive development. Piaget's studies help clarify the impact of cognitive development on moral sensibility. According to

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<sup>10</sup>Campbell, Ibid., p. 1116.

<sup>11</sup>See Peter Blos, On Adolescence: A Psychoanalytic Interpretation (Glencoe: The Free Press, 1962).

Piaget a process of social control through critical sensibility occurs about twelve years of age.<sup>12</sup> Piaget refers to this developmental acquisition as the cogito. At the time the child achieves the cogito, "he reaches the truths of rationalism. The cogito thus becomes the child's passport to adult society. As he learns the rules of his culture by living them, he develops a critical sense. Thus supported by the norms of his group, he acquires a sure standard of judgment. And as a self-assured judge, one is, of course, less vulnerable oneself to a critical assault. Such criticism may be taken as a narcissistic injury to self-esteem thus mobilizing narcissistic defense and anything which will preserve self-esteem, even reversing the judgment itself. It is almost as if to say, It is not I that am imperfect but those judging me."

The other major resistance to self-scrutiny and to addressing moral issues is our narcissism or sense of self. Narcissism derives metaphorically from the Greek hero Narcissus, who was a lad so beautiful that all the lovely maidens fell in love with him, but he was unable to care for any of them and left them broken hearted. Finally seeing his image reflected in a pond, he knew what they longed for, and fell in love with his own image. Narcissus's fate varies in different versions of the story. His outcome is pathetic. Some say he drowned trying to

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<sup>12</sup>Piaget, Ibid., p. 21.

merge with his image. Others say he pined away at the pool being unable to separate from his image.<sup>13</sup> In any case he left us with the flower bearing his name and the psychological condition of self-love.

The major problem in the narcissistic syndrome is uncertainty not confidence. For the narcissistic personality --and this applies to everyone to a degree--uncertainty about one's self, one's identity requires a mirroring reassurance from others that one is OK. The experience derives from earliest infancy and adolescence if all goes well, one may achieve a sense of stability. If however a culture fails to provide a mirror of stability by which one can define oneself, the resolution of a sense of self may not occur until much later in life if at all. It is often suggested that our own culture is such a culture of narcissism<sup>14</sup> and fails to provide clear-cut standards and ideals by which people may identify themselves and establish a sense of selfhood. The camouflaging of moral issues in scientific or value-neutral garb is one example of this failure.

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<sup>13</sup> See Edith Hamilton, Mythology. (Boston: Little Brown, 1942).

<sup>14</sup> See Christopher Lasch, The Culture of Narcissism: American Life in an Age of Diminishing Expectations. (New York: Norton, 1978).

In a pluralistic and rapidly changing culture, an adolescent may fail to get unambiguous messages about socially acceptable values and expectations. Even so the nuclear family or even single parents may still serve such a function, although this is increasingly difficult given the erosion of cultural support for the family. In the absence of stable families, family substitutes often emerge. The altruistic societies of the nineteenth century may have served as such value-defining groups. On the contemporary scene we witness the emergence of family-like cults, the Charles Manson "family," the Jones cult in Guyana. Whereas the nineteenth century communities were defined by positive or prosocial values, we are now seeing the institutionalization of anti-social or demonic values. This inversion of morality can only be seen as demonstrating the urgent need for self-definition when the self is confronted with total isolation and alienation.

Narcissism may be seen negatively as resulting from loss of inhibitory moral traditions resulting in unbridled grandiosity and self-interest. But the adaptive advantages must also be noted. In a complex urban world where individualism counts for very little, any attempt to define the self, however grandiose, may serve the individual well as a defense against

the worse fate of anonymity and dissolution. Reason itself may be understood as an ego ideal--never in fact quite attainable and only approximated at the cost of isolation from the self, i.e. from the feelings and passions which are as much a part of human actions as are abstract ideas, never completely explicit, never completely conscious. Ethics may get swept up in a ruthless perfectionism, treating its abstract ideals as moral imperatives, rather than recognizing the inherent limitations in every human endeavor.

During the (post) adolescent period, if all goes well, the moral personality emerges with its emphasis on personal dignity and self-esteem rather than superego dependency and instinctual gratification. The ego ideal has in many ways taken over the regulatory function of the superego, and has become heir to the idealized parent of childhood. The reliance once vested in the parent now becomes attached to the self, and sacrifices of all kinds are made in order to sustain the sense of dignity and self-esteem.

In summary I think it may be said that inhibitory moral traditions do indeed have a function. They have a function far more important and immediate than reproducing the genes. They serve as the vehicle of the transmission of culture from generation to generation and within a generation they serve to establish a sense of personal identity, a sense of integrity and a sense of self-esteem.

## CHAPTER THREE

### THE CARTESIAN LEGACY

#### I.

Questions of ethics, insofar as they present themselves for philosophical reflection, involve a fundamental tension between thought and action. Although we recognize the possibility of "good deeds" apart from any reflection on such actions, we also expect an account of what makes behavior or conduct moral. A method of ethics which stresses cognitive clarity of abstract principles risks compromise of broader principles if idiosyncratic desires are placed ahead of social concerns. Ethical reflection is usually thought to involve (1) the perception of a problem as an ethical problem, (2) an articulation of a principle and/or course of action, and (3) a test of the validity of that articulated statement. The test is often phrased, "How can we know that a given action is morally correct?" or "How can we be certain a given decision is 'right' or 'good'?" The focus on "knowledge" and "certainty" suggests an epistemological dimension to ethical reflection. How do we know? What does it

mean to be certain? The centrality of these questions is further suggested by their occurrence in the Garden of Eden story where eating the fruit of the Tree of Knowledge of Good and Evil brought about the uncertainties and necessities of the human condition.

Any inquiry into the nature and methods of ethics must, I believe, respect the very real tension between thought and action and must acknowledge it. It is neither sufficient to articulate, as Kant did, a universal maxim, nor to act unreflectively regardless of how confident one may be, without understanding the altogether human inclinations to both these extremes.

The philosophy of René Descartes expresses the thought-action tension so evidently manifest here and is most illustrative of the problems faced by ethical theory and the practical application in medical ethics. The standard (regnant) approaches to ethics are based on an epistemological sensibility which might properly be considered "Cartesian" or at least could be informed by an appreciation of what Descartes was attempting to accomplish. The extent to which his mission succeeds or fails suggests the boundary conditions for an objective and completely explicit epistemology and ethics. Our own choice is not whether to accept or to reject what Descartes proposed, but

rather we must understand how best to deal with the approach which has become so characteristic of the modern outlook. But modernity's appreciation of Descartes is ambivalent. He is alternately viewed as the hero who liberated knowledge from religious dogmatism and the villain who disembodied human mental life. In the remarks which follow, I hope that it will be possible by looking at Descartes as well as Cartesianism to explain more sympathetically why Descartes' outlook fails us in matters of human conduct, hence as a basis for ethics, and why the issues he struggled with remain very vital issues for each successive generation.

## II.

The questions "How can one know?" or "How can one be certain?" were questions which very much preoccupied Descartes. For centuries prior to the introduction into the world of Descartes' famous method, these questions would be taken as religious questions, and their answers were left to ecclesiastical authorities. Subsequent to Descartes, questions of knowledge were held to be primarily the domain of science. Hence it follows, they are not the domain of the Church, so any given individual, e.g. the scientist in pursuit of discovery, has access to the truth without the need of authorization from the religious community. It does not, however, follow that religious knowledge is public and scientific knowledge is

private, as Polanyi has taken great pains to demonstrate. But what does follow from Descartes is a bifurcation of doubt and faith, as approaches to knowledge.

The consequences for ethics of this unfortunate move are probably much more devastating than for either science or religion, both of which have maintained their respective traditions. The sources of ethics are seen as either religious or scientific, with "religious" and "scientific" having connotations which would seem to make them mutually exclusive. Thus ethics becomes lost somewhere in the void between science and religion. More broadly the question might be posed as to what are the sources of wisdom by which people might responsibly conduct their lives. More narrowly one would want to know the particulars of a given action or decision in terms of its value components. It is a feature of modern thought quite generally to analyze a problem, to factor out the components, and to formulate alternatives as exclusive of each other. I will presently argue for an approach to ethics which is inclusive rather than exclusive and integrative rather than dichotomous. Before that is possible it will be necessary to examine those patterns of thought which have come to dominate the modern era by which we customarily orient ourselves.

The origins in the seventeenth century of what would be called scientific thought were not far removed from religion. The liberation of the pursuit of knowledge from the authority of the Church was a truly astonishing accomplishment due to a great extent to the genius of René Descartes. Yet this appreciation is ambivalent, for the price of that liberation was a split of the material and spiritual worlds with the result that Man (as person) was to be impersonally studied by the methods of understanding physical objects in space and time. Although Descartes' influence on the history of ideas has been enormous, he can neither be credited nor blamed with the shape of the modern age. His influence, however, has been so singular that a closer look at his ideas and their origin will be useful in understanding the spirit of Cartesianism in current scientific and philosophic thought and particularly as it applied to ethics and medical ethics.

Descartes remained a faithful Catholic throughout his life. The existence of God was never questioned; in fact Descartes offered in his third meditation systematic "proofs" for the existence of God. The authority of the Church also remained unquestioned although it was ultimately undermined by the program of systematic doubt. In deference to the Church authorities, Descartes tended to avoid moral subjects in favor of

mathematical and scientific topics, and his treatise on morality, La Treatise des Passions sur l'âme, developed from his correspondence with his student, Princess Elizabeth of Bohemia, whose preference for discussing questions of a moral nature forced Descartes to be pragmatic and explicit.<sup>1</sup>

Descartes' view of God was so encompassing and so embracing he could not imagine man apart from God. He was God's and God was his. They were practically one and the same, not differentiated. His proofs for the existence of God proceed, as his system demands, only from the contents of his own consciousness and indeed from one item he finds there--an idea of God, a perfect and infinite being:

As for my parents, from whom it appears that I derive my birth, although all that I have ever believed about them be true, nevertheless this does not mean that it is they who conserve me, or who made me and produced me in so far as I am a thinking thing, since all they did was to put certain dispositions into this matter in which I judge that I, that is to say my mind, which alone I take now as being myself, is enclosed . . . from the mere fact that I exist, and that the idea of a sovereignly perfect being, that is to say, God, is in me, the existence of God is very clearly demonstrated.<sup>2</sup>

This sort of proof relied for its persuasion on a "clear and distinct idea" and was buttressed by the scholastic outlook, which his system was to leave behind in an understanding of the

<sup>1</sup> Jack R. Vrooman, René Descartes; A Biography. (New York: Putnam, 1970), p. 182.

<sup>2</sup> René Descartes, Discourse on Method, trans. F. E. Sutcliffe, quoted in John H. Hanson, "René Descartes and the Dream of Reason," in Marie Coleman Nelson, ed., The Narcissistic Condition. (New York: Human Sciences Press, 1977), p. 160.

physical or material world, but not of the spiritual or mental world. It was the very idea of consciousness that remained problematic for the modern world following Descartes.

Descartes' method for achieving certain truth was to doubt everything in a systematic way. His consciousness was the starting point. But he never doubted the fact that he was doubting. The fact that he was thinking was sufficient proof of his own existence. I think, therefore, I am (Je pense, donc je suis or in Latin Cogito ergo sum). He was, in his view, that which was thinking (a product of his own thought). From a modern psychological point of view, we would wonder if he did in fact literally doubt his own existence, such that he would feel a need to prove it and then be satisfied with such an abstract conception. Did he experience feelings of depersonalization? Was his conception of God as a perfect being merely a projection of his own grandiose wish, a denial of his own sense of smallness and imperfection? Descartes anticipated this modern objection and claimed that God was not just infinite beyond human conception, but actually infinite. Here he rests again on a conceptual argument. For Descartes and the philosophy he espoused, it seemed sufficient to argue that this was not what he meant, as if his conscious intention was sufficient to repudiate the implications of his claim.

For Descartes mathematics was the key to understanding the world, and geometry was "the queen of the sciences." One of his most unchallenged contributions to the history of thought is the system of mathematics he created which still popularly bears his name, Cartesian geometry, or analytic geometry, which located bodies (points) in space by a system of coordinates, measuring their distance from a central point of reference called the origin. This system of mathematics had obvious practical application in the physical sciences, mechanics, astronomy, and ultimately the exploration of space including extraterrestrial space, where the only limitation on knowing was the precision of the measuring instrument.

So successful was this system as a device for assuring certain knowledge that it becomes the paradigm for scientific knowledge. The twentieth century challenged the certitude of the Cartesian system as adequate and apodictic on several grounds. In the physical sciences, the Heisenberg uncertainty principle demonstrates the difficulty of measuring very small particles when the very act of measuring something as minute as a photon changes its location and thus falsifies the measurement. In psychology, behaviorism attempts to be rigorously scientific by limiting its concern to that which can be observed and measured, thereby idealizing the thing (person) measured by its

theoretical prejudices, while psychoanalysis accounts for the impact of the investigator on the subject by making the investigator part of the experiment in studying the relationship between the analyst and the analysand, giving better fidelity to human experience at the cost of precise certainty. The challenge to Cartesianism from the "human sciences" is a frank disgruntlement with the reduction of Man either to a physical entity or to a disembodied spirituality.

Descartes' world is described as dualistic: the realms of mind and body, of mind and matter, or of spirit and matter are separate substances. The world is divided into res cogitans, thinking things, and res extensa, extended things, three-dimensional objects in time and space. As Maritain poetically puts it,

Cartesian dualism breaks man up into two complete substances joined to one another no one knows how: on the one hand, the body which is only geometric extension; on the other, the soul which is only thought--an angel inhabiting a machine and directing it by means of the pineal gland.<sup>3</sup>

In trying to understand the contemporary significance of Cartesianism we are ourselves inextricably caught up in its dualistic tentacles. We know better than to accept such bifurcation, a soul (or mind) directing a mechanical body through the efforts of the pineal gland. And even when we concede the

<sup>3</sup> Jacques Maritain, The Dream of Descartes, trans. Marabelle L. Andison, (New York: Philosophical Library, 1944), p. 179.

anatomical error and recognize the mediation of brain and body through the autonomic and endocrine systems, we are still left with such a dichotomous view of ourselves that it is difficult to encompass spirituality and corporeality simultaneously. We know the mind-body problem is specious, but it won't go away.

If we attend to the thinking side of this dualism, we witness a contempt at a theoretical level for the body and the senses; there is nothing worthwhile but pure thought. Affective life is completely denied. Feeling is not a legitimate awareness of the body, but merely a confused idea. If we focus on the body side of the equation, we see how the body is lost: it is surrendered to the universal mechanism, to the energies of matter regarded as forming a closed world. It is not the dwelling place of a human being. The body is itself a physical entity, a three dimensional thing in time and space. There is no place in this scheme for love or will, intention or even action, except as thoughts or movements.

### III

For the scholastic world which nurtured Descartes, the senses played a prominent role in knowledge. The intellect was the basis for knowledge, and the senses guided the intellect. Realizing the unreliability of the senses, given the possibility of illusions, delusions, and hallucinations, Descartes could

place no confidence in knowledge derived from the senses. In the first meditation he expresses his predicament, which has come to be known as his "dream problem."

. . . I became aware that I had accepted, even from my youth, many false opinions for true, and that consequently what I afterwards based on such principles was highly doubtful; and from that time I was convinced of the necessity of undertaking once in my life to rid myself of all the opinions I had adopted, and of commencing anew the work of building from the foundation.

. . . although the senses occasionally mislead us, . . . there are yet many other of their informations (presentations), of the truth of which it is manifestly impossible to doubt; as for example, that I am in this place, seated by the fire, clothed in a winter dressing-gown. But how could I deny that I possess these hands and this body, and withal escape being classed with persons in a state of insanity, whose brains are so disordered and clouded by dark bilious vapours as to cause them pertinaciously to assert that they are monarchs when they are in the greatest poverty.

Though this be true, I must nevertheless here consider that I am a man, and that, consequently, I am in the habit of sleeping, and representing to myself in dreams those same things, or even sometimes other less probable, which the insane think are presented to them in their waking moments. How often have I dreamt that I was in these familiar circumstances,-- that I was dressed, and occupied this place by the fire, when I was lying undressed in bed?

. . . But I cannot forget that, at other times, I have been deceived in sleep by similar illusions; and, attentively considering those cases, I perceive so clearly that there exist no certain marks by which the state of waking can ever be distinguished from sleep, that I feel greatly astonished; and in amazement<sup>4</sup> I almost persuade myself that I am now dreaming.

<sup>4</sup>René Descartes, The Meditations and Selections from the Principles of René Descartes, trans. John Veitch (LaSalle, Illinois: Open Court Publishing Company, 1937) in Philosophers Speak for Themselves, eds. T.V. Smith and Marjorie Grene (Chicago: Phoenix, 1957), pp. 55-57.

Descartes found certainty only in geometry and God, hardly at all in sciences such as physics, astronomy, and medicine. He therefore resolutely determined to start completely anew with a method entirely derived from consciousness.

I will now close my eyes, I will stop my ear, I will turn away my senses from their objects, I will even efface from my consciousness all the images of corporeal things; or at least, because this can hardly be accomplished, I will consider them as empty and false; and thus, holding converse only with myself, and closely examining my nature, I will endeavor to obtain by degrees a more intimate and familiar knowledge of myself.<sup>5</sup>

Because the senses were an unreliable basis for knowledge, Descartes resolutely determined to start completely anew with a method derived entirely from consciousness. This method was, he claims, revealed to him in a series of dreams, which he had on the night of November 10, 1619, at the age of 23, while secluded in his stove-heated chamber. Given his profound distrust of sensory experience, feelings, and the affectual side of life, we might be surprised that Descartes placed so much credence in his dreams. This is a most unCartesian contradiction. Yet such a contradiction is telling of the limits of the Cartesian methodology so developed, for the program of systematic doubt can never function in a vacuum, devoid of social content, but always relies, even as it did for Descartes, on a sentient human being, who must do the doubting and who must reflect on the substance of that doubt. Descartes was subject to the vicissitudes of his historical and sensory experience.

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<sup>5</sup>Ibid., p. 69.

He recorded his dreams in a manuscript called Olympica, which is no longer available, but which was used by his biographer, Baillet, who preserved the text of the dreams.<sup>6</sup>

#### The first dream

Several phantoms presented themselves and frightened Descartes. Walking through the streets he had to turn to the left side to advance to where he wanted to go, because he felt a great feebleness on the right side, on which he couldn't support himself. Ashamed of walking this way, he tried to straighten himself, but an impetuous wind carried him in a sort of whirlwind ("tourbillon") and whirled him about three or four times on his left foot. He thought he would fall at each step, until having seen an open college on the road, he entered to find a retreat and a remedy for his sickness. He wished to reach it with the thought first of prayer, but having passed a man he knew without greeting him, he tried to retrace his steps to do so, but was pushed violently by the wind against the Church. In the middle of the college court, he saw another person who called him courteously by name, and told him that if he was looking for Monsier N., he had something to give him. Descartes imagined it was a melon which had been brought from a foreign country ("un melon qu'on avait apporté de quelque pays étranger.") What surprised him more was to see that those who were gathered around this person stood firm on their feet, while he always remained bent and unsteady ("courbe et chancelant"). The wind meanwhile subsided. He then awoke, and felt a real pain, which made him fear that some evil genius had wished to seduce him ("quelque mauvais génie qui l'aurait voulu séduire"). He had been sleeping on his left side, and turned to the right, praying God to save him from misfortune and punishment of his sins.

#### The second dream

He had fallen asleep after meditating for two hours on the goods and evils of this world. Then he dreams

<sup>6</sup>Adrien Baillet, Vie de Monsieur Descartes. English text is available in Norman Kemp Smith, New Studies in the Philosophy of Descartes, (London: MacMillan, 1952), pp. 33-39, and in Lewis S. Feuer, "The Dreams of Descartes," American Imago, vol. 20, no. 1 (Spring 1963):3-26.

that he hears a sharp and piercing noise, which he took for a peal of thunder ("un bruit aigu et éclatant, qu'il prit pour un coup de tonnerre"). The fright awoke him, and he perceived many sparks of fire scattered in the room ("beaucoup d'étincelles de feu repandues par la chambre"). This had often happened to him before. He would awake in the middle of the night his eyes quite glittering (les yeux assez étincellans"). But this time he desired philosophical reasons, and he drew conclusions favorable to his mind ("favorable pour son esprit").

### The third dream

This dream was not accompanied by feelings of anxiety. Descartes finds a book on the table, opens it, discovers it's a Dictionary, and is delighted with it. Then, the very instant he finds another book under his hand, and doesn't know where it had come from. He ascertains it is an anthology of poems of different authors entitled Corpus Poetarum. He was curious to read something, and at the beginning of the book, happened upon the verse: Quod vitae sectabor iter? At the same time he saw a man he didn't know but who presented him with a verse beginning Est et Non, which he praised. Descartes told him he knew what it was, and that it was one of the Idylls of Ausonius found in the big collection of poets on the table. He wished to show it himself to this man, and began to leaf through the book whose order and arrangement he had boasted he knew perfectly. While he was looking for the place, the man asked him where he had obtained the book, and Descartes answered that he was unable to tell him how he had it; but that a moment before he had held still another which had disappeared without his knowing who had brought it or taken it back from him. He hadn't finished when he saw the book appear once more at the other end of the table. But he discovered that this Dictionary was not complete as it had been when he saw it the first time. However, in perusing the Anthology of Poets, he came upon the poems of Ausonius; but not finding the piece which began with Est et Non, he told the man he knew another one by the same poet which was still more beautiful than the former, and which began with Quod vitae sectabor iter? The person asked him to show it to him, and Descartes set about looking for it, whereupon he found several small

portraits engraved in copperplate; this made him say that the book was very beautiful, but that it was not of the same printing as the one he had known. There he was when the books and man disappeared, and faded from his imagination, without nevertheless re-awakening him.

These dreams have received much attention from a variety of perspectives although it is striking the number of philosophical accounts of Descartes' work which ignore the dreams or treat them as a curious historical footnote. Maritain is unusual among the philosophical commentators in seeing the dreams as illuminating: "It is undoubtedly very annoying to find at the origin of modern philosophy a 'cerebral episode'," he writes in his thorough-going indictment of Descartes, one "which would call forth from our savant, should (it be met) in the life of some devout personage, the most disquieting neuropathological diagnosis."<sup>7</sup> Von Franz offers a detailed Jungian analysis interpreting the elements of Descartes' dreams according

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<sup>7</sup>Jacques Maritain, *Ibid.*, pp. 15-16. The presence of conflict may be interpreted as evidence of psychopathology as may be found in the accounts of John O. Wisdom, "Three Dreams of Descartes," The International Journal of Psycho-Analysis, 28 (1944):118-128, and Stephen Schonberger, "A Dream of Descartes: Reflections on the Unconscious Determinants of the Sciences," The International Journal of Psycho-Analysis, (1939):43-57. Presence of conflict is not in itself indicative of psychopathology, however. Our objection to Descartes is not for the conflicts he faced, but for the solution he chose in defending against those conflicts.

to their symbolic content of the Jungian archetypes.<sup>8</sup> Feuer accounts for the dreams in classical psychoanalytic format according to the sexual conflicts of the dreamer, but acknowledges that his analysis does not "show how the specific ideas of Descartes' philosophy, his unique emphases and standpoint, were linked to the character of the underlying anxieties suggested by his dreams."<sup>9</sup> Freud himself was invited to comment on the dreams by Maxine Leroy, but declined to offer an in-depth analysis on the grounds that such an analysis would be impossible without the associations of the dreamer to the elements of the dream. Freud suggested only that the dreams seemed to be the sort he described as "from above," meaning that the dream carried the content of conscious thought.<sup>10</sup> Freud here demonstrated a

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<sup>8</sup> Marie-Louise von Franz, "The Dream of Descartes," Timeless Documents of the Soul. (Evanston: Northwestern University Press, 1968), pp. 55-148.

<sup>9</sup> Lewis Feuer, "The Dreams of Descartes," American Imago 20 (1963):3-26. Another psychoanalytic account draws on the newer theories of narcissism: John H. Hanson, "René Descartes and the Dream of Reason," in The Narcissistic Condition; A Fact of Our Lives and Times, (New York: Human Sciences Press, 1977), pp. 155-178.

<sup>10</sup> Sigmund Freud, "Some Dreams of Descartes," in The Complete Psychological Works of Sigmund Freud (Standard Edition), trans. and ed. James Strachey, 21 (London: The Hogarth Press and the Institute of Psycho-Analysis, 1961), pp. 203-204.

scientific prudence, one might say of a Cartesian sort, and is correct that one cannot know with mathematical certainty the meaning of such dreams. Yet just as Freud offered speculation about Leonardo da Vinci, so it would be possible to relate the concerns of Descartes' life and philosophy as these concerns are manifest in Descartes' dreams, a task which merits consideration, not only because the dreams are intrinsically interesting, but also because of what may be learned of the character of Descartes' philosophy and its influence.

An interesting paradox is posed by a twentieth century retrospective on these dreams. Descartes proposed a method for achieving certain knowledge based strictly on conscious thought, yet, he claims, that method was revealed to him in his dreams. From a twentieth century vantage point, as difficult as it may be to accept specific unconscious meanings, it is even harder to accept the kind of purely conscious abstract thought Descartes proposed. Yet Descartes himself seemed to have little difficulty with this contradiction. He easily reconciled these seeming incompatibles of conscious and unconscious thought in himself. This paradox may offer a clue to understanding the workings of latter day Cartesianism: Descartes' dualism makes no more sense for all of us than it did for him, except inasmuch as we, like Descartes, remain sentient human beings, however unselfconsciously, always

integrating conscious and unconscious, always integrating our mental process in an embodied way, relying on our awareness of ourselves in the world, just as Descartes himself did. Cartesianism works, to be sure, as its success for three and a half centuries testifies, but it works only because it is possible to disattend from our awareness of ourselves to focus on the world outside of us and never because it is possible to negate human sentience entirely except in that denial of reality known as psychosis.

Descartes himself offered the first interpretation of his dreams. In fact the third dream contains its own interpretation, which Descartes dreamed while still asleep. It is this form of dreaming which suggests Freud's designation of the dreams as "from above." The interpretations Descartes offered must have been close to his waking consciousness. Freud would have liked associations to the elements of the dreamer's unconscious thought processes. Descartes offers us instead a stunning event in the history of consciousness in which he claims to have found the origins of a wonderful new science (scientae mirabilis). What was singular in the circumstances of the third dream, according to Baillet's account was that

Descartes, wondering whether what he had just seen was a dream or vision, not only decided that it was a dream, but rendered its interpretation even before he awoke. He judged that the Dictionary represented all the sciences gathered together; and that the

Anthology of Poems, entitled Corpus Poetarum, indicated particularly, and in a distant fashion, Philosophy and Wisdom joined together. For he believed one shouldn't be much surprised to see that the poets, even those who fool their time away, have many maxims which are deeper, more sensible and better expressed than those which are found in the writings of philosophers. He attributed this wonder to the divinity of Enthusiasm and the force of Imagination, which emitted the seeds of wisdom (which are found in the minds of all men, like the sparks of fire in flintstones) with much more ease and brilliance even than Reason can among the philosophers. Descartes, continuing to interpret the dream in his sleep, thought that the verse on the uncertainty of the way of life which one must choose, which begins with Quod vitae sectabor iter, marked the sound advice of a wise person, or even of Moral Theology.

Thereupon, uncertain whether he was seeing or imaging, he awoke without emotion, and his eyes open, continued to interpret his dream along the same line. By the poets gathered in the anthology he understood Revelation and Enthusiasm, which he hoped would still favor him. By the piece of verse Est and Non, which is the Yes and No of Pythagoras, he understood Truth and Falsehood in human knowledge and the secular sciences. Seeing that his work in all these fields was succeeding so well, he was bold enough to persuade himself that it was the Spirit of Truth which had wished to open for him (by this dream) the treasures of all the sciences. There was left for him only to explain the little portraits in copperplate, which he had found in the second book. He didn't try to explain this any more after an Italian painter visited him the next day.

This last dream, which was altogether very pleasant and agreeable, indicated to him the future and what must happen to him for the rest of his life. But he took the two preceding ones as threatening warnings concerning his past life, which may not have been as innocent before God as before men. And he believed that it was the reason for the terror and fright with which these two dreams had been accompanied. The melon, which was offered him in the first dream, signified, he said, the charms of solitude, but available

through purely human attractions. The wind which pushed him towards the Church of the college, when he felt bad on the right side, was nothing but the evil Genius which tried to throw him by force into a place he had voluntarily planned to go.

Descartes experienced great excitement and enthusiasm in these dreams. The turmoil of the tempest in the first, the struggle of alternative directions, feebleness in walking the right way, gives way to the excitement not unmixed with fear of the second dream, a room full of sparks, and a reworking of these conflicts in the third dream, which offers him an answer to the question, "Which way shall I choose?" (Quod vitae sectabor iter?) The affect (feeling tone) of the third dream is most pleasant and agreeable, for in it Descartes receives what he takes to be the blessing of God for his new vocation. Despite this turbulent night, Descartes continued to view his dreams favorably. In fact, he wrote his friend, Balzac, that he was sleeping ten hours a night without any care awakening him: "I mix insensibly my reveries of the day with those of the night," and later he proudly wrote to Princess Elizabeth of Bohemia that he had never had a bad dream ("ainsi je puis dire que mes songes ne me representent jamais rien de fâcheus").<sup>11</sup>

We can hardly begrudge Descartes his sense of confidence and security represented in this autobiographical note. In understanding how his philosophy relates to the conflicts

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<sup>11</sup> Feuer, *Ibid.*, pp. 22-23.

represented in these dreams, however, we are justified in looking deeper and asking if Descartes' solution to his own personal anxieties is adequate for successive generations. We may say in all fairness, I believe, that a defense against anxiety which accomplishes its mission at the expense of the complete elimination of all affective life simply will not do. In saying this I realize that the point is controversial, for there are those who would argue that emotions can easily get out of control and that they should be controlled however possible. For those holding such a view, the Cartesian system of rationality is very welcome indeed. And I would not wish to argue that if one had to choose between dispassionate rationality and unbridled emotion, there would be any security at all without rationality. Rather my claim would be that our notions of rationality can be more encompassing than Descartes ever believed possible. It is the very peculiar success of the Cartesian system, so useful yet so limiting, that mandates a closer investigation of Descartes' philosophy in light of what we know of his own inner life.

#### IV.

René Descartes was born on March 31, 1596, in a small town in Touraine. His mother suffered from a lung disease, and René claimed he inherited his own sickly disposition

from her. When he was but fourteen months old, his mother died in childbirth (May 13, 1597). Three days later her fifth and last child also died. It thus seems strange, though perhaps telling, that Descartes later wrote in a letter to Princess Elizabeth that his mother died "a few days after my birth from a lung ailment caused by some sort of grief."<sup>12</sup> Whether he was ignorant of the circumstances of his mother's death or whether his memory was distorted by the early trauma, it must have seemed to him that her death occurred very early indeed. It was as if he had never had a mother. What is certain is that his mother exerted very little influence on young René except by virtue of her absence. It is no wonder he could write in the third meditation that all his parents contributed to him was certain arrangements of matter in which his real self was enclosed.<sup>13</sup>

Descartes was not without a consistent mother-figure, however, for he was tended to by a devoted nurse and by his maternal grandmother. His father, a prosperous lawyer, apparently cared for the well-being of his sickly fourth child, but never developed an emotionally close relationship with young René. The child demonstrated an interest in academic studies from an early age, and when he was ten, his father placed him in the Jesuit Collège de la Flèche, where his scholarly interests could be nurtured.

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<sup>12</sup>Vrooman, *Ibid.*, p. 21.

<sup>13</sup>Hanson, *Ibid.*, p. 160.

Descartes quickly distinguished himself at La Flèche and was exempted from certain requirements because of his abilities for independent work. He often devoted this time to solitary repose in his bed, which earned him the nickname "le chambriste" from his schoolmates.<sup>14</sup> Descartes apparently loved the study of mathematics for its precision, and hated the scholastic method of disputation, which prevailed at La Flèche.

Descartes' life, his philosophy, and his dreams all reveal certain conflicts between a desire for certainty and security and a desire for independence and solitude, between a submission to authority and a defiance of that authority (his father, his school, the Church and its traditions) and between a fascination with and interest in his emotions and a rationality devoid of emotional content. These conflicts are by no means unique to Descartes; in fact it could be said that they are universal concerns of mankind, but what is unique is the creative way in which Descartes dealt with these conflicts.

In looking at Descartes' dreams and biography as clues to understanding his philosophy, we are deprived of the opportunity Freud would have liked of questioning the dreamer. What we have are not Descartes' associations to the dreams (which are different from the consciously considered interpretations he offers us), but instead we have other people's associations to and

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<sup>14</sup> von Franz, Ibid., p. 60.

conscious interpretations of Descartes' dreams. There is accordingly a risk that any such interpretations reflect the interests and biases of the interpreter as much as they do those of the dreamer. While this should not deter us from making the effort, it should alert us to the possibility that our conclusions may be merely useful and not necessarily valid or even true. For unlike the psychoanalytic enterprise, whose task it is to convince the dreamer of the (multiple) unconscious and historical determinants of his nocturnal productions, our task is to convince ourselves. It is sometimes suggested that literary criticism tells us more about each successive generation of critics than about the various authors so carefully interpreted. Similarly I would wish to acknowledge that my motives for looking at Descartes insofar as I am aware of them are not so much to explain Descartes as to understand him in light of the difficulties we encounter with his philosophy in our time. The task we face is rather like one of looking through both ends of the telescope simultaneously. We wish to attend to the small details but not at the expense of losing the larger picture.

Descartes' dreams reflect elements of classical sexual conflict and Oedipal struggle. There are often compelling suggestions of hatred of the father and of authority and

the fear of retaliation, even, of castration. What is absent to make the classical interpretation convincing is evidence that struggle with the father and the Church were motivated by competition for the love of the mother (who was absent from Descartes' dreams as she was from his life).

It is significant that the dreams occurred on November 10, 1619, in that this was St. Martin's Eve, a time customarily spent in debauchery in France. While debauchery was not unknown to Descartes, he spent this day in sobriety.<sup>15</sup> Although this night was for him, as it was for others, a time of intensified excitement, he spent the time in solitude, and the excitement he experienced was intellectual, not carnal, if it is fair to make such a distinction.

Looking at the dreams as a whole, we see a sense of keen anxiety and tension, confusion and fear of retribution give way eventually to a confident sense of vocation, bolstered with the conviction of divine blessing. Looking at the specific elements of the dreams, we get a better sense of what was and was not accomplished for Descartes by the dreams.

In the first dream, Descartes is walking through the streets, has to turn to his left side, and feels feeble on the right side. Walking through the streets was an uncommon

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<sup>15</sup> Feuer, *Ibid.*, p. 3.

activity for Descartes. For two years, from 1614 to 1616, he hardly left his house, viewing the streets as a threat to the "mask" (as he called it), which he constructed to hide from his insecurities. The turn to the left (or gauche) may represent a deviation from the approved traditions, and the weakness on the right, a sense of not being supported by those traditions. His attempt to stand erect may be taken as a symbol of his own potency, manhood (adulthood) or as an attempt at independence in standing on his own. The whirlwind may have been appropriated in Descartes' dream from the traditional Biblical symbol of God speaking to man, which surely would have been familiar to him from his religious training. The college could only be La Flèche, an attempt to review in his dream his differences with the security of the familiar order. The snubbed man could be any one of the friends he avoided, his awareness of the social impropriety of his solitary ways, and/or it could represent his father, whom Descartes snubbed in so many ways, notably in rejecting his father's bureaucratic style of life.

Monsieur N. is undoubtedly one of the curious verbal puns, which so often appear in dreams both to reveal and conceal the dreamer's concern. Father Mersenne was one of Descartes' closest personal friends and advisor. It was Mersenne who steered Descartes away from his profligate ways and his

predilection for gambling, and who inspired in him a greater delight in the pursuit of science. "They began to taste the sweetness of their innocent habits, and to ease each other in the search for truth." ("Ils commencaient à goter les douceurs innocentes habbitudes, et a s'entresoulager dans la recherche de la vérité").<sup>16</sup> Mersenne, however, was assigned by his order to teach in Nevers in 1614, a separation which was traumatic for Descartes, and to which he responded with two years of solitary withdrawal. "Monsiour N." in the dream may represent symbolically as well as phonetically "Mersenne" or the "M" of Mersenne and the "N" of Nevers. The "melon from a foreign country" is also a classical religious symbol representing the fruit from the Tree of the Knowledge of Good and Evil. As a forbidden fruit it suggests the excitement for Descartes in the study of science and mathematics. This excitement might be considered an "eroticization" of learning with forbidden sexuality as a paradigm for moral discrimination. It has also been suggested that the fruit is the maternal symbol of the female breast,<sup>17</sup> which in Descartes' case is corroborated by the sense of nourishment, even to a sense of defining his own existence, which he received from the pursuit of knowledge.

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<sup>16</sup>Baillet, Ibid., p. 227.

<sup>17</sup>Feuer, Ibid., p. 11.

Descartes' hatred of his father apparently stemmed more from his perception that his father falsely grieved his mother's death than from a recognition of the father as a rival for the mother's attention. This is not surprising since at the time of his mother's death, when Descartes was but fourteen months old, he would not have had a sense of his mother even as a separate person, but only been aware of her insofar as she provided nurturance or failed to. Descartes writes, apparently in reference to his father, of the "secret joy" of a bereaved husband:

when a husband laments his dead wife whom (as sometimes happens) he would be sorry to see brought to life again. . .it may be that some remnants of love or pity which present themselves to his imagination draw sincere tears from his eyes, notwithstanding that he yet feels a secret joy in the inmost parts of his heart, the emotion of which possesses so much power that the sadness and the tears which accompany it can do nothing to diminish its force.<sup>18</sup>

Whether Descartes' perception of his father's reaction to his wife's death is correct, we do not have the evidence to determine. We might also wonder if Descartes' hatred for his father stemmed from the father's failure to take the mother's place and provide the nurturance and security he so desperately longed for.

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<sup>18</sup>The Philosophical Works of Descartes, vol. I, trans. Elizabeth A Haldane and R. T. Ross. (New York: Human Sciences Press, 1955), p. 398, quoted in Feuer, *Ibid.*, p. 12.

Feuer suggests that the bent and unsteady gait represent impotence, castration anxiety, born out of his revolt against his father.<sup>19</sup> The source and nature of this anxiety remain, I believe, in question. There is little question, however, that Descartes feared retaliation for his rebellion, symbolized by the sparks of the second dream, and his sense that God is to punish him for his sins.

The third dream presents to Descartes and to us a way of resolving these conflicts and avoiding the feared retaliation. It was not sufficient that Descartes found his vocation and sense of manhood in the discovery of the scientific method, the answer to the question "Quod vitae sectabor iter?" That alone did not secure his confidence because his method was revolutionary; it struck at the very heart of the scholastic tradition, the "Est et Non." His revolution was a form of academic parricide. He needed and thought he found in his dream the blessing of one no less powerful than God, whose allegiance was also claimed by the scholastics. The use of the Idylls of Ausonius from the anthology Corpus Poetarum is telling not only of the unconscious trickery to which Descartes resorted, but also of his genius in introducing his method in such a way that it would undermine, but not directly challenge the traditional authorities. Ausonius

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<sup>19</sup> Feuer, *Ibid.*, p. 13.

was a fourth century Latin poet, who had been at most nominally Christian. When a friend of his had begun to base his life upon Christian principles, Ausonius was "totally unable to understand his friend's attitude" and could only believe that he was "crazed."<sup>20</sup> Ausonius himself "conformed decorously to Christianity as a matter of expediency, to avoid collision with the dominant cult."<sup>21</sup> Descartes, in choosing Ausonius as a model, thus found a strategy for his rebellion. He would wear a "mask," appear to agree with the authorities, maintain the stance nominally at least of a devout Christian, avoid controversial subjects, i.e. subjects of a moral or emotional nature and confine his activities largely to science and mathematics, or at least maintain that "innocent" posture.<sup>22</sup>

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<sup>20</sup> Ausonius, trans. Hugh G. Evelyn White, quoted in Feuer, *Ibid.*, p. 17.

<sup>21</sup> H.J. Rose, A Handbook of Latin Literature from the Earliest Times to the Death of St. Augustine, (London, 1954), p. 528, cited in Sister Marie Jose Byrne, *Prolegomena to an Edition of the Works of Decimus Magnus Ausonius*, (New York, 1916), p. 82, cited in Feuer, *Ibid.*, p. 17.

<sup>22</sup> Another interesting seventeenth century variation of this tactic was employed by Thomas Willis, Oxford contemporary of William Harvey, and author of Cerebri Anatome, in which he describes vessels still known at the Circle of Willis, the first observer to describe a case of manic-depression, coiner of the term "neurology," and author of the first textbook of neuropsychiatry, De Anima Brutorum (1672). Here he adapts a metaphysical solution (from Gasseni) which enabled him to carry out neuroanatomical studies without conflicting with the ecclesiastical authorities. Gasseni had claimed that animals must have souls since they show evidence of memory, reason, and other traits common to man. Willis attributed these psychological characteristics to the corporeal soul, or soul of brutes.

Descartes' seventeenth century solution is the twentieth century's problem. What at the time and in retrospect appears to have been a revolution of liberation from a most oppressive dogmatism, we now recognize as a compromise solution at best. Intellectual freedom was accomplished at the expense of loss of personal and moral (emotional) wholeness. At the heart of the Cartesian method of abstraction lies a fundamental deception, the mere appearance of conformity and subjugation to an awesome authority. Descartes believed (and perhaps rightly so) that a direct confrontation with the authorities would result in the destruction of one or the other of them. Indeed his mother had died just as he was taking his first steps toward independence. Of course, there was no causal relationship, as any rational mind can see, between Descartes' first autonomous acts and his mother's death, but Descartes did not at fourteen months possess a rational mind. The attribution of "magical" powers to thought, the foundation for the clarifications of later rationality, is commonplace in primitives, in infants, with some residue in the neuroses of adults.

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But in the case of human beings the corporeal soul is under the control of a rational soul. Thus by attributing man's higher functions to an immortal rational soul, Willis appeared to leave theological questions to the unchallenged authority of the Church and separated anatomical questions completely from metaphysical issues. Furthermore, by postulating twin souls he was able to speculate on highly controversial aspects of psychiatry and neurology which had hitherto been regarded as the domain of the theologian.

The origins of scientific thought seemed to require the repudiation of infantile thinking, yet paradoxically maintained it. The liberation of the intellect from the dependency on traditional authority could only be accomplished, it seemed, by reifying thought and abstracting it from the thinker. Galileo could make his discoveries, then, when challenged, repudiate them; they were not part of him; what an expedient compromise!

Modern science similarly recognizes the revolutionary character of scientific advances, the challenge to tradition and authority. As heated and controversial as such advances may be--and the heat and controversy are testimony to the fact that the advances are not impersonal--no one supposes that a challenge to authority or tradition will result in anyone's destruction. Ideas, which were once accepted as fact, may be destroyed, but no person will be demolished, except in the figurative sense in which it is sometimes suggested that one is identified with one's ideas. The hurt and pain are affective, and they are within the body as feelings and sensations, but the body is not injured.

#### V.

Was Descartes a Cartesian? My analysis would suggest that he could not have been because he was a human being,

and no human being, except in psychosis, could maintain the denials of sensory experience, of affective life, which Cartesianism requires. Descartes was only sometimes a Cartesian, just as Cartesianism works for us if we appeal to it only sometimes when in the process of abstractly trying to solve problems. Descartes himself recognized and obliquely acknowledged his reliance on his historical self:

I am a thing which thinks, that is to say, which doubts, which affirms, which denies, which knows a few things, which is ignorant of many, which loves, which hates, which wills, which rejects, which imagines also and which senses. For . . . although the things which I sense and which I imagine are perhaps nothing at all apart from me and in themselves, I am nevertheless sure that those modes of thought which I call sensations and imaginations, only insofar as they are modes of thought, reside and are found with certainty within myself.<sup>23</sup>

His attempt to reunite mind and body tenuously through the pineal gland may have been an attempt to remedy the excesses of earlier speculation in face of various criticisms. In his Replies to the Objections, an attempt to answer the critics of the Discourse on Method, he states,

I think that I took sufficient care to prevent anyone from inferring that man was simply a spirit that makes use of a body; for in this very Sixth Meditation in which I have dealt with the distinction between mind and body, I have at the same time proved that mind was substantially united with body; and I employed

<sup>23</sup> René Descartes, Philosophical Essays, trans. L. Lafleur. (New York: Bobbs-Merrill, 1964), p. 91.

arguments, the efficacy of which in establishing this proof I cannot remember to have seen in any other case surpassed.<sup>24</sup>

We may rejoice at these telltale inconsistencies and concessions, which reaffirm what we already knew, namely that knowing does indeed rely on our experience in the world prior to detached reflection. Descartes, were he in possession of the self-reflectiveness and self-awareness of modern psychology, so much stimulated by his own errors, might have wished to echo Carl Jung's protest: "Thank God I am Jung and not a Jungian."<sup>25</sup>

In looking at Descartes as well as the philosophy of Descartes, Cartesianism, we are better able to see how Cartesianism served the person Descartes and how it continues to serve us moderns, not so well as a method for apprehending reality, except geometric realities, but as a psychological defense "mechanism," which enables us to disattend from affectual realities, which may be unpleasant, by focusing on the world around us as if we were not a part of it. The Cartesian method is at root a deception, not a fundamental truth and not capable of delivering truth. The Enlightenment ambition of being able to control Nature through understanding has for all its prodigious accomplishments been ultimately a

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<sup>24</sup> René Descartes, Philosophical Works, vol. II, trans. F. Haldene and G. Ross. (New York: Dover, 1955), p. 102.

<sup>25</sup> Sharon Webb, "Descartes and Cartesianism: Some Phenomenological Reflections," unpublished manuscript.

false promise, as we are all too acutely becoming aware as we begin to confront the limitations of science and technology in solving our problems, particularly ecological, social, and ethical problems.

In the chapter which follows I will contrast the Cartesian legacy of critical thought with Polanyi's post-critical alternative and particularly draw the implications for ethics. I will attempt to demonstrate with Polanyi that the accomplishments of modern science have been based not on the Cartesian method but have been possible because scientists have largely ignored it. Polanyi's first contribution in redressing the Cartesian imbalance is the rehabilitation of trust in one's own perceptions as a fundamental step in the establishment of knowledge. Science proceeds not by a repudiation of sensory experience, but by a reliance on it. Polanyi's next important contribution is to stress the importance of participation in one's culture as essential in the process of discovering and establishing new knowledge. For the scientist new knowledge is established with the assent of the scientific community. For any knower the role of what Polanyi calls the "convivial order" is important, and for other cultural activities, art, religion, morality, politics, one exists not in isolation, but

in a continuous and continuously renewing culture. For Descartes knowing was to be a solitary, guarded activity between the knower and the known. Polanyi has stressed what might be called the "third pole" in knowing: the knower and the known exist in relation to some form of community or cultural tradition.

I summarize these differences in preface to my remarks on Polanyi and in conclusion to my remarks on Descartes in order to demonstrate what I consider to be the most fundamental issues at stake in terms of the liability of an impersonal approach to knowledge giving false legitimacy to an impersonal approach to ethics.

These contrasting approaches to knowledge may be described and further understood by what psychoanalysts Robbins and Sadow call "dyadic" and "triadic" reality processing.<sup>26</sup> The aberrations in knowledge which Descartes feared might occur from the incorrect perceptions due to illusions, delusions, or hallucinations, have traditionally been considered by psychiatrists as defects in reality testing, the inability to distinguish reality from non-reality or more specifically, the inability to distinguish between mental representations stimulated by external, objective, manifest events and those mental representatives arising from internal events, memories and fantasies. This is

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<sup>26</sup> Fred P. Robbins and Leo Sadow, "A Developmental Hypothesis of Reality Processing," Journal of the American Psychoanalytic Association 2 (1974):344-363.

the test which is definitive of psychosis, and though problematic as to what reality is, it usually relies on some general social consensus to define psychosis only in terms of the grossest perceptual aberrations. The undergraduate who considers the college administrators to be wicked ogres involved in a diabolical plot to destroy him might be considered psychotic. The law student who considers her professors to be paragons of wisdom and virtue might be considered neurotic if one ever stopped to reflect on the matter.

The distinction between dyadic and triadic reality processing draws on developmental considerations, the increasingly complex mental life of the developing infant. The dyad refers to the infant-mother relationship and the mental processes that the infant acquires in the first and second year of life. Initially the infant-mother relationship is properly described as a "symbiosis" both biologically and psychologically. The infant perceives the world and its mother only in terms of satisfactions provided or not provided. If the mother is present physically and emotionally, i.e. if the mother is empathic, the infant develops a sense of fairness and consistency, a sense of basic trust, which is the basis of later development, and particularly the basis for the development of an autonomous self.

Robbins and Sadow describe these phases of development in terms of its "nurturing and narcissistic" aspects, based on the caring of the mother and mirroring of the infant's needs in establishing a sense of self. They refer to the famous statement by the pediatrician and child analyst Winnicott on the matter:

If one is fortunate enough to have received 'good enough mothering' in the first and second years of life, the core of a positive sense of identity (self) will have been formed. This core permits the partial relinquishment of instinctual demands upon the object and in turn permits the partial acceptance of the separateness of objects. It is this process upon which reality testing hinges.<sup>27</sup>

The triad or "third pole" is acquired later when the child realizes that there are parents of distinct sexes and that his or her relationship to the two parents is different. These differences, though they are sexual, are more than just sexual and the difference is more than just the difference between three and two. With the emergence of more complex mental capabilities, the child perceives not just another figure in its environment, but both positive and negative (i.e. ambivalent) feelings and combinations thereof for each and both parents at different times. It is the developing skill of being able to discriminate among these complex perceptions that form the basis for social interactions and for discriminating subtleties of complex realities. Though Polanyi does not draw on such

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<sup>27</sup> Ibid., p. 347.

insights--and in fact might not find them congenial--they provide substantiation for the importance of the convivial order and Polanyi's attempts to draw attention to the cultural pole in mental life. The autonomy of the individual knower is grounded in the community of knowers. The knower cannot be solipsistically isolated, nor can he be indistinguishably merged in the group, even though both aberrations do occur.

The Cartesian system may be described as a dyadic system of reality processing. Though incomplete, it attempts to describe the establishment of knowledge as a solitary achievement. Only in highly abstract forms of knowing does this system begin to approach reality. In the Cartesian system "it is not reality which requires science to be true, it is Science which requires reality to be 'scientific,' and to produce its credentials."<sup>28</sup> Polanyi quite correctly elaborates the triadic components of reality processing, which have always been present, but which have not always been given recognition. In so doing he rehabilitates the possibilities for the human mind to know things which cannot be impersonally conceived and to dwell in complex realities.

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<sup>28</sup>Maritain, *Ibid.*, p. 50.

## CHAPTER FOUR

### THE POST-CRITICAL ALTERNATIVE

#### I.

The contrast between what has come to be called a critical view of the world and what might be called a post-critical outlook is essential to the consideration of ethics in the modern age. Critical thought attempts to establish knowledge by a presumably value-neutral standard, which holds as its ideal an absolute point of reference by which (the articulated forms of) knowledge may be assessed. According to Polanyi this assessment is fraught with error because it is itself a value judgment which cannot be made impersonally, but it is not acknowledged as such. His epistemology is called "post-critical" because it attempts to go beyond the limitations of critical thought to acknowledge the role of the person in knowing, the person who cannot escape making judgments.

Both Descartes and Polanyi were concerned with guarding against the excesses of dogmatism and both with accrediting an approach to knowledge which was, to state it boldly, "true." Descartes was concerned with guarding against the excesses of authoritarian religious dogmatism without falling prey to the

errors of wanton subjectivism, while Polanyi's concern was to guard against the dogmatism of objectivist science by demonstrating the inevitability of holding beliefs even in the process of systematic doubting. He observes that

In the days when an idea could be silenced by showing that it was contrary to religion, theology was the greatest single source of fallacies. Today, when any human thought can be discredited by branding it as unscientific, the power exercised previously by theology has passed over to science; hence, science has become in its turn the greatest single source of error.<sup>1</sup>

Though it may seem heretical, Polanyi challenges the ideal of a strictly detached, objective knowledge, which is the declared aim of modern science. Polanyi considers this a false type of objectivity:

I start by rejecting the ideal of scientific detachment. In the exact sciences, this false ideal is perhaps harmless, for it is in fact disregarded there by scientists. But . . . it exercises a destructive influence in biology, psychology and sociology and falsifies our whole outlook far beyond the domain of science.<sup>2</sup>

Objectivism is even more problematic in ethics, where what we know (believe) to be right or wrong is very closely related to

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<sup>1</sup>M. Polanyi, "Scientific Outlook: Its Sickness and Cure," Science CXXV (March 15, 1957):480.

<sup>2</sup>Michael Polanyi, Personal Knowledge (London: Routledge and Kegan Paul, 1958), p. vii. Also Idem., (New York: Harper Torchbook, 1964), p. xiii. Pages are the same in both editions, except that the Torchbook edition contains an additional preface. Hereinafter references will be to the Torchbook edition.

who we are as people, i.e. to the totality of our personhood, our histories, our culture, our relationships with others.

In our discussions to this point we have been trying to understand ethics in relation to our culture and its values. We have witnessed in various examples from medicine and politics equivocations and confusions as to the status of values and their relation to what are held to be facts; we have witnessed a conceptual confusion at numerous points between what "is" and what "ought" to be. It is this confusion in our culture which occasions close scrutiny of epistemology as a way of understanding the tasks of ethics, and it is this confusion, which particularly motivated Polanyi to turn from science to philosophy in order to demonstrate how a misunderstanding about what science is and how it proceeds leads to some very serious consequences for ethics. Polanyi asks us to believe--indeed insists that we recognize--that morality is a reality, i.e. that morality exists as part of culture and human experience and continues to have the power to influence the things that people in a culture do. This act of intellectual probity stands in stark contrast to those nihilistic threads of Western civilization, which scoff morality, proclaim its demise, and extol science as an alternative, sufficient unto itself. Polanyi invites our attention to moral realities by reconsidering what any reality is in order that we may be alert to the dangers of excesses of morality. Such excesses of morality, when not recognized as such may lead to

actual inversions of morality by insisting on a ruthless moral perfectionism. Responding to this warning and recognizing the impossibility of absolute perfection in human affairs has led me to the conclusion that in this culture we have a tendency to hold our ideals as imperatives, rather than to recognize them as standards toward which we should strive.

## II.

Polanyi writes about the twentieth century (Western) intellectual tradition because of the moral problem he sees in our culture, a problem stemming from an "objectivist" view of knowledge, a view which divorces the knower from the things known and thus eliminates any sense of personal responsibility or commitment to the holding of one's own beliefs. It is thus no small task to be asked to consider morality as a reality when our notions of "reality" are so tied up with our notions of "objectivity." Objectivity is so tied up with the Cartesian outlook that such things as social or moral realities have little credence when "objectivity" is understood to refer to material things as opposed to mental concepts, ideas, or beliefs, or when "objectivity" is understood to mean being uninfluenced by emotion, passion, or personal belief, the latter affective realm being the province of unreliable "subjectivity."

Dichotomies such as objective/subjective are in themselves spurious for Polanyi even though he continues to use these concepts, but now in quite different ways. Knowledge is neither

objective nor subjective, but rather it is "personal" insofar as it relies on the personal commitments of a person holding something to be true. Strict objectivity for Polanyi is but the tip of the iceberg in terms of what we know. Knowledge can never be totally explicit, but must rely on tacit components which cannot be completely specified. "We know more than we can tell and we can tell nothing without relying on our awareness of things we may not be able to tell."<sup>3</sup> Tacit knowledge is that which we know but cannot tell. Explicit knowledge is that which we know and can tell. The strict explicitness of the sort objectivity demands is an abstract idealization, to be approached only asymptotically in the mathematical metaphor of two lines getting ever closer but never intersecting. But in reality explicit knowledge is an ideal which never can be reached because we always know more than we can tell. The analogy which must be stressed for ethics is that any attempt to translate the ideals of a particular culture into objective and unambiguous imperatives is a misguided aping of a false view of the scientific outlook.

Polanyi's theory of knowledge, or knowing, and all his reflections on culture derive from his attempts to justify knowledge for its own sake. When physics is so often held to be the paradigm for knowledge because of the high degree of explicitness in it, Polanyi, who was first accomplished as a physical scientist, takes great efforts to demonstrate that even in the

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<sup>3</sup>Personal Knowledge, p. x.

physical sciences, scientists in pursuit of discovery rely on aspects of knowing, hunches, intuitions, and some general sense of the nature of what they are studying, which they cannot completely specify. Central to this understanding of nature or of anything else is Polanyi's concept of tacit knowing, which derives from the findings of Gestalt psychology. In Science, Faith, and Society (1946) Polanyi considered science as a variant of sensory perception. The act of scientific discovery is as unspecifiable as the tacit perception of a form or the recognition of a face in a crowd. Polanyi's reliance on sensory experience is probably the starkest contrast with Descartes' (largely unsuccessful) attempts to deny sensory experience.

Polanyi's analysis of the process of discovery revives and solves a question which had plagued man's understanding of science for centuries, the apparent paradox that Plato articulated in the Meno: In the pursuit of a discovery either one knew what one was looking for, in which case there was nothing to be discovered, or else one did not know what one was looking for, in which case one could not hope to discover anything. Or as Plato puts it in Meno's words:

And how will you inquire, Socrates, into that which you do not know? What will you put forth as the subject of inquiry? And if you find what you want, how will you ever know that this is the thing which you did not know?<sup>4</sup>

<sup>4</sup>Plato, Meno, trans. Benjamin Jowett, (Indianapolis: Library of Liberal Arts, Bobbs-Merrill, 1949), p. 36. In picking up on the Meno, Polanyi carried forth the age old debate on the relationship of knowledge and virtue, which is the subject of the dialogue.

Polanyi's realization seems so obvious that one wonders how it could have been overlooked for so long: Every interpretation of nature, whether scientific, non-scientific or anti-scientific, is based on some intuitive conception of the general nature of things. Every scientific discovery or investigation proceeds by some unspecifiable hunch or intuition about the nature of things and the possible outcome of the experiments.<sup>5</sup>

An important juxtaposition immediately emerges from the very irony of Socrates himself and was not to be resolved in the ensuing two and a half millenia. Socrates poses the paradox of the Meno, as so many of his arguments, in the syllogistic forms of formal logic. Socrates, the master logician, employed the forms everyone respected and demonstrated the fallacies of his opponents' logic. Yet the questions he raised have a cogency not expressible in the atemporality of logic and have endured for centuries. As with the Meno, no logical solutions could be offered for Socrates seemingly innocent inquiries. Hence the irony; and hence the juxtaposition Polanyi offers of the logical and the psychological.<sup>6</sup>

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<sup>5</sup>Michael Polanyi, Science, Faith and Society (Chicago: Phoenix, 1949), p. 10.

<sup>6</sup>Polanyi, "Logic and Psychology," American Psychologist XII (1968):27-43. Also Personal Knowledge, pp. 332-335. See also my article, "R.D. Laing in Post-Critical Perspective," British Journal of Psychiatry 124 (March 1974):252-259.

The logical refers to the attempt at solving problems by strict inference. The psychological refers to the reliance on tacit or unspecifiable factors.

In working out the structure of tacit knowing, Polanyi relies on two important distinctions: (1) the distinction between tacit and explicit knowing, and (2) the distinction between focal and subsidiary awareness. These two kinds of awareness are mutually exclusive, but related. In driving a nail and hammer, we are focally aware of the nail receding into the wood, but subsidiarily aware of our hand gripping the hammer. We attend from the subsidiaries of our muscular functions to the focal task at hand to accomplish our feat. If we should suddenly shift our focal awareness to that which had hitherto been subsidiary, the relationship of hand to hammer, the previous meaning of the task would be lost and we would become self-conscious and awkward.

It is at this point that Polanyi draws heavily on the findings of Gestalt psychology. The familiar optical illusions of the Gestaltists provide a basis for perceiving and knowing quite generally: In one, two opposing silhouettes become a goblet by a slight change in perspective (See Figure 6). In another, a cube is viewed alternately from above and outside or from below and inside, but not simultaneously from both perspectives (Figure 7). Two lines of equal length appear to

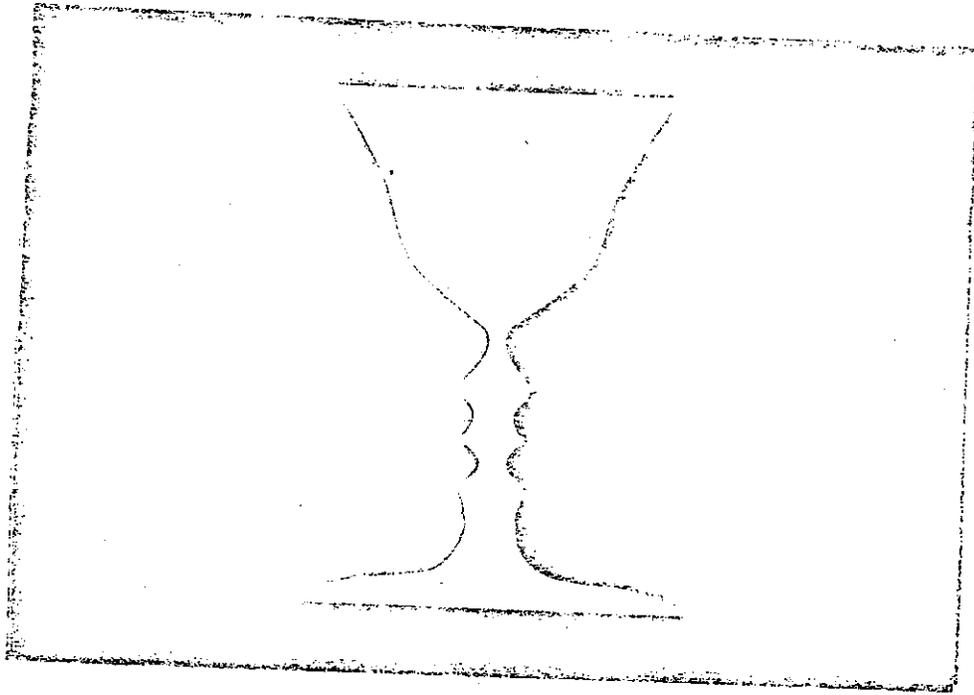


Figure 6

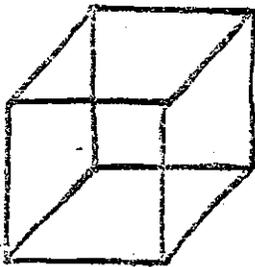


Figure 7



Figure 8

be different lengths when arrows pointing in opposite directions are drawn on these lines (Figure 8). In each of these instances there is a mutually exclusive but related awareness of (1) the figure and (2) its ground. The perception may be changed by focally attending to the figure as ground and vice versa.

All acts of knowing involve an active perception of what is known by a sentient knower in a particular context of knowing. The figure/ground device calls our attention to the ground or context in which something is perceived. Critical-analytical thought isolates the figure, understanding it out of any ordinary context. Opposed to this analytical consciousness is the post-critical alternative, which does not isolate the figures under consideration, but rather surrenders to a pre-reflective, lived-through experience and utilized subsidiary awareness as a ground for understanding. Our various cultural activities, including science, religion, art and morality, are the contexts for our understanding. Thus Polanyi's use of tacit knowing is conceptually related to Heidegger's being-in-the-world, Merleau-Ponty's pre-reflective consciousness, and Tillich's ground of being. Science is not an enterprise opposed to our culture, nor is it a culture unto itself. Furthermore it is dangerous to conceive of science in such terms, Polanyi believes, because of the damage that is done to other cultural institutions, particularly morality.

In order to fully appreciate the implications of Polanyi's perspective, it is necessary to consider the concept of "reality." We are cautioned against accepting reality too

glibly as "that which is" without considering the ingredients that constitute the acceptance of 'that which is believed to be.'" If one views science as the only vehicle for apprehending reality, one has a very different notion of culture than if one fully appreciates the bearing on reality offered by such human endeavors as art, religion, and morality as well as science, which are realities in their own right because of a very real power they have to carry us away. They invite our participation and change the way we live and view the world in which we live, no less than does science, which commands the curious attention of the scientist. In fact it may be said that many of our cultural institutions have a greater power over us and for us than does science because of the special talent and preparation which are required to appreciate scientific achievement.

Though the modern mind tends to identify the "real" with the tangible, when we refer to the "real" we generally understand the comprehensive organization of the whole entity and not just an enumeration of its tangible parts. For example, a grandfather clock cannot be explained according to the laws of physics and chemistry, but we must rely on our understanding of what a clock is and the meanings it conveys. Polanyi holds that minds, which are intangible, are, if anything, more real than stones, which are tangible. Minds are richer in unexpected

possibilities for future self-manifestation than are stones.<sup>7</sup> Furthermore life cannot be understood in physical-chemical terms for the same reason. Though physiological processes of organisms may be so understood, the purposes of living organisms and our understanding of them cannot be reduced to physics and chemistry.<sup>8</sup>

Polanyi's description of the two kinds of awareness, focal and subsidiary, parallels the consideration of the figure/ground relationship of Gestalt psychology. What is novel in Polanyi is the recognition of the from-to structure of tacit knowing. Consider the blind man's probe or a lover's exploring caress. These extensions of a person's sensory experience involve a proximal and a distal component, the proximal of which is rooted in one's own body. In any form of knowing or perceiving, one apprehends the world by relying on subsidiary clues within one's own body. The human mind integrates the clues it receives through the senses of the body. Unlike Descartes' split of mind and body, Polanyi's approach integrates the two with mental processes grounded in the body.

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<sup>7</sup>Polanyi, Knowing and Being, pp. 119-120; Personal Knowledge, pp. 117, 303, 324; The Tacit Dimension, pp. 31-32. See also "On the Modern Mind," Encounter XXIV (May 1965), and Harry Prosch, "Polanyi's Ethics," Ethics 82 (1972):95.

<sup>8</sup>Polanyi, "Life Transcending Physics and Chemistry," Chemical and Engineering News XIV (August 21, 1967), pp. 55-66. Polanyi's reminder is a stark contradiction to the dogma of much of biological science, which takes as an accomplishment the progress made in furthering physical-chemical understanding and the reduction to lower (smaller) levels of understanding living progress, if not life.

## III.

Polanyi quite candidly declares his personal motives for writing Personal Knowledge, and the text is laced with an uncommon number of first person pronouns. In the preface to Personal Knowledge, he tells us,

The enquiry of which this volume forms part started in 1939 with a review article on J. D. Bernal's The Social Functions of Science. I opposed this view, derived from Soviet Marxism, that the pursuit of science should be directed by the public authorities to serve the welfare of society. I held that the power of thought to seek the truth must be accepted as our guide, rather than be curbed to the service of material interests.<sup>9</sup>

Polanyi recognized that,

A defense of intellectual freedom on such metaphysical grounds was no more acceptable to the dominant school of Western philosophy than to the Marxists.<sup>10</sup>

Part of the difficulty he faced was untangling rival ideals and ideologies, for a justification of intellectual freedom

<sup>9</sup> Polanyi, Personal Knowledge, p. ix.

<sup>10</sup> Ibid. Consider as an example Hume's famous attack on Metaphysics, which might be taken as a credo of logical positivism: "When we run over libraries, persuaded of these principles, what havoc must we make? If we take in our hand any volume; of divinity or school metaphysics, for instance; let us ask, Does it contain any abstract reasoning concerning quantity or number? No. Does it contain any experimental reasoning concerning matter of fact and existence? No. Commit it then to the flames: for it can contain nothing but sophistry and illusion." This statement from David Hume's Enquiry Concerning Human Understanding is quoted in the Editors Introduction to Logical Positivism, A. J. Ayer, editor, p. 10.

did not mean opposing the public welfare, but rather seeking the best means of serving those ends. Four decades later the distinction between pure and applied science is all but lost, and we in the United States have come to accept vast research enterprises directed by centralized government agencies. Even more so today, the moral concerns Polanyi raised are inextricably twined with the epistemological and political.<sup>11</sup>

Polanyi seeks to accredit what Descartes sought to deny. Where Descartes saw the personal dimension of knowing as subject to error against which his method of doubt was to provide protection, Polanyi sees in such systematic doubting the seeds of a nihilistic alienation. Descartes intended to purge his mind of all opinions based solely on trust and to require a

<sup>11</sup>The personal or biographical concerns reflected in Personal Knowledge and Polanyi's other writings could no doubt be amplified beyond what Polanyi himself discloses at various points. Polanyi was born in 1891 in Budapest, then a part of the Hapsburg Empire and all that stood for culturally; he grew up in a home regularly filled with artists and intellectuals. When I visited him in Oxford in 1969, he spoke with some melancholy about the "dissolution of European culture," referring primarily to the havoc wreaked on the values of peoples by two world wars. To an American viewing the museum of European heritage, it was sobering to think that the continued presence of medieval architecture and art did not in itself constitute a continuous culture. For Polanyi the culture he knew as a young man, and most particularly the Hungary which he knew as a child, no longer existed. One of his most incisive articles, "The Message of the Hungarian Revolution," [Christianity and Crisis (October 31, 1966), pp. 240-243, also in The American Scholar XXXVI (Autumn 1966): 661-676.] cogently documents Polanyi's challenge to Marxists values. Even more poignant is his bewilderment at his own siblings who became Marxists and even members of the Communist party. His philosophical enterprise must in part have been an attempt to communicate with lost family.

knowledge firmly based on abstract reason. Polanyi attempts to demonstrate that all knowledge is based on personally held beliefs, and that attempts to deny these beliefs are acts of self-deception. "Objectivism," according to Polanyi,

requires a specifiably functioning mindless knower. To accept the indeterminacy of knowledge requires on the contrary, that we accredit a person entitled to shape his knowing according to his own judgment, unspecifiably. This notion -- applied to man -- implies in its turn a sociology in which the growth of thought is acknowledged as an independent force. And such a sociology is a declaration of loyalty to a society in which truth is respected and human thought is cultivated for its own sake.<sup>12</sup>

Doubt in such a society occupies a position at a fundamental psychological level quite akin to belief. The Cartesian method of doubt is a logical corollary of objectivism, but it must rely on faith that the uprooting of all voluntary components of belief will leave behind a residue of knowledge that is completely determined by the objective evidence. Critical thought has trusted this method unconditionally for avoiding error and establishing truth.

But what is such doubt upon which we have come to feel we can base such knowledge? Is it not but a temporary hesitancy in belief, stripped of any personal affirmations of such belief? A marksman taking aim may be said to be in doubt until he pulls the trigger. A poet reworking a line again and again to get it just right may be filled with numerous doubts of a most existential nature until he believes he has it right and puts forth his words with confidence. Kant in his Critique of Pure Reason

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<sup>12</sup>Ibid., p. 264.

spoke of the almost superhuman effort involved to avoid the relaxation of doubt:

The root of these disturbances, which lies deep in the nature of human reason, must be removed. But how can we do so, unless we give it freedom, nay, nourishment, to send out shoots so that it may discover itself to our eyes, and that it may then be entirely destroyed? We must, therefore, bethink ourselves of objections which have never yet occurred to any opponent, and indeed lend him our weapons, and grant him the most favorable position which he could possibly desire. We have nothing to fear, but much to hope for; namely, that we may gain for ourselves a position which can never again be contested.<sup>13</sup>

The psychological struggle involved in doubting is clear, but what is not clear is just what it means to doubt, or more properly to claim to doubt. Polanyi calls our attention to the fact that any doubt is a doubt of an explicit statement, and that such doubting merely implies an attempt to deny the belief expressed in the statement in favor of other beliefs which are not at that moment being doubted. When one claims to be doubting something, there are basically two things that can be meant by such an assertion. Suppose somebody says, "I believe  $p$  where  $p$  stands for "planets move along elliptic orbits," or for "all men are mortal." And someone else replies, "I doubt  $p$ ." This may be taken to mean that the doubter contradicts  $p$ , which could alternatively be expressed by "He believes not- $p$ ." Alternatively, he may be merely objecting to

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<sup>13</sup> Immanuel Kant, Critique of Pure Reason, quoted in Personal Knowledge, p. 270.

the assertion of  $p$  as true, by denying that there are sufficient grounds to choose between  $p$  or not- $p$ . This may be expressed by saying "He believes  $p$  is not proven." Polanyi calls the first type of doubt "contradictory" and the second "agnostic."<sup>14</sup> What is significant is that both are expressions of alternative beliefs. Thus Polanyi suggests that all declarative sentences be prefaced with "I believe that. . . ." to remind ourselves of the beliefs we hold in making statements of fact.

It is also of significance that such doubt is expressed as an articulate form. When we speak of critical thought, we are speaking of the criticisms of articulate forms:

All kinds of articulate affirmations can be made more or less critically--and indeed quite uncritically. Where there is criticism, what is being criticized is, every time, the assertion of an articulate form. It is our personal acceptance of an articulate form that is judged to have been critical or uncritical. . . . It is the mind granting acceptance which is said to be acting critically.<sup>15</sup>

It is on this realization that the post-critical project hinges. Tacit knowing cannot be judged by critical standards because it rests on unspecifiable and unarticulate grounds. Tacit knowing may not be said to be critical or uncritical,

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<sup>14</sup>Ibid., p. 272.

<sup>15</sup>Ibid., p. 264.

but rather acritical. This does not mean that tacit knowing is subjective and not subject to judgment, but rather that other standards must be employed, namely the knower's universal intent and ever present awareness of the standards of the community of knowers, what Polanyi calls the "convivial order."

The convivial order is the third pole in knowing. The acquisition of knowledge is not, as the positivists such as Carnap would hold, a solipsistic undertaking, or a dyadic undertaking, the knower apprehending the known according to strict principles which could be carried out in isolation.<sup>16</sup> Rather the establishment of an hypothesis as "fact" requires the affirmation of a community of knowers--reality processing at a triadic level.

When Polanyi described his enterprise as "scandelmongering," he meant the attempt to show that the abstract accounts of the history of science did not in fact explain the process of scientific discovery in that they gave no account or only false accounts of the mental life of the scientists involved in various discoveries and their interaction with the scientific community. Personal Knowledge is full of such scandals, illuminating the workings of the scientific

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<sup>16</sup>Ayer, Ibid.

community. The theory of relativity, for example, was not put forth as is usually held, to explain the negative result of the Michelson-Morley experiment, which attempted to measure the speed of light by using revolving mirrors, but rather was advanced from other considerations, as confirmed by an interview with Einstein.<sup>17</sup> Another example from Polanyi's own experience also involved Einstein: In the years just before World War I, Polanyi developed a theory of adsorption, which was opposed by Einstein and Fritz Haber on the basis of evidence then available. Because of the influence of the senior scientists, Polanyi (and his theory) were discredited, though he was many years later proven right when in the 1930's new evidence became available. Today Polanyi's theory of adsorption is widely accepted. What is striking about Polanyi's use of this story is not that he uses it to show that he was ultimately vindicated, which he was, rather he uses it to explain the inevitable and proper conservatism of the scientific community and to demonstrate its rule by orthodoxy and the limits of dissent.<sup>18</sup> This is not a case of sour grapes,

<sup>17</sup> Polanyi, *Ibid.*, pp. 10-11.

<sup>18</sup> Richard Gelwick, *The Way of Discovery; An Introduction to the Thought of Michael Polanyi* (New York: Oxford University Press, 1977), p. 33-33; Michael Polanyi, "The Potential Theory of Adsorption," *Knowing and Being*, ed., Marjorie Grene (Chicago: University of Chicago Press, 1976), pp. 87-96.

but a humble disclosure of the risks involved in the pursuit of discovery. A fact is not a fact until it is accepted as fact. No matter how "objective" is the sound of a tree falling in a wood with no one to hear it, even if we acknowledge the vibration of air molecules, it cannot be accredited in a vacuum devoid of human confirmation.

Thus we hear from Polanyi, the scientist-humanist, some rather bold, yet humble, declarations of intent, which he calls "the fiduciary programme":

I believe that in spite of hazards involved, I am called upon to search for the truth and state my findings.<sup>19</sup>

[The fiduciary program] is a systematic course in teaching myself to hold my own beliefs.<sup>20</sup>

[What] I am seeking to establish here, is to restore to us once more the power for the deliberate holding of unproven beliefs, which could be tacitly taken for granted in the days before modern philosophical criticism reached its present incisiveness. Such powers may appear dangerous. But a dogmatic orthodoxy can be kept in check both internally and externally, while a creed inverted into a silence is both blind and deceptive.<sup>21</sup>

The principal purpose of this book is to achieve a frame of mind in which I may hold firmly to what I believe to be true, even though I know that it might be conceivably false.<sup>22</sup>

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<sup>19</sup>Polanyi, Personal Knowledge, pp. 299, 315.

<sup>20</sup>Ibid., p. 299.

<sup>21</sup>Ibid., p. 268.

<sup>22</sup>Ibid., p. 214.

Personal knowledge is an intellectual commitment, and as such inherently hazardous. Only affirmations that could be false can be said to convey objective knowledge of this kind. All affirmations published in this book are my own personal commitments; they claim this, and no more than this, for themselves.

Throughout this book I have tried to make this situation apparent. I have shown that into every act of knowing there enters a passionate contribution of the person knowing what is being known and that this coefficient is no mere imperfection but a vital component of his knowledge. And around this central fact I have tried to construct a system of correlative beliefs which I can sincerely hold, and to which I can see no acceptable alternatives. But ultimately, it is my own allegiance that upholds these convictions, and it is on such warrant alone that they can lay claim to the reader's attention.<sup>23</sup>

Polanyi returns to pre-critical St. Augustine as the first example of a philosopher operating in the "post-critical" mode. Augustine examined his own life in search of faith and understanding. He taught that all knowledge was a gift of grace, for which we must strive under the guidance of antecedent belief: nisi credideritis, non intelligitis ("Unless ye believe, ye shall not understand").<sup>24</sup> In the Augustinian view, faith is

<sup>23</sup> Ibid.

<sup>24</sup> Ibid., p. 266. David Burrell and Stanley Hauerwas also use Augustine's story as an example of how narrative can shape ethics. Augustine's autobiography is the spiritual odyssey of a man who spent years examining the notions or "stories" of Manicheism and Platonism. He could find no satisfying answers to his twin desires for understanding evil and God until, in one moment of searing truth in the Garden, "the darkness of doubt was dispersed." The search of the years suddenly came to an end in Augustine's acceptance of the Gospel story, and thereafter, that story shaped every moment of his life. [David Burrell and Stanley Hauerwas, "From System to Story: An Alternative Pattern for Rationality in Ethics," Knowledge, Value, and Belief, eds. H. Tristram Engelhardt, Jr., and Daniel Callahan, (Hastings, NY: The Hastings Center, 1977), pp. 111-152.]

an essential ingredient of knowledge, and he is referring, of course to the Christian faith. By the seventeenth century faith had declined and was seen to have no role in demonstrable knowledge. Polanyi cited Locke in distinguishing between knowledge and faith:

How well-grounded and greatsoever the assurance of faith may be wherewith it is received; but faith is still and not knowledge; persuasion and not certainty.<sup>25</sup>

Faith has been reduced in status from a power that reveals to us knowledge lying beyond the range of observation and reason to a mere personal acceptance which falls short of empirical and rational demonstrability. The mutual position of the two Augustinian levels, faith and knowledge, is inverted. Polanyi notes that

Here lies the break by which the critical mind repudiated one of its two cognitive faculties and tried completely to rely on the remainder. Belief was so thoroughly discredited that, apart from specially privileged opportunities, such as may be still granted to the holding and profession of religious beliefs, modern man lost his capacity to accept any explicit statement as his own belief. All belief was reduced to the status of subjectivity; to that of an imperfection by which knowledge fell short of universality.<sup>26</sup>

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<sup>25</sup>Locke, A Third Letter on Toleration, quoted in Personal Knowledge, p. 266.

<sup>26</sup>Ibid.

Polanyi recognizes the precariousness of our knowledge. Our basic beliefs are not indubitable in any empirical sense; they are only indubitable in the sense that we believe them to be so.

Science exists only to the extent to which there lives a passion for its beauty, a beauty believed to be universal and eternal. Yet we know also that our own sense of this beauty is uncertain, its full appreciation being limited to a handful of adepts, and its transmission to posterity insecure.<sup>27</sup>

Our liberation from objectivism occurs when we realize that we can voice our ultimate convictions only from within our convictions. If any ultimate logical level is to be attained and made explicit, it must be a declaration of our personal beliefs.

This is what Augustine undertook to do, and what Polanyi undertook in Personal Knowledge. They each then demonstrate that you cannot expose an error by interpreting it from the premises which lead to it, but only from premises which are believed to be true. Augustine's maxim nisi credideritis non intelligitis expresses the logical requirement of understanding that

the process of examining any topic is both an exploration of the topic, and an exegesis of our fundamental beliefs in the light of which we approach it; a dialectical combination of exploration and exegesis.<sup>28</sup>

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<sup>27</sup> Ibid.

<sup>28</sup> Ibid., p. 267.

It then becomes necessary

to recognize belief once more as the source of all knowledge. Tacit assent and intellectual passions, the sharing of an idiom and of a cultural heritage, affiliation to a like-minded community: such as the impulses which shape our vision of the nature of things on which we rely for our mastery of things. No intelligence, however critical or original, can operate outside such a fiduciary framework.<sup>29</sup>

Polanyi goes to great lengths to explain what might be called the "mental life of the scientist." He readily acknowledges that this might be entirely unnecessary if there were nothing at stake but the progress of science, which he believes would proceed unselfconsciously without the sort of reflective analysis he offers. Physical science at least, which seems to be the paradigm of what it means to know in a precise and specifiable way, largely ignores the objectivist assumptions which are said to characterize scientific activity. Thus the disclosures of a physical scientist about what really goes on in physical science may provide a more encompassing model of scientific endeavor for the biological and social sciences, where abstract precision is neither possible nor desirable.

But underlying Polanyi's endeavor is the essentially moral problem he sees in modern society, namely the damage done to our moral ideals by an objectivist epistemology. When knowledge is seen to be held impersonally, and modern man has lost

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<sup>29</sup>Ibid., p. 266.

all ability to accept and acknowledge any explicit statement of his own beliefs, then statements of value are depreciated to the status of mere subjectivity and are held to have no legitimacy at all in a world which demands factual justification. Instead the only strategy which appears to be workable is to translate moral considerations into considerations of fact, which have objective credibility, thus appealing to moral sensibilities only in a covert manner. One might argue in a head-on fashion for the legitimacy of ethics in its own right, or one might argue for specific values however passionately by whatever methods might gain credence for the values one holds to be important. Polanyi's point is not that people do not hold beliefs and values, but that it is very difficult to acknowledge them as one's own. Hence, what are in fact personally held commitments are often disguised as an objective view of reality.

#### IV.

Polanyi's notion of the moral inversion provides a useful conceptual framework for understanding how ethics can go awry in an age whose habits of thought have become abstracted from personal experience, an age both scientifically skeptical and morally perfectionistic. Moral inversion is a phenomenon in which moral passions are repudiated in the face of the demand for strict scientific objectivity. What happens in the repudiation is often a reversal or inversion in which quite immoral

ends are justified scientifically. The inversion occurs when an individual is unable to meet the demands of moral perfection and, seeing perfectionism as hypocritical (literally less than critical), repudiates it in the name of something honest, authentic, or real. The ideal of critical objectivity causes such a person to repudiate exclusively the validity of any moral passions or value judgments whatsoever. However such repudiation on an explicit level does not do away with moral passion, nor does it do away with the force of moral claims. What has been repudiated at an explicit level has a life of its own, undomesticated by reflection, which will assert itself in some disguised form.

Modernity has been inspired simultaneously by a high moral dynamism and a stern critical passion for an objectivist perspective on human affairs. The objectivist view seeks ruthlessly to discredit as merely subjective--and therefore spurious and thus essentially hypocritical--all of those values which have been sought and are embodied in the traditions of society and which must be replaced by a new order based entirely upon a value-free rationality. Since in such scheme there is no longer a natural and legitimate setting for the embodiment and exercise of our moral passions (which do not simply disappear because they have been denied in an objectivist philosophy), they no longer are able to do their work in accrediting and upholding moral judgments and masquerade as the

engine of a morally passionate denial of morality. As Polanyi has said,

Moral passions are thereby cast in the form of a scientific affirmation. . . These supposedly scientific assertions are, of course, accepted only because they satisfy certain moral passions. . . Unfortunately, moral passions undergo a fateful change<sup>30</sup> when decked out as scientific statements.

Legitimate moral motives, stripped of their moral context, become isolated and inaccessible to ethical reflection. When moral passion is thus philosophically dispossessed and disappears from view and hence from all criticism, it is displaced by the moral passion which underlies the demand for objectivity, in which view morality has no undisguised place. This is moral inversion.

In its extreme forms, the inversion of morality may lead to overt violence, war justified on moral grounds, in which category we might place the Russian revolution, or Nietzsche's repudiation of morality and its devastating consequences in Nazi Germany. Though moral inversion is a particularly modern phenomenon, it is possible to witness moral inversion in modernity's ancient Greek antecedents. In contrast with the moral relativism of the early sophists, the later sophists, such as Thucydides and Pericles, pretend they dislike morality; the moral people are sheep, and people who are weak, and the stronger people claim not to care about morality, but that's

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<sup>30</sup> Ibid., pp. 230-321.

their morality, the right of the strong to rule. The powerful conceal their morality under a machinery they pretend is not moral.<sup>31</sup>

In the modern era one finds numerous examples in existentialist literature, in which gratuitous acts affirm the reality of the individual who would otherwise feel dehumanized in an objectivist world. In Crime and Punishment Dostoevsky's Raskolnikov is a prime example. By murdering the old woman for no reason he can order his otherwise senseless existence around an act he unquestionably chose for himself. André Gide's Lafcadio similarly vindicates himself in a minor altercation by pushing his antagonist to death from a moving train. In American cinema the moral inversion is so prevalent as to be commonplace. The cinema extols its anti-heroes; the good guys are the bad guys, who are admired for their audacious defiance of hypocritical social convention. Butch Cassidy and the Sundance Kid rob banks for the sheer fun of it. Bonnie and Clyde perform the same crimes to overcome impotence. In A Clockwork Orange an honestly self-serving psychopath is attractive when compared to the behavior modifiers, whose aversive conditioning techniques are morally justified but not humane.

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<sup>31</sup>I am indebted to Marjorie Grene for these Greek examples of moral inversion as well as for incisive criticism, which has shaped my discussion of moral inversion.

Polanyi's key example of the moral inversion is what he calls the "dynamo-objective coupling" of Soviet Marxism, which he uses to illustrate the proximity of morality with politics and the close reciprocal workings of moral passions with an objective view of reality. In the dynamo-objective coupling, alleged scientific assertions, which are accepted as fact because they satisfy moral passions, will excite these passions still further, and thus lend increased convincing power to the scientific affirmations in question. Moreover, such a dynamo-objective coupling is also potent in its own defense. Any criticism of its scientific part is rebutted by the moral passions behind it, while any moral objections are coldly brushed aside by invoking the inexorable verdict of its scientific finding.

In the Marxist example, one sees a coupling between the utopian ideals, liberty, justice, and brotherhood, and their translation into an objectivistic view of the social order, namely dialectic materialism. By covering moral passions with a scientific disguise, moral sentiments are protected against depreciation as mere emotionalisms. They acquire instead a sense of scientific certainty. On the other hand, material ends are impregnated with the fervor of moral passions.

#### V.

The workings of the dynamo-objective coupling alert us

to the possibility of subtle moral inversions at work in contemporary ethical debate. One of the problems contemporary ethics faces is choosing among rival ethical positions or principles, often argued as rights, when these positions are put forth not as personally held commitments, but as impersonal social realities. This attempt at objectification has the effect of depreciating the moral considerations and denying that they have a validity of their own. Instead one often finds a rather quick translation into legal considerations, which in the United States often get translated into Constitutional issues. While the courts may be the appropriate arena for the resolution of social conflicts, the attempt at objectification is pre-emptive and limiting if ethical reflection is short-circuited.

Consider the following example, which is illustrative because the controversy is quite genuine.

A 23-year-old mother was transferred from the obstetrics service to the psychiatry ward because of disturbing fantasies that she might harm her baby by stuffing rags into its mouth. Three days later she was released against medical advice when she insisted she had to take care of her baby. Two days after that she returned to the Emergency Room saying that she could not tolerate her baby and was afraid that she might hurt it. She refused admission but was committed.

A team of civil liberties lawyers opposed the commitment and opposed efforts of the Social Services agency to take legal custody of the baby. They argued that she had a "right" to care for her baby, and that attempts to separate her from the baby would only make her worse. After several months involving several court appearances, she was arrested for creating a public disturbance. In jail she hanged herself, not deprived of her civil

rights, but deprived of the psychiatric help she so desperately needed.

Here we see a very real conflict between opposing moral principles. The physicians (including the psychiatrists, the pediatricians, and the obstetricians) argue for the need for psychiatric treatment. The patient sometimes wants this and sometimes doesn't; her will is ambivalent. The lawyers argue that, since the patient sometimes says she does not want to be in the hospital, holding her would be a violation of her civil rights. The principle of the physicians, which could be identified as the principle of beneficence, is suspect by virtue of its liability to paternalism: on what grounds do the physicians argue that the patient would be better off if treated? The principle of the lawyers, which could be identified as the principle of respect for the autonomy of the person, is beyond question in principle, but its abstract application without consideration for the ambiguous needs of the person involved becomes cruel and insensitive, even as this case so tragically illustrates, sacrificing the person for the principle.

A fairly typical ethical analysis of the situation might attempt to juxtapose the two ethical principles in order to or in hopes of subjecting them to a critical analysis and arriving at a correct position. The tragic outcome of the case notwithstanding, the task is difficult to accomplish. A teleologist or consequentialist might point to the outcome

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an an important consideration, but the outcome was not available data at the time the commitment option was being considered. Even though the outcome might have been predicted, it could not have been predicted with any objective certainty. A deontologist would want to hold to the ethical principles involved independent of the consequences.

The ethical analysis is in fact a retrospective reflection on a situation, which at the time of the debates was rather tumultuous. Though the analysis might be carried out in a somewhat cool, dispassionate manner, affects ran high among the various actors in the drama, each pressing for his or her own values and commitments, which they believed to be right. In a thoroughgoing analysis of the situation, these various personal beliefs and passions are not irrelevant, indeed one wishes to know something of the motives of the actors involved, the physicians, the lawyers, the social workers advocating the interests of the child, and no less the most confusing and contradictory aims of the patient herself.

The goal of the critical approach is conceptual clarity, and for this the adversarial legal system is well-suited. If an ambiguous situation can be translated into an either/or alternative, the two sides can be debated and an answer may be achieved. The decision (not to commit the patient) is made on the grounds of the facts of the case, and the values and value conflicts, though very much involved

in personal ways, are not the subject of the debate. The critical adversarial system is preemptive of a fiduciary search for the truth. The opportunity for a cooperative alliance, searching for the best solution for this particular person, is lost. The principle of autonomy is served, the principle of beneficence is subserved. The convivial order, which would be required in a post-critical framework, is ruptured. Damage is done. Though there are conflicting ethical principles, the dynamo-objective coupling is at work, and we must suspect that morality is inverted.

Polanyi writes about the dynamo-objective coupling and moral inversion in situations where they occur together. In our pluralistic culture there are numerous situations, such as the above example, where a genuine conflict of values exist. Since there is no commonly accepted morality, it is often impossible to claim that morality is being inverted. What we can do is recognize the existence of the dynamo-objective coupling, and in those situations where it is operating, where the distinction between values and facts is not made clear, we may be alert to the possibility that morality is being inverted.

Such questions do not arise in a time of social stability and shared community values. To make a compelling diagnosis of moral inversion in a particular situation, further analysis of the traditions of the community or society are in order as well as the notion of "freedom" as was Polanyi's concern in his

discussions of the free society and the freedom of the scientific community (freedom to search for the truth and state one's findings). The damage Polanyi saw from a scientific or objectivistic outlook was a damage to our moral ideals. Moral ideals in face of scientific skepticism can be held with no demonstrable validity. They lose their capacity to function as inspirational of high standards of personal conduct because no human being can live up to such high standards. Yet in the face of moral perfectionism, ideals are translated into imperatives, unyielding in their demand for correctness. In such a situation, a conflict between moral principles yields to the principle which can be precisely adhered to. Precision and clarity have themselves become dominant values.

What is at stake for a theory of ethics is not so much the outcome of a particular controversy as the process by which the controversy might be resolved. For the ancient Greeks politics was a branch of ethics. In contemporary life much the reverse is true with ethical matters being subsumed into political resolution. In the extreme forms of moral inversion, such as the "magic of Marxism" which Polanyi discusses, what is clearly at issue is the frank and even violent oppression of one moral position with another which denies any moral intent. Morality thus disguised is hence not subject to moral suasion, criticism or renewal. It is in fact enforced by power, as Nietzsche recognized and is in fact the case in the Soviet Union and other totalitarian regimes. One might say this is a strategically

appropriate way to accomplish political ends, believed to be desirable, "right," and "good." A problem with the moral inversion in political terms is that the power of morality as a stabilizing and renewing force is eliminated.

The moral dilemmas faced by the Catholic clergy in response to liberation theology are illustrative of the importance of keeping a sharp distinction between ethics and politics. Realizing the desperate plight of its members in many Third World countries, particularly in Latin America and Africa, many clergy advocate the overthrow of repressive governments on the basis of a social analysis upon explicitly Marxist grounds. This advocacy takes a variety of forms including theological and political analysis, preaching, political organization, and outright monetary grants, such as those the World Council of Churches to guerrilla forces in Zimbabwe-Rhodesia. A complex nest of questions emerges starting with the awareness of the plight of the poor in these countries (an awareness which we might call "consciousness raising" in a liberation perspective, "focal awareness" in post-critical terms, or "conscientization" as the neologism would have it). Given this social awareness, one must then ask what the role of the Church should be. If one believes the Marxist social analysis to be correct, it could be argued, then one should work for the redistribution of capital. For a member of the clergy this decision would necessarily involve utilitarian considerations and questions

about ends justifying means. Would it be justifiable to support the violent overthrow of the government, for example?

This moral dilemma, like so many moral dilemmas, is confounded by the fact/value confusion, which makes it liable to dynamo-objective coupling. What facts would be necessary to establish the correctness of the Marxist interpretation, that is, to make the Marxist analysis compelling enough to justify a particular course of action such as working towards a revolution? As evidence one might cite the presence of wealthy landlords in comfortable haciendas. Does one then require economic data to demonstrate that redistribution of this capital will significantly alter the social conditions of the poor? Or conversely would a devout Marxist organizer be much deterred by economic data which suggested that a redistribution of the limited resources of some impoverished country, beset by urban migration, overpopulation and any number of problems, would do little to improve the material circumstances of the poor?

The moral questions remain, and are unquestionably a legitimate concern of the Church. What force or suasion does morality have? Can a priest from the pulpit or soapbox force the landlord to feel sufficiently guilty to treat his peasants better or perhaps to bring about land reform or to influence the outcome of an election? If not, what sort of ancillary forces would it be legitimate for the clergy to bring to bear

in bringing about morally desirable reform: political organization, overt violence or the instigation of violent revolution.

In reviewing these possibilities I am in no way trying to depreciate the spectrum of alternatives nor to justify a capitalist system per se. Rather I am attempting to consider the unique position of moral concern in contemporary intellectual life. The liability faced by the Church in allying political force with its moral position is that of undermining whatever influence morality might realistically have.<sup>32</sup> Once the new order is inaugurated by force, will it be subject to moral influence and renewal or will it in fact require even more repression in order to maintain its influence? It would seem that the Church would be on much more solid ground by relying on the power of its moral teachings to bring about its ends, rather than in giving up on morality and allying with supposedly non-moral forces.

## VI.

Thus when we are asked to believe that morality is a reality, we can take this step with Polanyi without too much difficulty, for moral realities are familiar to us, though the

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<sup>32</sup>One particularly cynical interpretation holds that the Church recognizes that the social order is crumbling and wishes to preserve its domination of the masses by identifying with the new political force. Such a view, while undermining altruistic credibility, does little to identify the moral dynamics at issue.

vocabulary for discussing them has become somewhat atrophied in the modern era. What is required of us is a conceptual reorientation. In fact many of the conclusions of the physical sciences require a much more passive dependent trust on experts in order to believe what we are told should be undoubtable facts. How many of us have personal grounds for believing the atom theory, for example? The table which we experience to be so solid is really composed of vast, empty spaces with minute atoms in constant motion, or so we are asked to believe. This would be an utterly preposterous conclusion, but for the faith we place in those whom we suppose to understand such things and convince us of this most unlikely reality. Yet concerning moral realities, who among us has not experienced shame or guilt and modified our customary ways of behaving in order to live more comfortably and harmoniously with others in the social order?

It is because these affects are so real that morality is so problematic for the modern mind, i.e. for the modern person. Nowhere in human affairs are we more exposed (to potential criticism), more open and more vulnerable than when we choose to articulate something we believe to be important, our values, our beliefs, our commitments. And even if we refrain from making such disclosures articulate, we are still known by what we do. Morality has thus become for moderns a more or less covert enterprise: people may try to be moral and strive to be moral, but most likely this occurs in very private ways. Any-

one who professes to be moral and declares that his maxims are those on which everyone should act appears to be very much out of line, hypocritical, moralistic, and of dubious morality.

As knowing has come to be separated from believing, modern man has lost the capacity to accept any explicit statement of his own belief as well as any inclination to acknowledge moral beliefs. Yet unacknowledged moral passions cannot be repudiated. Descartes offered us a system which has appeared to obviate our precarious position in the social order by allowing us to attend focally to the external world. He elevated doubt, which is the inability to trust, paranoid suspiciousness in its extreme pathological form, to an organizing principle of reality and proclaimed it as a virtue. His optimism for his method and for science caught the spirit of the times, for it holds that man has the power to control nature if he but employs the methods of science in order to understand nature. So successful has this promise been for three centuries that we have only recently realized that it has been a false promise, a wish, a deception, and only recently have we realized that there have always been limits on man's ability to control nature, the environment, life itself, and other men. This I believe is a particular problem for modern medicine, a prodigious product of the Enlightenment at long last, and now just as we have become so accustomed to its accomplishments, we must come to realize its limitations, its cost, and its inability to solve all human problems, ensure happiness, and conquer death.

Throughout the Enlightenment there has been a certain uneasiness about the role of science in human affairs. The ideal for certain knowledge, which would be reassuring if possible, has always been an abstraction from human experience. The ambiguities of human existence, meaning and value were inevitably left behind as reality came to be viewed as only material fact, and only those facts which could be systematically doubted and consensually validated. Man in this understanding, once the holder of a unique dignity in the universe, became an object, a three dimensional thing (res extensa). Poteat has shown the consequences of this view of man:

[It] caused a feeling of ambivalence; in it there was something supremely satisfying, something flattering to human vanity and the desire to become as gods, not only knowing good and evil but having the power over the very earth itself. Yet this self-flattery had to be purchased at the awful price of something terrifying to human vanity, at the price, namely, of losing any assurance that human life has any unique status in a world the last reality of which is the 'hurrying of matter endlessly, meaninglessly'. For this reason, modern thought has been vacillating between pride and despair--the pride bred of man's power to control nature, the despair bred of his fear that it is really nature that has the last word.<sup>33</sup>

Psychoanalyst Heinz Kohut speaks of the transformations of narcissism: wisdom, tolerance, compassion, recognition of

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<sup>33</sup> William H. Poteat, Pascal's Conception of Man and Modern Sensibility (Ph.D. dissertation, Durham: Duke University, 1950), p. 121.

limitations and acceptance of the finiteness of life.<sup>34</sup> These might be called the hallmarks of maturity, though not reached by all adults, and in fact they are issues with which each person must deal throughout life at times of setback, disappointment, and particularly as one confronts one's own mortality (often in a medical setting). It is useful to keep an awareness of narcissism in mind when dealing with ethics because the perfectionism to which we aspire could be born out of our grandiose infantile wishes instead of our most candid appraisals of reality. To say that ours is a culture of narcissism is unflattering, but to ignore the narcissistic elements with which we must all struggle is to deprive ourselves of the possibilities of the transformation of narcissism and a more harmonious and vital civic and personal culture.

Descartes and the narcissistic threads of our culture have led us to believe that if we're deprived of our mothers or something on which we can depend (nature predictable through scientific mastery), then we may deny that we needed any of that sort of thing, our past, our history, our culture; we don't need to believe in anybody or to trust anyone, because we are self-sufficient, autonomous, and have extraordinary powers in our ability to control the world through

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<sup>34</sup>Heinz Kohut, The Analysis of the Self (New York: International Universities Press, 1971).

knowledge. In short we may defend against our narcissistic vulnerability by substituting a dependency on a predictable and dependable physical universe for the unpredictable and ultimately undependable reliance on other human beings. Stated so starkly, but not unfairly, I hope, this is an obviously unsatisfactory justification and basis for knowledge of our relationship to the world in which we live. It starts with reality as we might wish it to be rather than reality as we find it. Polanyi reverses all of this. For Descartes' systematic denial of dependency, Polanyi substitutes a system of dependencies, the fiduciary programme. This may explain why Polanyi's work is met with such feelings of ambivalence. What he says is so obviously true--trivial some have claimed--but it is a truth that may be difficult to acknowledge, if one were to wish things to be different.

The most devastating aspect of the Cartesian legacy for modern medicine is the depreciation of the person to the status of a thing in order to be understood scientifically. Medical practice can be approximated by medical scientists, but this move falsifies the ideal of the physician in caring for the patient as a fellow human being. Polanyi enriches our understanding of human beings and human cultural life and by properly locating science as a human

(and humanistic) activity, accrediting the judgments which must be made, and thus restoring the possibility of medicine as a personal undertaking. Whereas science, objectivistically understood, fails significantly to acknowledge the triadic relationship between the knower, and the known, and the cultural situation, Polanyi insists that such knowing must be a fiduciary activity:

We therefore recognize and study the coherence of living things by integrating their motions-- and any other normal changes occurring in their parts--into our comprehension of their functions. We integrate mentally what living things integrate practically.

Chess players rehearse a master's game to discover what he had in mind. Generally we share the purpose of a mind by indwelling its actions. This is my answer to the great question: How do we know another mind?<sup>35</sup>

Similarly we know another person by indwelling his actions, by living with him and sharing his experience. Beyond the experience shared in physical proximity, we have access to another's experience only through his communications, articulate and bodily (or tacit). We all know more than we can tell of our own experience, but none of us dares tell more than trust of another person warrants. The knowledge of another person comes through mutually trusting self-disclosure. Without such trust it is impossible to speak

<sup>35</sup> Polanyi, "Logic and Psychology," p. 34.

it is impossible to consider medical practice in any but impersonal terms.

The following chapter will examine selected issues in medical ethics and medical practice to demonstrate how the Cartesian outlook prejudices the encounter between physician and patient and actually falsifies an ethical outlook by holding us to a dichotomous view of the person. Many such attempts to improve the status of the person as a patient and redirect the attentions of the physician may actually fail and actually invert morality by inadvertently subscribing to the Cartesian epistemological outlook as the only intelligible way of knowing and doing. The effect of this error is that many of the well-intended efforts of medical ethics may actually make matters worse, rather than better, by failing to appreciate the integrated, historical, culturally-rooted situation of both physician and patient.

## CHAPTER FIVE

### MIND-BODY DUALISM IN MEDICAL ETHICS

#### I.

The Cartesian approach to knowledge has greatly enhanced biomedical technology by liberating the study of man from medieval theology. By legitimizing the study of the human body as a thing, i.e. as a physical entity (res extensa), great technical advances have been possible, which could not have occurred if for example anatomical dissections and other experiments which might have challenged the authority of the church were prohibited. But when we refer to "the study of man" in the traditions of philosophical anthropology, we understand much more than the study of human physiology, and the "soul", which Descartes split off from the body, has all but lost any compelling significance in modern culture; even the word "spirit" barely conveys the more-than-physical concerns which are inevitably a part of the physician's concern for the patient.

Thus our culture, for all its diversity, experiences the full force of the Cartesian legacy in modern medicine. It is now possible to conceive of medicine as an almost totally impersonal, technological enterprise, or it is possible to conceive of medicine in very personal terms and quite broadly as concerned with suffering of human beings. Medicine and physicians are criticized both for being too impersonal and for being concerned with too broad a range of problems. It is a paradox of our culture that medicine should be denounced for being too concerned with human suffering, yet any number of purportedly radical critics of medicine including Ralph Nader, Ivan Illych, Thomas Szasz<sup>1</sup> and many others hold that medicine should limit its concern to strictly physical matters. It is also paradoxical that just as medical technology has really been able to demonstrate prodigious accomplishment, public satisfaction with medicine has been rapidly declining as the following graph suggests.<sup>2</sup>

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<sup>1</sup>See Ralph Nader and Sidney Wolfe, "Is the American health system bad for America's health?," Practical Psychology for Physicians, December, 1976; Ivan Illych, Medical Nemesis (New York: Pantheon Books, 1976); Thomas Szasz, The Myth of Mental Illness (New York: Harper and Row, 1974).

<sup>2</sup>I am indebted to my colleague John Crellin for this semi-quantitative perspective on medical history.

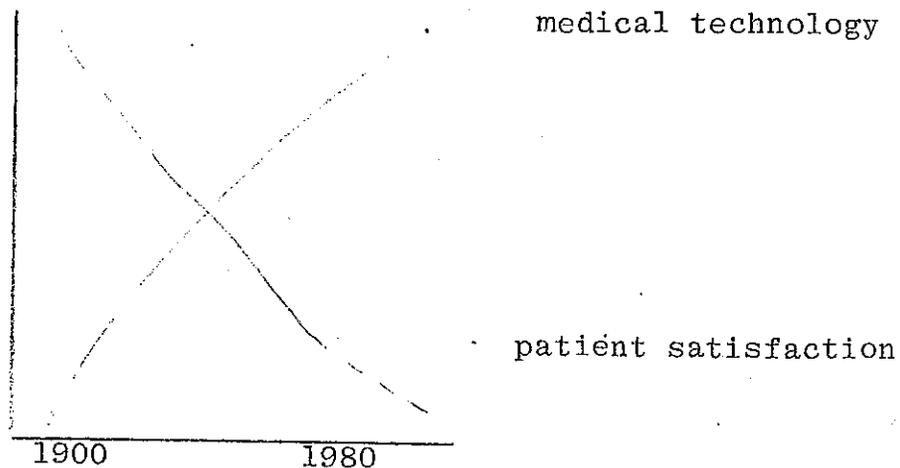


Figure 9

The paradox here is not that the public is dissatisfied with medical technology, but that technical virtuosity has led the physician to concentrate more on the physical aspects of disease with the appearance at least of decreased concern for the patient who suffers. No one would wish a return to the turn-of-the-century physician, the "horse and buggy doctor," romantically remembered as sitting all night at the bedside of the dying patient, to whom he could offer little but compassion, but we might wish for more of the humane concern manifested by physicians of old.

It is one of the tasks of medical ethics to deal with this dichotomous view of medicine. Recalling the discussions of the manifold tasks of medical ethics from Chapter One, it may now be restated that medical ethics is both the transmission

of professional tradition and the vehicle for calling those traditions into question. Recalling Chauncey Leake's distinction between matters of ethics and matters of etiquette, we may now paraphrase his concern as follows: While medical ethics is properly concerned with the ultimate conduct of physicians toward their patients, and toward society as a whole, the consideration of the will and motive behind this conduct involves matters of etiquette and manners in the forms of life that constitute medical practice. It is possible for ethics to avoid such personal, historical and cultural considerations and to achieve explicit clarity on abstractly formulated questions, but it does so at the risk of moral inversion and at the risk of further impersonalizing medical practice. Or to reformulate the problem: in order for medical ethics in the standard (regnant) account to achieve the kind of conceptual clarity which the Cartesian outlook requires, it must sacrifice any awareness of a whole, integrated, historical human being living in a cultural situation in favor of the Cartesian split personality. The Cartesian legacy in our culture leads us to either mentalistic or materialistic formulations of our problems, and this is especially the case in medicine.

Just as the appreciation of technology in our culture is ambivalent, so also is the appreciation of medicine. And herein lies the confusion, for medicine as an institution is comprised of individuals, physicians and patients, each unique by virtue of unique historical experiences, whatever experiences they may share as citizens of a particular culture. Physicians do not act in a cultural vacuum devoid of the expectations placed on them by their patients. Indeed for all the standardization of practices which medical technology has accomplished, the physician's practice starts with an assessment of the needs of each patient who appeals to the physician for help. It is often held that the so-called "medical model" entails certain values of a technological sort, namely an approach to the body as thing as opposed to the patient as person, when in fact this may not be the case at all. What the "medical model" entails is very ambiguous, as is the scope of medical concern, what is meant by health, illness, etc. The extremes may be distinguished by what Dr. Otto Guttentag calls "the biological medical model" and "the anthropological medical model" to avoid conceding that medicine is just concerned with physiological matters and that doctors are not concerned with people.<sup>3</sup> Thus we see basically

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<sup>3</sup>Otto E. Guttentag, "The Attending Physician as Central Figure," presented at the Conference on Changing Values in Medicine, Cornell University Medical College, New York, November 12, 1979, (to be published by University of Chicago); also see Idem, "Care of the Healthy and the Sick from the Attending Physician's Perspective: Envisioned and Actual," ed. S. F. Spicker, *Organism Medicine and Metaphysics*, (Dordrecht, Holland: D. Reidel, 1978), p. 41-56. Alternatively to enlarge the scope of understanding biology as the study of life, we might distinguish the biological-technological medical model from the

two kinds of moral inversions in medical ethics: (1) the body treated as a machine (res extensa) and (2) discarnate mentality (res cogitans). The former is overly materialistic; the latter is overly rationalistic.<sup>4</sup> Throughout this dissertation I have been attending to the limitations of an approach to ethics which

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biological-anthropological medical model.

<sup>4</sup>As an example of the materialistic problems in medical ethics, we may consider attempts to resolve ethical dilemmas in medicine by identifying life in mechanical or physiological terms. These problems often appear as attempts to "define" life or death. When may an artificial respirator be turned off, for example? At first glance it might appear that a new definition of death might make this decision easier to make, but the issues involved are not technical in nature, but personal. For a detailed discussion of the ethical and legal issues involved in such a decision, my article, "Natural Death in Medical Practice" provides more detail than is possible here. (See Allen R. Dyer, M.D., and William B. Bunn, M.D., J.D., "Natural Death in Medical Practice," North Carolina Medical Journal 41 (March 1980):147-151).

Abortion is another particularly distressing example where the conflicting values of our culture are camouflaged as concern about a definition of life, the origin of life. The abortion debate involves many issues simultaneously, including the rights of a woman to self-determination of her body, the potential rights of a fetus to life, attitudes toward sex, reproduction and responsibility for offspring, knowledge of the consequences, physical and emotional, of sexual intercourse, birth control, family planning, and population limitation in an overcrowded world, but not the definition of life, which is an issue almost irrelevant to the passions which stir the debate. It is ironical that we are asked to consider this moral issue on terms that equate life with cellular metabolism, when the concern is how to assess the value of human life and living of the human person. No one would base an ethical argument on the "right to cellular metabolism," when by human life we understand so much more. Though space does not permit the examination these issues warrant, they need to be identified in the context of our understanding of what a person is, and what medicine's responsibility to that person is.

attempts complete specifiability. In this chapter I shall attempt to demonstrate that something greater than inadequacy is at stake for ethics, namely that this regnant approach to ethics, depending on an impersonal view of man (the person) and relying on the Cartesian mind-body dichotomy, contributes to the dehumanization experienced in modern medical practice.

## II.

How is medicine to be conceived? What is the legitimate purview of the physician? Unquestionably the physician is to be concerned with physical illness, an infection, a myocardial infarction, a neoplasm. But what about "mental illness?" Should the physician be concerned with emotional problems, anxieties, depressions, psychoses? These concerns might once have been in the spiritual realm, the subject of religious counseling or advice. Does their legitimacy as medical problems stem from a demonstrated organic etiology or do such mental problems stemming from "problems in living" legitimately belong in the medical purview? What about those patients who perceive themselves to have physical problems, but problems for which no organic etiology can be demonstrated: the "hypochondriacs," to put it politely, "crocks" they are sometimes disparagingly called, technically "conversion hysterics," if their symptom masquerade is unconscious, "malingerers" if it is conscious and

willful. Should the physician be taking care of these people or should they be kicked out of our hospitals and clinics? What about matters of preventive medicine, fluoridation, nutrition, sanitation, environmental pollution, industrial safety, family planning and birth control, abortion, nuclear energy and war, homosexuality, child abuse, and lifestyle including "bad habits" such as reckless driving, smoking, drinking, overeating and underexercising? Are these appropriately matters of the physician's concern or are they an intrusion into matters that should be of no more concern to the physician than to any other citizen? Medicine is criticized as being both too much concerned and too little concerned with many of these areas.

There is no general agreement about these questions even among physicians. There is a tradition of broad concern for the well-being of the patient which inclines the physician to adopt a broad definition of medicine. Notable in this tradition is Dr. Otto Guttentag, who defines medicine as "the care of health of human beings by human beings" to stress the physician's fellow-concern for another human being.<sup>5</sup> Also in this tradition is the World Health Organization definition of medicine, which stresses physical, emotional and social well-

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<sup>5</sup>Otto E. Guttentag, "On Defining Medicine," The Christian Scholar XLVI (Fall 1963):200-211.

being. Yet there is another tradition which says the physician should tend only to matters of physical disease. Many of today's young physicians and medical students are defensively adopting this posture in response to the more hostile of medicine's critics. "Why take unnecessary risks, which aren't appreciated anyway? Better to specialize narrowly in an area where I can be sure of my competence," they are saying explicitly and implicitly. Others, sensing a growing resentment of medical paternalism, will say, equally defensively, "Patients are responsible for their health; if they want to kill themselves by smoking, I can't stop them. I will help those who ask for my help."

These are issues which no physician escapes. Whether or not they are reflected in an ethical context, they are dealt with as physicians make choices about how they will practice as well as in each encounter with each patient. Inevitably there will be differences in expectations in any human encounter, no less so in the doctor-patient encounter. Often patients will come to physicians expecting something other than what the physician is prepared to offer. Undoubtedly clarification of expectations should be very much part of the negotiations between physician and patient and involve them together in partnership in planning a treatment upon which both agree. It is frequently

a problem that physicians do not adequately ask patients to clarify their expectations or do not adequately explain the treatments they recommend, just as it is a problem that patients are often surreptitious with physicians about stating what they want. A patient may complain of back pain, for example, leading the physician to believe that the patient wishes to be relieved of the symptoms when in fact the symptom is tolerable, and the patient consciously desires the physician's aid in gaining monetary compensation and unconsciously may want dependency gratification, but not cure.

One way of clarifying these differing expectations is to distinguish between disease and illness. Though disease and illness are practically synonymous in everyday usage, they are not necessarily the same thing, and herein lies the confusion. Illnesses are experiences of disvalued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicine, are abnormalities in the structure and function of body organs and systems. To state the distinction tersely: patients suffer illnesses; physicians (in the Cartesian paradigms, which reduce life to physics and chemistry) diagnose and treat diseases.<sup>6</sup>

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<sup>6</sup> See Leon Eisenberg, "Disease and Illness; Distinctions Between Professional and Popular Ideas of Sickness," Culture, Medicine and Psychiatry, 1 (1977):9-23.

Disease and illness may not always occur simultaneously. A patient may complain of symptoms for which the doctor can find no organic explanation, or conversely the doctor may make a diagnosis of disease which the patient does not experience as illness. In the former category may be conversion hysteria and malingering; in the latter hypertension and asymptomatic diabetes, which may subsequently become illnesses if the patient does not comply with the doctor's prescriptions. The following chart illustrates some of the dichotomous possibilities and the value choices that must be made by both physicians and patients in determining the role of medicine in one's life.

	illness	no illness
disease	congestive heart failure ← diabetic ketoacidosis ←	hypertension diabetes
	conversion reaction } following whiplash }	
	conversion reaction, malingering	
no disease	masturbation in 1900 → homosexuality in 1970 → (sexual orientation disturbance in 1980)	masturbation in 1980 homosexuality in 1980?
	child abuse in 1980 ←	child abuse in 1900

Figure 10

Just as the perception of a problem as an illness or a disease may change from time to time in any given individual so also may the perception in a society change. Masturbation, for example, was widely considered an illness around the turn of the century, though now with recognition of its statistical "normality," it is no longer considered a medical problem, even though many people still experience feelings of shame and guilt about masturbation, perhaps not so much about the act itself as about the fantasies which accompany masturbation.<sup>7</sup> Many forms of behavior, which were once considered moral problems, "perversions," have been humanistically appropriated into the medical realm, relabeled as "illnesses" perhaps even as "diseases" and given the supposedly value-neutral status of "deviations". Alcoholism as well as sexual perversions might fit in this category. Homosexuality was formally reclassified in 1974 by the American Psychiatric Association, and removed from the Diagnostic and Statistical Manual-II (DSM-II), being replaced by "Sexual Orientation Disturbance (Homosexuality)" a move which was made presumably because not all people who claimed the identity of homosexuality considered themselves to be ill. Thus, what was recently a moral problem, a "perversion,"

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<sup>7</sup>H. Tristram Engelhardt, Jr. "The Disease of Masturbation: Values and the Concept of Disease." Bulletin of Historical Medicine 48 (1974):234-248.

was demoralized and medicalized as a "deviation" and then partially demedicalized as an "elective form of sexual behavior." The process works the other way too, as exemplified by the situation of child abuse, which is now viewed as a medical problem, reflecting in part the newer skills of psychotherapists and community agencies to identify, intervene and "treat" the problem.

Value choices reflecting cultural attitudes are made at a most fundamental level concerning "sickness" (disease and/or illness). Not only in the examples discussed to illustrate the scope of possibilities, but in any number of situations which come to the physicians attention, decisions must be made as to what should best be the physician's response to the request for help. Often in our culture the problem is perceived to be either a physical or a mental problem, the latter being the province of the psychiatrist as the specialist dealing with functional or non-organic problems. Thus there is a confusion about the relationship of mind to body, and this can be understood by considering the relationship of psychiatry to the rest of medicine. The Cartesian dualism creates something of an identity problem for psychiatry depending on the view of the medical model one holds. There are some adherents of "biological psychiatry" who hold that psychiatry's legitimate place in

medicine derives from its treatment of mental problems with a biological basis, "biological" being understood to mean "physical-chemical." This view accepts the supremacy of the "biological medical model." Alternatively, others such as George Engel argue that the medical model must be understood to encompass, not only biological phenomenon, but bio-psycho-social problems, broadly conceived.<sup>8</sup> The dichotomy itself is spurious, but focusing on it provides a useful context for understanding some of the debates in medical ethics, which take the Cartesian epistemological outlook for granted.

### III.

Questions of ethics have led to questions of philosophical anthropology: how is man to be conceived or how is the person to be conceived in medicine? Since Cartesianism splits man into mind and body, conceived dichotomously, we have been led to consider the place of psychiatry in medicine and in relation to the rest of medicine. The physician is often presented with the question as to whether a certain problem is physical or emotional, "mental" or some variant of a non-physical problem. Faced with such dichotomous alternatives, we may say

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<sup>8</sup>George Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," Science 196 (April 8, 1977): 129-136.

medicine should be limited to the strictly physical, or we can say that medicine should be broadly conceived to deal with the problems which persons suffer including mental or emotional problems. I have been arguing for the more encompassing and personal approach to medicine. Thomas Szasz takes exactly the opposite approach: He argues that medicine's only proper concern is physical illness and that mental illness is a "myth".

Szasz is aware of the impact of Cartesianism on medicine and accepts it as proper and inevitable. Without awareness of epistemological alternatives, the question Szasz faces is not how to conceive of medicine, but rather accepting the Cartesian dichotomy, how to conceive of moral problems, problems in living, and problems involving human ambiguity in a system which insists on conceptual clarity. Says Szasz, "Strictly speaking, disease or illness can affect only the body; hence, there can be no mental illness."<sup>9</sup>

Since we are prepared to consider epistemological alternatives to the Cartesian system, which Szasz is not, we must consider the full import of Szasz's statement for our conception of medicine. "Myth" itself has many possible interpretations. In the Cartesian system and as Szasz uses it, "myth" refers to a non-reality, something which is not to be believed. Alternatively, "myth" to a cultural anthropologist studying the

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<sup>9</sup>Thomas Szasz, The Myth of Mental Illness, p. 267.

religion of a particular culture, or to a theologian studying his own religion, is a system of belief, a story of narrative, which organizes the way reality is to be understood in a particular culture or religion. Thus we may understand the "myth of mental illness" to mean a non-reality in which we should not believe or a reflection of the organizing beliefs of our culture, a way of understanding "reality". As Polanyi points out, if we equate the real with the tangible, then minds may not seem real, even though they are in a sense more real than stones, which are tangible. Similarly if we expect illnesses to be tangible in order to be real, then we may easily conclude that mental illnesses are not real, though they are real indeed to those who suffer from them.

Szasz rightly deserves to be discredited for his over-reliance on the Cartesian outlook, for his overly narrow conception of medicine, and most especially for his absolute opposition to involuntary commitment of mental patients. But I cite his work not just to discredit it, for he is among the most prominent contributors to medical and psychiatric ethics, discussing many issues with a nuance of understanding and a sensitivity which is uncommon. Rather I cite Szasz to demonstrate how, even with the kind of sensitivity he demonstrates, it is possible to come to some very rigid conclusions, which may

actually make matters worse rather than better--and do so in the name of ethics.

Particularly to Szasz's credit and indispensable for our understanding of contemporary medicine's dilemmas is his analysis of hysteria, which he uses as a prototype of the myth of mental illness, but which we might equally well use as a basis for understanding medicine in personal rather than physical terms. He cites Freud's account of Charcot's pioneering work on hysteria:

[Charcot] explained that the theory of organic nervous diseases was for the present fairly complete, and he began to turn his attention almost exclusively to hysteria, thus suddenly focusing general attention to this subject. This most enigmatic of all nervous diseases--no workable point of view having yet been found from which physicians could regard it--had just at this time come very much into discredit. . . . First of all Charcot's work restored dignity to the subject; gradually the sneering attitude, which the hysteric could reckon on meeting when she told her story, was given up; she was no longer a malingerer, since Charcot had thrown the whole weight of his authority on the side of the reality and objectivity of hysterical phenomenon.<sup>10</sup>

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<sup>10</sup>Sigmund Freud, "On the History of Psychoanalytic Movement" (1914), in The Standard Edition, XIV:13-14, quoted in Szasz, Ibid., pp. 21-22.

Thus by virtue of his authority, according to this account, Charcot restored a modicum of human dignity to those who suffered from non-organic illness. It remained for Freud himself, initially in collaboration with Breuer, to further dignify the illness by explaining how and why the hysteric suffered and by offering a method for treating the hysteric's symptoms. Breuer discovered that the symptoms disappeared if the patient recalled under hypnosis the time when the symptoms first appeared. Freud later found that hypnosis was unnecessary and substituted the method of free association, by which analyst and patient working together could come to understand the origin and meaning of the symptoms and possibly find alternative ways of dealing with heretofore unconscious conflict.

Observing these historical "facts," a value judgment must be made. Was what Freud did good or was it bad? Szasz makes an interesting observation in this regard. He notes that

Although Freud regarded hysteria as a disease, he clearly understood it far better than his language allowed him to express it. He was in a sort of semantic and epistemological strait-jacket from which he freed himself only rarely and for brief periods. The following passage is an example of description in plain language, unencumbered by the need to impress the reader that the 'patient' is truly ill and a genuine patient.<sup>11</sup>

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<sup>11</sup>Szasz, Ibid., p. 73.

Szasz then goes on to quote Freud's account:

Here, then was the unhappy story of this proud girl with her longing for love. Unreconciled to her fate, embittered by the failure of all her little schemes for reestablishing the family's former glories, with those she loved dead or gone away or estranged, unready to take refuge in the love of some unknown man-- she had lived for eighteen months in almost complete seclusion, with nothing to occupy her but the care of her mother and her own pains.<sup>12</sup>

Szasz is entirely correct that Freud relied heavily on scientific or mechanistic paradigms in explaining his theories, perhaps in order to make them intelligible to the scientific community. He used those paradigms metaphorically to explain the suffering of hysterical persons (usually women) who presented themselves to physicians (originally neurologists, then psychiatrists) asking for help. Freud was thoroughlygoingly scientific insofar as he relied closely on his observations in order to draw his conclusions, but not in his reliance on mechanical terminology to explain emotional and moral phenomena. Use of such terms as "forces," "determinants," "impulses" and the like have left Freud open to the criticism that he was "reductionistic" though it should be acknowledged that he wisely decided not to publish his "Project for a Scientific Psychology" (1895), where he speculates on the physiological

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<sup>12</sup> Joseph Breuer and Sigmund Freud, Studies on Hysteria (1893-1895), pp. 143-144, quoted in Szasz, Ibid., p. 73.

determinants of behavior.<sup>13</sup> Thus a critic such as Szasz might well go on to reinterpret the moral dimension of the suffering hysteric, but instead he himself remains locked in the same Cartesian straitjacket, which he claimed was shackling Freud. Szasz, faced with the same moral dilemma which Freud faced, and faced with the same "facts," arrives at a different value judgment, namely that it is not the physician's place to help these people because they do not suffer from "real" illnesses.

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<sup>13</sup>There can be no question, however, that Freud equivocates on the relationship between the psychological and physical sciences. He strove to be scientific and succeeded, but not because he offered physical explanations for mental phenomena, but because he offered an explanatory system based on his careful observations, which was "real" and "believable." His reliance on mechanical metaphors stated as fact continues to be a point of contention in Freudian criticism and interpretation. The working psychoanalyst is successful, just as the working physicist is successful, by ignoring the would-be explanations of a positivist philosophy. A psychoanalyst comes by his understanding of the historical antecedents (or "determinants") of adult rationality as much through his own experience in personal psychoanalysis as through a study of the writings of Freud. A literary critic or philosopher, however, trying to understand Freud strictly through his writings, may be seriously misled about the meaning of such concepts as "overdetermination," for example, which was Freud's creative equivocation for saying that although there are many antecedent "causes" for the things people experience, these causes do not have a strict cause and effect relationship: there are too many determinants to permit quantification.

Polanyi is among those who criticize Freud on these grounds. Yet Polanyi himself was entirely baffled about how to give account of the phenomena Freud described. On one occasion he was attempting to describe to me the work of his wife, Magda. At that time in the late sixties, there was a movement in Britain (as well as in this country) to release as many patients from psychiatric hospital as possible and return them to their communities. Magda was working with the communities to help organize services for these people, whom Michael could only think to describe as suffering from "diseases of the brain." On another occasion he similarly referred to the illness of a family member, apparently a depression, as a "disease of the brain."

It could be argued that it matters little whether mental illness is considered a myth or a reality as long as one is sensitive to the value dimensions involved in making such a choice and as long as the value judgments are acknowledged as such. Both Freud and Szasz are exquisitely sensitive to such issues. But there is one problem which cannot be overlooked in this analysis and that is the possibility of moral inversion when moral ideals are held as absolute moral imperatives. I believe Szasz falls prey to this problem in his conclusion that involuntary commitment should be absolutely prohibited on the grounds that there is no such thing as mental illness.

The dilemmas posed by the schizophrenic woman who killed herself in jail (discussed in Chapter Four) are illustrative of the kinds of concerns which must be dealt with, but which an absolutist approach fails to adequately consider. Any action in such a situation will be less than perfect because conflicting ideals are involved. Were the patient perfectly rational, there would be no problem, but she says at one minute she wants to be in the hospital; the next minute she does not. Her psychopathology does not allow her to integrate her impulses over time. It is the very ambiguity of the situation which the civil liberties lawyers (and Szasz), expecting matters to be

clear and distinct in strict Cartesian fashion, can't tolerate. In order to clarify such ambiguity and to defend against the dreadful anxiety of trying to empathize with the schizophrenic turmoil, the civil liberties lawyer abstracts certain facts from the complexity and tenaciously insists on nothing less than moral perfection, which is determined a priori with no reference to the needs of the individual patient.

This may be considered moral inversion because the moral thing to do would be to assure this confused woman a stable environment where her impulses could be controlled and integrated over time, i.e. to insure her of psychiatric care or, to translate this concern into the language of rights, to insure her right to treatment. What the schizophrenic woman needs is not an adversarial proceeding in order to obtain an abstract clarity at her expense, but rather a cooperative exploration of how her needs can best be met with all interested parties attempting to formulate a plan which assures her the best treatment available without violating her civil rights and yet guaranteeing her right to treatment. Such an approach, admittedly novel in our judicial system, would properly be called fiduciary insofar as it would rest on trust and cooperation, rather than control and competition between parties of different methods and outlooks, but similar goals, namely the interests of the patient.

An exhaustive analysis of all the legal, medical, and moral aspects of the issue of involuntary commitment is beyond the scope of this inquiry. My purpose in raising the issue in this context is to relocate the issue which I believe cannot be ignored, namely the conception of the person. A view which focuses on "freedom" as an absolute, or on civil liberties, however desirable, without also accounting for the attendant limitations, such as the limitation of the mental patient to think rationally, is inevitably incomplete.<sup>14</sup> What it means to think rationally, is something which, of course, must be interpreted epistemologically, and that is where the debate should be located. In the sections on informed consent later in this chapter, it will be possible to say more about how these judgments might responsibly be made.

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<sup>14</sup>A system which does adequately account for these tensions is that of Paul Tillich in Love, Power and Justice: Ontological Analyses and Ethical Applications (New York: Oxford University Press, 1954) or his Systematic Theology (Chicago: University of Chicago Press, 1951-63) where he discusses "finite freedom." Finite freedom is fundamentally a recognition of our own mortality and of the limitations inherent in the human condition. The wish for absolute freedom, on the other hand, is a remnant of our infantile narcissism, the grandiose desire that our impulses not be bound by the limitations of necessity and the reality principle.

## IV.

The person suffering from non-organic "ills" is not always identified as a psychiatric patient. Many people come to the doctor with poorly defined symptoms, experienced, perhaps as pains, in the body. In urban areas, where it is possible to obtain psychiatric consultation, these problems may be translated into psychiatric problems and a treatment approach developed which attempts to get at the etiology of the problem. But in many instances the problem may be treated symptomatically, perhaps with a placebo medication, or perhaps the patient may benefit from what might be considered a placebo effect of the encounter with the physician, someone who listens to the patient, does not criticize or demean the patient, and "seems to understand."

Into these "therapeutic encounters" enter matters of clinical judgment for the physician, value judgments which can and should be subject to ethical reflection. As with so many ethical issues, care must be taken in asking the proper questions and keeping clear distinction between matters of value and interpretations of fact. On the specific matter of placebos, for example, do we raise the issue as a matter of "truth-telling" or do we enquire into the best method for caring for the hysterical patient in a medical system, which reflects a culture tending

to maintain rather sharp divisions between problems of the mind and problems of the body? Or perhaps it is best to do both.

Sissela Bok analyzes placebos as an issue of truth-telling, actually as an example of lying, and her analysis is informative, not only on the use of placebos, but of the pitfalls of ethical analysis in the standard account. Bok quite correctly realizes that there is a toll for lying, namely an erosion of trust, as much for liar as for the victim of the deception, but in her fervor to denounce lying, she herself resorts to deceptions and partial truths, relying on promiscuous notions of the truth, notions which would lead to an easy virtue, rather than relying on a careful search to understand the truth.

Bok's difficulties stem in part from the same debate with traditional epistemology which has plagued so many considerations in ethics. She argues that theoretical philosophy predisposes the questions dealt with in applied ethics in such a way that lying is not given careful consideration as an ethical issue because the epistemological priority as to what truth is takes precedence over practical questions, such as when one should tell the truth:

Applied ethics, then, has seemed uncongenial and lacking in theoretical challenge to many moral philosophers even apart from any belief in epistemological priority and from muddles about the meaning of "truth". As a result, practical moral

choice comes to be given short shrift, and never more so than in the case of lies.<sup>15</sup>

Her point is an important one, and her assessment that many epistemological discussions lead to "muddles" about what the truth is should serve as a warning to fellow philosophers not to ignore urgent practical problems in favor of theoretical issues. Nonetheless the theoretical questions remain, and an understanding of what the truth is remains indispensable to any decision about when if ever it might be acceptable to lie. Bok's dismissal of questions she doesn't want to consider is reminiscent of Descartes when he denied that his conception of God as a perfect being was a projection of his own wish for a perfect being, then satisfied himself that to have anticipated the question and denied it was sufficient to settle the argument. Similarly Bok dismisses questions that are beyond her purpose, such as the epistemological questions, leaving one to wonder what are her purposes, or what is the purpose of any philosophical endeavor, if not to search for truth and understanding. Her arguments about lying are essentially valid, but she has difficulty making them legitimate because she does not adequately settle the antecedent epistemological questions. She recognizes that the regnant epistemological outlook is inadequate but immediately falls prey to its seductive familiarity.

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<sup>15</sup>Sissela Bok, Lying: Moral Choice in Public and Private Life (New York: Pantheon Books, 1978); p. 11.

Bok is a victim of our culture, and without awareness of epistemological alternatives to the Cartesian demand for explicitness, she understandably misperceives an epistemological issue as an ethical problem, as we are all inclined to do. When asked to comment on Uncle Joe's new necktie, for example, how often we understand the request as a request for an (objective) assessment about the tie, rather than an invitation to say something about ourselves, our (aesthetic) values, our tastes, our judgments. We lie and say the tie is lovely (a white lie, to be sure; trivial, maybe), when in fact once again we so easily substitute a statement of fact for the disclosure of a judgment of value.

Ethically, a question even more difficult than whether to lie is how to understand and communicate the truth: how to understand what Uncle Joe really wants to know and how to tell him our feelings. For the physician the question is how to understand the patients' human as well as physical needs and how best to serve those needs.

These are the questions which are conspicuously absent from Bok's discussions of lying. As an example of this kind of pre-judging of an issue, consider this statement from her Scientific American article on "The Ethics of Giving Placebos":

The derivation of "placebo," from the Latin for 'I shall please,' gives the word a benevolent ring, somehow placing placebos beyond moral criticism

and conjuring up images of hypochondriacs whose vague ailments are dispelled through adroit prescriptions of beneficent sugar pills.<sup>16</sup>

With this curt dismissal, Bok depreciates the frustrating agonies of physicians in dealing with an issue of great practical importance, namely how effectively to deal with and help the hypochondriac or hysterical patient, whose problems do not fall into strictly somatic categories. Far from being beyond moral criticism, they are questions that most physicians are very deeply concerned with, if for no other reason than their prevalence and the difficulty of dealing with them. Bok seems to feel that physicians treat these problems cavalierly, and from this unarticulated, and I believe wrong conclusion, she departs from an analysis of the moral issues as moral issues, in which she might attempt to ally those who share her concerns, especially physicians, into a quasi-sociological documentation of the shortcomings of physicians in dealing with these sensitive issues, substituting innuendo and partial truths for facts and careful analysis of values, ignoring the possibility of a fiduciary search for the truth, and attempting an adversarial denunciation of the medical profession.

Bok cites a number of examples of use of placebos, some of which are very disturbing. For example,

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<sup>16</sup>Sissela Bok, "The Ethics of Giving Placebos," Scientific American 231 (November 1974):17.

In 1971 a number of Mexican-American women applied to a family-planning clinic for contraceptives. Some of them were given placebos, or dummy pills that looked like the real thing. Without knowing it the women were involved in an investigation of the side effects of various contraceptive pills. Those who were given placebos suffered from a predictable side effect: 10 of them became pregnant. Needless to say, the physician in charge did not assume financial responsibility for the babies. Nor did he indicate any concern about having bypassed the "informed consent" that is required in ethical experiments with human beings. He contented himself with the observation that if only the law had permitted it, he could have aborted the pregnant women.<sup>17</sup>

One can only say that the situation is deplorable, and that the physician acted in a most reprehensible manner. That any physician could act in such a fashion raises questions about the adequacy of the teaching of ethics in medical schools and the adequacy of professional standards for safeguarding patients. Had Bok raised any of these questions, no one could take issue with her, but instead she concludes, generalizing beyond the data she has, that

the physician was not unusually thoughtless or hardhearted. The fact is that placebos are so widely prescribed for therapeutic reasons or administered to control groups in experiments, and are considered so harmless, that the fundamental issues they raise are seldom confronted. It appears to me, however, that physicians prescribing placebos cannot consider only the presumed benefit to an individual patient or to an experiment at a particular time. They must also take into account the potential risks, both to the patient or the experimental subject and to the medical profession. And the ethical dilemmas that are inherent in the various uses

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<sup>17</sup>Ibid.

of placebos are central to such an estimate of possible benefits and risks.<sup>18</sup>

Here we see a curious mixture of fact and value. Bok tells us that such practices are widespread, and indeed the use of placebos is widespread, but placebos used in experiments are given with the informed consent of the experimental subjects and this does not involve deception, as does the use of placebos for their therapeutic benefit in patients suffering from no organic disease. Bok asks us to believe deception in experimental procedures is widespread, which is simply not true, even though there are unfortunate exceptions such as the example she cites. The physician in question was indeed "unusually thoughtless and hardhearted," a deviant at best.

Her case would be philosophically no less strong, indeed it would be stronger, if she indicated that there was a problem, which did not receive adequate attention, without resorting to deceptions in attempt to exaggerate the extent of the problem. One is sidetracked into wondering about the sociological dimensions of the problem, which is an irrelevant issue, because the problem is real nonetheless. Bok actually goes so far as to provide some data, but unfortunately the data she provides are misleading. She points out that active therapeutic agents can be used for their placebo effect if prescribed for situations or in doses in which they have no pharmacologic effects. Prescribing antibiotics for viral (rather than bacterial) illnesses is an

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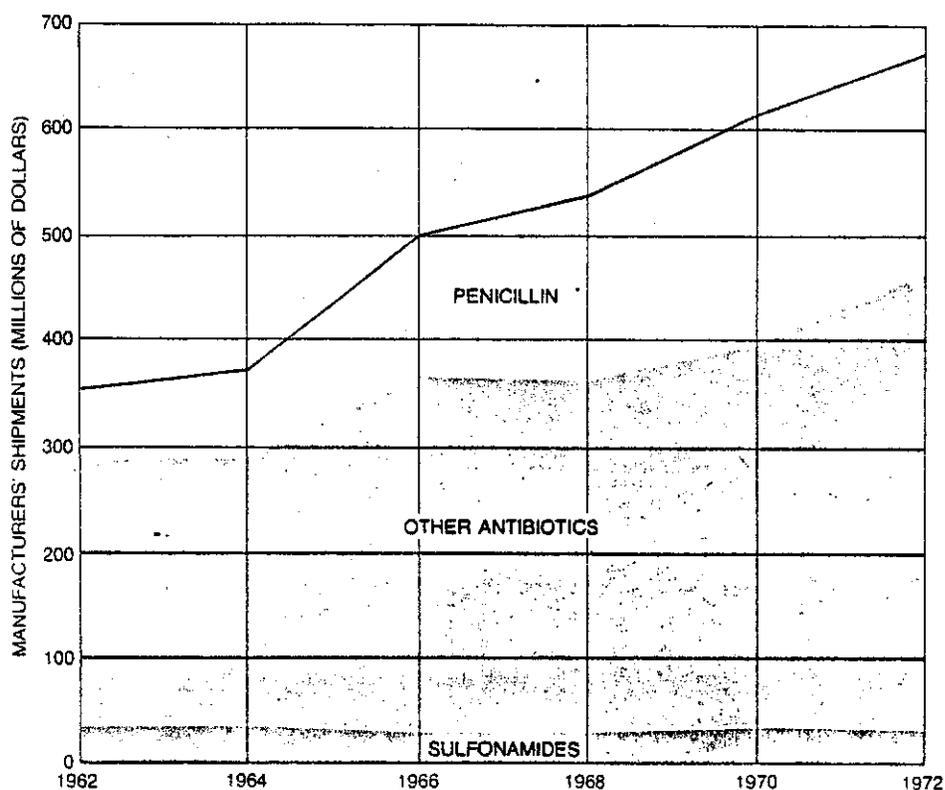
<sup>18</sup>Ibid.

example of this. A common problem in pediatric practice is the parent who demands antibiotics for treatment of a child's infections, colds, flus, and the like, even though these may not be bacterial infections. It is a common problem, and one which is widely discussed in pediatric training programs. Bok tells us, "Parents demand antibiotics even when told they are unnecessary, and physicians may give in to the demands."<sup>19</sup> This is of course true, physicians may give in to the demands, but the fact is that physicians are very cognizant of this problem, and are very unlikely to prescribe antibiotics for viral infections. (The risk of indiscriminate use of antibiotics is that bacterial mutation causes evolution of strains of bacteria resistant to antibiotics.) Bok presents data in her Scientific American article that the practice is increasing rather than decreasing. The graph in Figure 11 shows the increase in the use of penicillin and other antibiotics in the ten year period from 1962 to 1972 and appears with a caption explaining that antibiotics may be placebos.<sup>20</sup> The graph does not tell us how extensively antibiotics are used as placebos, only that the use of antibiotics increased during that decade, a decade which also witnessed a growth of affluence in the population, and a greater access of the population to medical care.

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<sup>19</sup> Ibid., p. 22.

<sup>20</sup> Ibid., p. 20.



ANTIBIOTICS serve primarily as placebos when they are prescribed for minor virus diseases such as the common cold. Curves, based on Department of Commerce figures, show the value of manufacturers' shipments of systemic antibiotics and of sulfonamides, which are chemical anti-infective drugs. Among antibiotics, single penicillin preparations are shown separately. Antibiotic-sulfonamide combinations are included with other antibiotics.

Figure 11

One wonders what purpose such misleading data serve in an article whose intent is to impress upon us the importance of telling the truth. Surely Bok does not consciously intend to deceive, but her prevarications illustrate the difficulties of

doing ethics when scientific facts are seen to have more influence over us than moral arguments advanced on strictly moral grounds. That Bok allows herself to be overcome by the apparent power of scientific data and does not seem to realize the power of morality as a reality in itself should only alert us to the indispensability of a firm epistemological grounding in doing ethics. A misunderstanding as to what truth is predisposes the philosopher to falsehood no less than it does the physician or the patient who disguises an emotional problem as a physical problem, consciously or unconsciously.

The problems Bok attempts to deal with as ethical problems recur as matters of genuine perplexity for most physicians in clinical practice. These patients, for whom placebos may legitimately be an option, more ethical than using dangerously addicting analgesics, may be called "hysterics," but must be recognized as fellow human beings in need of help, and cannot be dismissed (as moral degenerates) by the physician, by the medical profession, or by critics of the medical profession, no matter how frustrating, time consuming or expensive their care may be. The mind-body problem recurs as the basis of so many problems in medical ethics and the practice of medicine in part because hysterics refuse to think of themselves and refuse to experience their bodies in the ways demanded by Cartesian notions of rationality. One of the differences between practicing

medicine and reflecting on the practice of medicine is that the physician must actually deal with (often irrational) fellow human beings and not just idealized approximations thereof. The doctor-patient relationship, therefore, continues to be an important focus for understanding ethical dilemmas which issue from medical practice. The remaining sections of this chapter focus on the doctor-patient relationship, particularly as that relationship is understood in considerations of informed consent.<sup>21</sup>

## V.

Whether medicine is properly conceived in personal or physiological terms, there exists a relationship between the doctor and the patient, and that relationship cannot be totally impersonal. Inevitably there must be some element of mutuality in the encounter of physician and patient if only in their search for common goals. Furthermore, as fellow human beings, the physician and patient exist as epistemological peers; the physician knows no more about his patient than he knows about himself. And, as Guttentag reminds us, the humanness stressed is from the perspective of a person who experiences himself as someone, not something.<sup>22</sup> Yet the

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<sup>21</sup> See also my chapter "Can Informed Consent be Obtained From a Psychiatric Patient? Reflections on the Doctor-Patient Relationship," in John Paul Brady and H. Keith H. Brodie, eds. Controversy in Psychiatry (Philadelphia: W. B. Saunders, 1978), pp. 983-996.

<sup>22</sup> Otto Guttentag, "Ethical Problems in Human Experimentation," in E. Fuller Torrey, ed., Ethical Issues in Medicine: The Role of the Physician in Today's Society (Boston: Little Brown, 1968), p. 199.

patient goes to the physician, not (primarily) because of the physician's human qualities, but because of the physician's expertise, what he knows. The physician's expertise enables the physician to conceive of the patient as a thing, and in the Cartesian tradition, the physician may unfortunately conceive of the patient as an object of nature to be controlled. Thus the relationship of the doctor and the patient is subject to liabilities, and it is as a protection against such abuses that continued vigilance to the interaction between physician and patient must be given.

Traditionally the doctor-patient relationship is spoken of as a fiduciary relationship, a relationship based on trust, but it is possible for it to be a relationship based on the control of a thing in nature, and may become an adversary relationship, if either physician or patient attempt to control the other. The patient may appeal to the physician for something other than the treatment of physical diseases, and the physician as medical scientist may be interested in organism physiology as well as treatment of the patient's problems. Clearly the patient is in greater need of protection than is the physician, and we have come to require more than just moral reminders that the physician must be considerate of the wishes of the patient. For both research (experiments involving human subjects) and practice, we require the informed consent of the patient.

Informed consent is both an administrative procedure and an ethical concept. The substance of consent is very carefully specified by regulatory guidelines: It must be informed, voluntary, and competent and must include the following elements: (a) a fair explanation of the procedures, (b) a description of discomforts and risks, (c) a description of expected benefits, (d) disclosure of alternate procedures, (e) an offer to answer any inquiries, and (f) an instruction that the person is free to withdraw consent and discontinue participation in the project or activity.<sup>23</sup> When one speaks of "consent" what is often meant is a form specifying all of the above, which is reviewed by an institution's Institutional Review Board (IRB), and signed by the patient or subject. This explicit "consent" might better be described as the "information," in order to focus on the human process of consenting, the interaction between the doctor and the patient, which cannot be explicitly reviewed in each individual case. Inevitably these transactions involve intangible factors, which rely on some measure of good faith between human beings, a trust which remains tacit and unspecifiable, which may go unspoken at least in part. Further analysis of the workings of informed consent, both on an explicit and on a tacit level, will be illustrative of the way our epistemological outlook shapes the ethical choices we are able to conceive.

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<sup>23</sup> "The Institutional Guide to DHEW Policy on Protection of Human Subjects," (NIH) 72-102.

## VI.

Is there a fundamental ethical principle governing informed consent? We have seen that it is possible to emphasize the information or the process of consenting. "Consent" in the dictionary definition derives from the Latin com- + sentire to feel, hence to feel together. It means "agree," "assent," or "give permission" and indicates involvement of the will or feelings and compliance with what is requested or desired. Consent by itself is not enough for our ethical requirements and must be "informed" meaning that the patient/subject must understand what he or she is consenting to. What constitutes adequate information is an epistemological question related to our understanding of how it is we know.

Implicit in the definition of consent is a community of feeling, a shared trust. With recognition of this mutuality, Guttentag offers a useful definition of informed consent:

Informed consent may be defined as the experimenter's willing obligation to inform the experimental subject, to the best of the experimenter's knowledge, about the personal risk that the experimental subject faces in the proposed experiment, the significance of the experiment for the advancement of knowledge and human welfare, and last but not least, the stakes involved for the experimenter himself. In short, informed consent implies that the experimenter has made the most honest effort he can to say everything that will enhance the experimental subject's freedom, so that

the subject can make the most adequate choice of which he is capable in agreeing or refusing to become a volunteer.<sup>24</sup>

Following this very personal view of ethics, Guttentag offers the notion of "partnership" as the basic ethical principle in experiments involving human subjects.

With reference to the relationship between experimenter and experimental subject, it is the concept of partnership between the two, resulting from the fact of their being fellow human beings, that reflects our basic belief and cannot be subordinated to any other.<sup>25</sup>

By partnership he does not imply a legal contract or business association, but rather "sincerity without reserve," a relationship of mutual trust and confidence, or openness between experimenter and subject, and a blind reliance that discards any guardedness. A criterion of this partnership, Guttentag insists, is the personal effort involved in its enactment, "the amount of 'loving care,' or devotion given to disclosing to the experimental subject and to 'making' the content and limits of any actual partnership. It is the antipode to negligence."<sup>26</sup>

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<sup>24</sup>Otto E. Guttentag, *Ibid.*, p. 208.

<sup>25</sup>*Ibid.*, pp. 200-201.

<sup>26</sup>*Ibid.*, p. 202.

Recourse to such words and phrases as "trust," "sincerity," and "loving care" may well seem vague, if not downright anachronistic to those seeking operational guidelines, but to the experimenter as human being this should not be the case.

An alternative contender for the title of "fundamental ethical principle" needs to be considered here because it will help focus an aspect of an underlying controversy in approaches to medical ethics. In a major position paper entitled "Three Theories of Informed Consent: Philosophical Foundations and Policy Implications," Robert Veatch argues that the most plausible foundation for informed consent is the principle of autonomy.<sup>27</sup> This principle holds that individuals are the possessors of individual rights including the right to self-determination.

The respect for the rights of individuals would seem to be an aspect of the fiduciary relationship, which Guttentag refers to as partnership. But Veatch insists that this is not what he has in mind. He refers to three different theories of informed consent, which he sees as mutually exclusive. The fiduciary tradition of Hippocratic medicine Veatch refers to as the Patient Benefit Theory of Informed Consent. He rejects this because its purpose is to protect patients from harm, which could be done by banning non-therapeutic research. Also the reason

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<sup>27</sup> Robert Veatch, "Three Theories of Informed Consent: Philosophical Foundations and Policy Implications," The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, February 2, 1976.

patients are to be protected from harm is because they possess the right to self-determination. The second principle, utilitarianism, the greatest good for the greatest number, he rejects because it permits too much. The third principle, which Veatch favors to the exclusion of the first two, is the principle of autonomy, the right of the individual to self-determination.

The principle of autonomy has the heuristic merit of bolstering against possible violations of trust. It has the liability of degenerating to an abstraction, of being applied individualistically to persons in isolation, or of being applied to groups without due regard for the idiosyncrasies of individuals. Fundamentally, the principle of autonomy makes sense not as an abstraction but as an extension of the fiduciary principle. Autonomy becomes meaningful not in isolation but only when it is respected by other persons.

The inclination to view autonomy as dichotomous from trust is another of the Cartesian traps, into which we so easily fall. Autonomy is an idea, and a noble one, but it is also an experience. In developmental psychology, autonomy is a developmental task subsequent to the formation of basic trust. In Erikson's developmental schema,<sup>28</sup> failure to develop a sense of trust as an infant results in a sense of mistrust of others and

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<sup>28</sup>Erik H. Erikson, "Identity and the Lifecycle," Monograph, Psychological Issues I (New York: International Universities Press, 1959).

suspiciousness. Successful establishment of a sense of basic trust (by "good enough mothering") leaves one free to master subsequent developmental tasks, the next of which, Erikson characterizes as autonomy. This is accompanied by locomotor skills and the early use of language, the first mastery of the body. The ability to leave the mother, briefly at first, trusting that she will be there upon return, and begin to relate to others, characterizes the emergence of autonomy. Failure to master this developmental step leaves the individual with a sense of shame and doubt. Margaret Mahler describes this process as "separation-individuation."<sup>29</sup>

The omission of considerations of trust in epistemological and ethical discourses from Descartes to modern medical ethics is understandable since trust is assumed as a prerequisite for the successful mastery of all subsequent development. But this assumption is not warranted, because it is especially the prevarications about trust, which characterize both ethics and epistemology in the modern age. Not all persons have developed even a sense of basic trust. Furthermore, trust or mistrust is an important element in all human affairs involving more than one person. Unless we are to assume that a person is to decide to consent or not consent in the privacy of his own imagination,

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<sup>29</sup> Margaret S. Mahler, Fred Pine, and Anni Bergman. The Psychological Birth of the Human Infant: Symbiosis and Individuation (New York: Basic Books, 1975). Mahler's work adds a pioneering dimension to the methodology of psychoanalytic research. While Freud attempted to reconstruct childhood experiences from the memories of adults, Mahler and others amplify these findings by the direct observation of children.

we must consider the nature of the relationship which obtains between doctor and patient, experimenter and subject. One of the great virtues of the Hippocratic tradition in medical ethics is that it has kept the fiduciary commitments of physicians in focus over the centuries.

#### VII.

The notion of informed consent, increasingly coming to stand at the center of our thinking about ethical problems in human experimentation or in medical practice, has two requirements which are not always easy to meet. The "consent" requires a mutual trust, and the "information" requires a certain amount of rational understanding. Both of these requirements are problematic with certain groups of people, who may have difficulty thinking rationally. Psychiatric patients are particularly problematic in this regard, but not uniquely so. Children, prisoners, the senile, the comatose, and participants in research involving deception (social psychology) all lack the inner freedom to give a truly informed consent. In fact, it might be questioned whether even more or less rational and sane people are really capable of giving a truly informed consent given the complexity of much contemporary research and practice and the complexity of human motivations. We might consider banning all people not capable of giving informed consent from participation in non-therapeutic research, but this risks infringing on their

rights, for example, to participate in research about their condition or to be of service to humanity. Furthermore there is an inherently paternalistic danger in making such decisions administratively on behalf of a group of people presumed incapable of making such decisions for themselves. Many people not designated as "psychiatric patients," for example, have difficulty forming trusting relationships, and few people think rationally at all times and in all areas of their lives with never a lapse into irrationality, impulsivity, or spontaneous passion. Thus, we need to avoid any tendency to think of psychiatric patients as somehow categorically different from ourselves and our fellow human beings, even though the great Kraepelin, who described dementia praecox (schizophrenia), is said to have found these people as alien to him as the birds in his garden.<sup>30</sup>

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<sup>30</sup>The schizophrenic and the scientist are epistemologically antithetical poles for modern civilization: each is problematic to the other. The tension rests in our confused phenomenology of perception. What is a valid perception? The schizophrenic trusts his unique perception of reality even though his delusions, illusions, and hallucinations conflict with almost every other person's perception of reality. The scientist on the other hand, doubting with Descartes everything except the fact that he is doubting, does not even trust his own perception but requires instead consensual validation, the validation from other senses, other perceptions.

It is sometimes said that it was the existence of such phenomena as illusions, delusions, and hallucinations that engendered Descartes' distrust of perception. Indeed the clear and distinct notions of "reality" by which we assess "non-reality" and define "psychosis" owe much to the Cartesian method and its attendant consensual objectivity. Its liability has always been in the realm of the interpersonal, the realms of reality which are experienced, not observed, and which if communicable at all, can only be understood through the rich ambiguities of

We are a rationalistic society, yet there is no logical cogency in the truth of a personal relationship. And if by "psychiatric patient" we include the "neurotics" as well as the "psychotics", their ambivalences undermine the principles of rationality on which we would like to conduct the affairs of cognitive and ethical discourse, and which would be necessary if a consent could be considered "truly" informed. The difficulties we have in considering informed consent with psychiatric patients disclose underlying conflicts in the values held by our society. The premium we place on "rationality" and "intelligence" conflicts sharply with the ambiguities so

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language. Psychological science--and the same might be said of ethical "science"--has always been plagued by problems of methodology insofar as the experimenter by virtue of his interaction with the experimental subject participates in the outcome of the experiment. In order to achieve the kind of objectivity that was possible in classical physics before Heisenberg recognized the influence of the observer on the observed, it was necessary either to limit the focus to observable behavior or to deliberately involve the experimenter as a partner in the experiment, which was Freud's novel solution. Ethics faces a similar methodological dilemma. Either it may strive for a conceptual clarity on a level of abstraction, which risks loss of empathic contact with the emotions and motives of the people whose values are considered, or it may focus on personal interactions risking the ambiguities of such communications. In this sense ethics may be said to follow epistemology. In the critical tradition of analytic philosophy, ethics may be seen as an attempt at clarifying principles of behavior. In the phenomenological tradition (including the post-critical alternative) ethics attempts the at least equally difficult task of understanding and reconciling human commitments and decisions. The knowledge required is self-knowledge: Know thyself.

It is difficult to see these two alternatives as mutually exclusive options. The phenomenological view is in many ways antecedent to any critical undertaking, and the only option is whether or not and how to attend to the personal ambiguities in the decision-making process.

characteristic of human emotional life and interpersonal relationships. Unless we remain sensitive to the rich complexities of human existence, our attempts to regulate ethics may ironically protect our cherished notions of rationality more than the experimental subjects who can never quite conform to our ideals. Paternalistic attempts at protecting such subjects may be motivated more out of guilt or fear of our own irrationality than a willing interaction or partnership. Prohibitive regulations may exclude a psychiatric patient rather than mandate the difficult task of making human contact.<sup>31</sup>

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<sup>31</sup> There is a stark contrast between the flagrant irrationality of the psychotic and the appearance of rationality in those who are only minimally neurotic. Often psychotics are referred to as "orphans" or "therapeutic orphans" when deemed incapable of participating in ordinary human affairs including giving informed consent. This metaphor is illuminating because it suggests estrangement from the human family as well as somewhat arbitrary notions as to what might be required for inclusion. Indeed the notion of "orphanage" from a "family" suggests that a look at the early expectations in family life is warranted.

It may seem an obvious truism to say that an adult thinks differently from a child or that a psychotic thinks differently from a sane man. But unless a sane adult can recognize or recall antecedents of his own world-view in that of the child or psychotic, he has little hope of being able to communicate with that person.

Respect for autonomy that does not respect fiduciary interaction may be a confusion of "autonomy" with "autism" and "solipsism." If subject and object are seen on different levels of human value, there is no prospect of mutuality. As Hans Jonas has said, "Not that anyone but a madman has ever taken solipsism seriously: arguing for it, except in soliloquy, is to acknowledge the "other" whose consensus is sought. The argument is then frivolous, quo dialogue, while absolute monologue is the madman's privilege." [Hans Jonas, The Phenomenon of Life (New York: Harper and Row, 1966), p. 32.]

In common practice the transaction of informed consent is seen as an instantaneous event, which occurs once before the start of the experiment or procedure and is conditioned temporally only by the statement that the patient/subject is free to withdraw at any time. The establishment of a trusting relationship is never a static event, but rather endures through time. The unrealistic thinking of a psychotic may not be a global phenomenon, but may be limited to certain periods of time or to certain aspects of a patient's mental life. It is seldom an all-or-none, either-or phenomenon.

In psychotherapeutic work with psychiatric patients, the establishment of a trusting alliance is one of the first tasks in therapy and one which endures as prerequisite for all the work that occurs in the psychotherapeutic relationships. The working alliance of the psychoanalyst and the neurotic analysand may be considered as a prototype of an idealized understanding of informed consent in any context. Here the "experimenter" and "experimental subject/patient" have one overriding goal in their joint work together, which is to understand as much as possible of the motives of the life of the latter. The ambiguities of communication are taken with utmost seriousness and respect. The over-determined as well as self-determined quality of human action is appreciated in each step of self-understanding. The

psychotherapeutic partners recognize that an articulated statement may have many levels of meaning, conscious and unconscious, and that not all can be appreciated simultaneously. Informed consent in the psychotherapeutic experiment occurs not once, but continually, as the partners work together to bring into conscious awareness that which had hitherto been unknown.

The transaction of an informed consent invariably relies on the use of language, which is meant to clarify, but which might also confuse or conceal. Unless one assumes that an articulated statement can be understood literally, it is always a challenging task to discern meaning in what people say. This is especially the case with psychiatric patients. When a hospitalized patient announces that he wishes to be discharged immediately to attend to important business matters, he may be responding to mundane necessity or he may be manifesting psychotic grandiosity. His statement of intent may be a veiled test of his physician: "Do you really care about me?" Or his statement may be a realistic protest of his incarceration.

The following example illustrates the difficulties of attending to the meaning in articulated statements, when such statements contain manifest ambivalence:

Mrs. J. was admitted to the plastic surgery service of a teaching hospital for skin grafts on an ulcerated foot. She was transferred to the

psychiatry service when she became disoriented and disruptive at night. She was brought to a teaching-working conference where the residents and medical students met and interviewed the patients of their colleagues, whom they would care for evenings and weekends in a "group practice" arrangement. Medical student A was designated to interview Mrs. J. The interview went something as follows:

Medical student A: Good morning, Mrs. J., could you tell us something about how you came to be here and how we might be of help to you?

Mrs. J.: I don't want to be here and I don't want to answer any questions.

Medical student A: How long have you been in the hospital?

Mrs. J.: Don't talk to me.

Medical student A: Have you been told why you are on the psychiatry service?

Mrs. J.: How would you feel if someone made you come to this conference?

Medical student A: I think I know how you feel. (Pause) Are you married?

Mrs. J.: (Angrily) Don't you think that's a little bit personal, Sonny?

Medical student A: Would you rather not answer that question?

Mrs. J.: (Pause) I've been married twice and divorced twice.

From that point on, the interview proceed relatively smoothly with Mrs. J. disclosing relevant aspects of her life-history and current situation. After the interview was concluded, Medical student B inquired if informed consent

had been obtained for the interview. Although technically a formal informed consent for an interview is not required, the question was germane, especially in view of Mrs. J.'s articulated statement that she did not wish to be interviewed. However, when offered the option of not answering the question, she chose to answer in personal detail. At least we could say Mrs. J. was ambivalent about the interview, an ambivalence which she disclosed in her manner of relating to Medical student A and which, as it turned out, characterized many of her relationships with other people. Medical student A, by respecting her need for distance and control and by not responding defensively or punitively to the negative side of her ambivalence, was able to establish himself as someone worthy of Mrs. J.'s trust. As Mrs. J. became less antagonistic, she was able to acknowledge her fears of surgery without becoming overwhelmed by them. When it became necessary for her ulcerated foot to be amputated, she was able to accept some emotional support from her physicians and family and make realistic adjustments to her changed life-situation. Although there was no correct solution to Medical student A's dilemma, the interview could have been terminated for lack of adequately informed consent. He would have technically protected Mrs. J.'s rights, or at least her prerogatives, thereby missing an opportunity for a therapeutic encounter.

## VIII.

The act of obtaining an informed consent involves us in two contradictory movements simultaneously. On the one hand we strive for a conceptual clarity in the full disclosure of the enterprise for which we wish to obtain consent. On the other hand we abandon such abstract clarity on behalf of the person from whom we wish to obtain such consent: the form must be understandable. As long as our criteria of adequately informed consent rest on the information transmitted, only a case by case review will strictly satisfy our demands, yet from a practical standpoint this is unrealistic.

Therefore the trust of a fiduciary relationship as the ultimate criterion of an informed consent has been stressed with the full realization that such trust can never be measured or quantified. The model of such a relationship is the doctor-patient relationship, where the doctor's interest is to serve the needs of the patient, and the patient's interest is to participate in his health care. This is symbolized for modern medicine in the patient-benefit tradition of the Hippocratic Oath. The physician-scientist, however, has a conflicting loyalty to the outcome of his investigation; he is committed to search for the truth. For this reason his trust cannot be assumed. It may then become necessary to separate the roles of the physician-friend and the physician-scientist in

obtaining informed consent.<sup>32</sup>

If we keep in mind the simultaneous movements in obtaining an informed consent, the basis for separation becomes evident.

We have

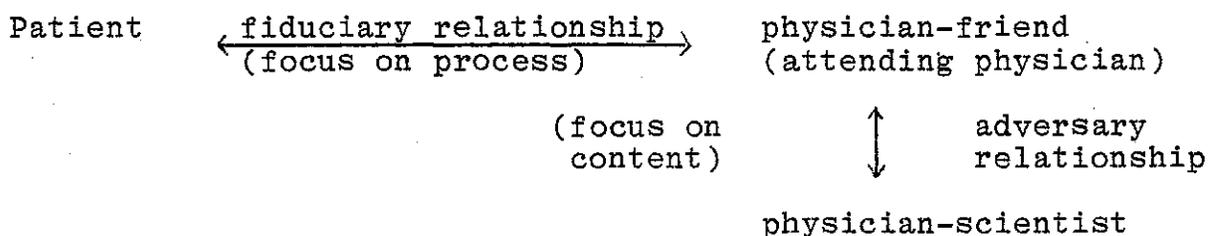


Figure 12

or more generally,

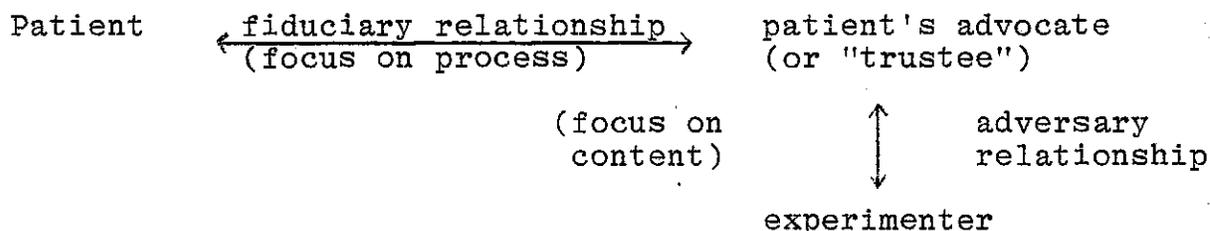


Figure 13

Informed consent is thus formally a two-step process recognizing the two movements that inevitably occur in obtaining an informed consent. In formalizing this as a two-step process, we avoid confusion as to the relative emphasis on the information and on the content. Both are important but must be handled in

<sup>32</sup> Otto E. Guttentag, "The Problem of Experimentation on Human Beings: The Physician's Point of View," Science 117 (1953):205.

different ways. The patient is not required to negotiate in both an adversary and a fiduciary mode simultaneously, which might be especially difficult if he also felt himself to be dependent on that same person for his health care.

The notion of informed consent has evolved into a central position in our medical and scientific procedures involving human beings. It serves to focus our thinking and practice on the ethical dimensions of our activities. Obtaining informed consent is problematic with psychiatric patients for the same reasons that all our dealings with psychiatric patients are problematic. It is the focus on informed consent which forces us to rethink our value of rationality, our tradition of intellectual clarity, the ambiguities attendant to communication through the symbolism of language, and how we deal with ambivalent affects. In so doing we might decide to disenfranchise those dissimilar from ourselves, or we might come to recognize something of ourselves in the psychiatric patients with whom we are concerned. This may be a humbling experience, especially if our concept of ourselves has tended to stress the cognitive side of our being, but it may be a humanizing experience as well. The view of informed consent stressed here has emphasized the relatedness of people more than their autonomy. This approach brings us into closer proximity with human suffering than may be

comfortable, but it seems at least a minimum ethical requirement for participation in those procedures for which we have come to expect an informed consent.

#### IX.

In this chapter a number of ethical issues have been examined in order to demonstrate the impact of the Cartesian outlook on medical ethics. The Cartesian approach, with its split of the person into mind and body and its demands for conceptual clarity, explicitness, and perfection, predispose us to an impersonal view of medical practice and of medical ethics. This approach places the emphasis in ethics on establishing policy over personal reflection and the need to establish a sense of personal responsibility.

In the ideal sense responsibility should be shared between physician and patient in their partnership. It must be acknowledged, however, that the Cartesian outlook is so pervasive in our culture that it is often hard to imagine a trusting, fiduciary relationship between doctor and patient, and even harder to effect and sustain such a relationship in actual practice. For the physician the Cartesian outlook eliminates the affective dimension of personhood and leaves the patient as a thing of nature to be understood physically and controlled. Though the intent is to control the thing-ness of the body, it is often experienced

by the patient as an attempt at subjugation. For the patient, the Cartesian outlook has equally disastrous consequences because the denial of affective life has all but eliminated any effective vocabulary for communicating personal experience or moral concern. Feelings, for example, are spoken of as abstractions, "anxiety," "sadness," "joy" with hardly any reference to the body which senses: "gut reactions," "pains in the neck," etc. Thus someone who doesn't feel good, may take these concerns to the physician asking for help, a request which is translated symbolically into a physical concern, a concern with the body as the only tangible manifestation of the person.

It might, therefore, be hoped that the teaching of the humanities and ethics might restore the influence of the humanistic tradition in medical education. But an approach to ethics which relies on the same epistemological foundation not only does not offer the prospect of rehabilitation, but will likely make matters worse by narcissistically and perfectionistically holding ideals as imperatives which no human being could meet, by accepting medical practice as inevitably technological manipulation, by ignoring the ambiguities of the personal, historical, and cultural dimensions of the medical encounter, and even at times preempting any attempt at mutual understanding, trust, shared concern and partnership by inserting an adversarial thrust in vain hopes of achieving the

kind of explicit clarity that science, improperly understood, is presumed to offer.

Polanyi refers to this process as moral inversion. In the liaison between facts and values, values are the illegitimate bastards and scientific facts are the true offspring because only scientific facts can be accredited by the regnant Cartesian epistemology: only facts can be consensually validated. Thus, as we have seen in so many examples--reducing medical costs, maintaining patients' civil liberties, avoiding lies--very legitimate values are justified by appeal to purported facts. In such dynamo-objective couplings, we are able to look at the supposedly objective facts, but have great difficulty in looking at the moral dynamos which stir persons to action.

The difficulty of assessing moral inversion in our pluralistic society (cultures) is that without a homogeneous community, the individual is left without clear-cut moral guidelines. What is moral in one culture, might be immoral in another group or subculture. The once nomadic Navajo value self-reliance and autonomy; the communal Hopi abhor individuality and refuse to distinguish themselves. In face of such pluralism, each patient may represent different cultural values, assumptions, and expectations. How would it be possible to say that morality is inverted in such a situation,

when it is so difficult to say what morality is? In our discussions to this point it has only been possible to recognize the workings of the dynamo-objective coupling, then infer that where the dynamo-objective coupling exists, morality may also be inverted. We must now take a closer look at the dynamos that stir controversies in medical ethics to see if there is anything that it may be said about moral realities in medical practice which might serve as guidelines for the self-accrediting judgments which physicians must make if their practice is to be at all responsible.

## EPILOGUE

### THE RESPONSIBLE PHYSICIAN

Medical ethics focuses on the moral obligations of physicians in attempt to provide prescriptive guidelines for situations of moral ambiguity and conflict. One of the serious shortcomings of medical ethics in the standard account is the focus on the implications of particular actions without adequate attention given to the context in which the actions occur. Notably the physician's actions occur in interaction with a patient who is unique and cannot be generalized as if to say physicians should treat all patients in a certain way. The practice of medicine relies so heavily on the knowledge of that physician about the unique situation of each patient that any attempt to isolate the doings of the physician from the knowings of the physician, to isolate action from thought, falsifies the physician's understanding of himself or herself as a moral agent, acting in a cultural situation. Polanyi says of his efforts in Personal Knowledge to redress this imbalance

The attempt made in this book to stabilize knowledge against skepticism, by including its hazardous character in the considerations of knowledge, may find its equivalent, then, in an allegiance to a manifestly imperfect society, based on the acknowledgment that our duty lies in the service of ideals which we cannot possibly achieve.<sup>1</sup>

For the physician moral obligation lies in the response to the patient who appeals, requests or demands help from the physician. Though it is possible to conceive of medicine in impersonal and technical terms, in actual practice, medicine inevitably and fundamentally involves the relationship of the doctor with the patient.

It is an idealization to speak of the relationship as a fiduciary relationship, a trusting relationship. The physician should strive to be trustworthy and to trust and so should the patient, but, of course, not everyone is equally trustworthy and equally capable of trusting. Furthermore our culture holds a conflicting ideal of abstract and completely specifiable knowledge, based on systematic doubt and skepticism, which verges more than occasionally on suspiciousness when our relationships with other people follow our attempts to understand the impersonal world, that is, when we view people as things. Thus the patient may become a thing to the physician, especially in the brief encounters so prevalent in modern medicine, where only a short segment

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<sup>1</sup>Polanyi, Ibid., p. 245.

of the patient's life is known to the physician, the history of the present illness. Also in face of the increasing litigiousness of our society, which also may be a result of greater impersonalization and erosion of stable communities in which one is known to others historically, the physician may feel forced to practice defensive medicine, ordering additional X-rays and lab studies "for medical-legal reasons" to "objectively" document findings in a way which would satisfy a court's standards for evidence, even though physical examination and analysis of the history of the symptoms might provide adequate basis in clinical judgment for deciding on a treatment approach, if only the interest of the patient were at stake.

A decade ago and throughout the history of medicine, physicians expected and were expected to be "paternalistic," to take responsibility for patients, to take care of them, even--and here is the problem--to decide on their behalf.<sup>2</sup> This nurturing aspect of medicine might equally well be called "maternalistic," even though most physicians have been male. Nonetheless the past decade has witnessed a dramatic rethinking about the attitude of paternalism, so

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<sup>2</sup>There is an important difference between the legal and medical concepts of trust. In law, a fiduciary stands for the client and decides in the client's best interests. In medicine, the physician is expected to decide in partnership with the patient.

that today paternalism has become a dirty word, and physicians, who once would have been concerned about being inadequately paternalistic and felt guilty about not doing enough for their patients, now are reluctant to assume this role for fear of being resented for their efforts. This development is not to be deplored insofar as it serves to provide greater equality of epistemological peers in the health-care partnership, but just as excesses of paternalism must be kept in check, so also any attempt to make adversaries of physician and patient must be carefully scrutinized.

An example from a medical student paper will help focus the concerns young physicians are facing:

A 12-month-old baby was brought into the pediatric surgery room by his mother with a two day history of fever, crying, and decreased appetite. Over the last several hours he had become increasingly irritable to the point that he could not be comforted by being held. He also resisted any efforts to move his head. On closer examination he was found to have an ear infection that had apparently developed into meningitis. Effective treatment required hospitalization and intravenous antibiotics. If accomplished rapidly, one is virtually always assured of a quick return to health without any aftereffects. In this case the mother was 15 years old, below the age of giving consent for her child although she desired treatment. Attempts to find the baby's grandmother were unsuccessful at first until neighbors finally located her at a tavern. Although she was not drunk, she was outraged that no one had informed her that "her baby" was being taken to the hospital and refused to give her permission for any intervention. After much persuasion, we finally succeeded in obtaining her consent. But in its absence, we were certainly prepared to admit the child, even if it meant

securing the assistance of the hospital police to restrain the grandmother.<sup>3</sup>

The legal implications of conflicting rights and responsibilities complicate this case. Who really has and should have the right to consent or refuse to consent in this situation? The inevitable "paternalism" concerning the welfare of an infant is evident here. This student goes on to speculate how things might have been different if the patient were a different age:

I have often wondered what I would do in a similar situation involving a 24-year-old with probable meningitis who refused admission for himself because he wanted to die. Considering the probable results of no treatment, I'm sure that I would be prepared to take the same action. In the case of a 65-year-old with widely disseminated cancer and a similar infection, I might be more inclined to honor his refusal of treatment.

These situations, which are by no means uncommon, pose some very important dilemmas for the physician, for the ethicist, for the law, and for society in general. Our idealized understanding of the working of informed consent presumes a rational (adult) mind, or in the case of an incompetent patient, a rational guardian. The grandmother,

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<sup>3</sup>Allan Crimm and Raymond Greenberg, "Reflections on the Doctor-Patient Relationship: Paternalism and Autonomy," presented at the Fourth Undergraduate Bioethics Symposium, Duke University, February 25, 1979.

whose legal right it was to consent was not acting rationally; she was offended because of an irrational claim she felt she had on her grandchild as "her baby." Yet if we know this family as people, we might find some legitimacy in the grandmother's claim as the one who in fact was parenting the baby. The medical student says he would be inclined to take the same action with a 24-year-old who wanted to die, presumably because the wish to die (in someone so young and otherwise healthy) could not be fully rational. In practice the physician would not likely make such a decision without the consultation of a psychiatrist to determine whether the patient were truly depressed, and the wise psychiatrist might avoid initiating legal commitment in attempt to ally the patient in discovering more hopeful options. Such speculations notwithstanding, the physician or student physician cannot be faulted for his concern for the patient, but might be faulted for attempting to enforce treatment on a supposedly rational adult.

It is here that the issue of patient autonomy becomes crucial for understanding how to practice medicine and how to reflect ethically on that practice. Patient autonomy and patients' rights are hot affective issues in contemporary medical ethical debate, and rightly so, for they identify concerns in our culture which go beyond the scope of medical practice.

Autonomy and paternalism are viewed as antithetical, mutually exclusive attitudes in medical practice and medical ethics. The paternalistic physician is seen as limiting patient autonomy; the autonomous patient is seen as not needing to be dependent on the physician. What is missing from this analysis is the dimension of time. The static formulations of physician as paternalistic or of patient as autonomous are characterizations that may approximate a given person at a particular instant, but say nothing about their relationship over time, its possibilities for change as the physician confronts the patient about undue dependency and unwillingness to get well, as patient confronts physician about undue withholding of information, as they get to know each other and engage in dialogue, assessing and reassessing each other's needs and resources. It is this dynamic mutuality which may be said to characterize medical practice in the ideal sense of a mutual partnership between physician and patient.

The complicating factor in this equilibrium is the issue of dependency. The patient may wish for dependency and at the same time fear it and so may the physician. The wish/fear and the psychological defense against it/them may be so close as to be almost indistinguishable. It therefore makes sense to keep autonomy in mind as an ideal, not as an imperative

to be administratively regulated. The physician does not refuse the patient's dependency wishes, but neither are those dependency wishes unduly gratified, but rather they are temporarily accepted as part of the patient's sick role with the autonomy of the patient the telos of the therapeutic approach.

The choice of the terms "autonomy" and "paternalism" and their opposition is somewhat unfortunate. "Autonomy" has too much the connotations of isolation and defensive, even defiant, refusal to affiliate with others. "Paternalism" has not only the masculine connotation, but the pejorative sense of authoritarianly controlling another. It might be better to coin the neologism "parentalism" for the more caring and nurturing aspects of the doctor's concern for the patient. Just as the responsible parent(s) do not forever keep their children dependent on them but rather help them move toward independence, self-reliance, and autonomy, so the responsible physician accepts that at a time of illness the patient must inevitably be temporarily dependent on the physician as a person and on the skills the physician possesses, this neither implies that the physician is an omniscient/omnipotent god, nor does it imply that the physician must or should accede to the patient's every wish and demand.

Another example will serve to illustrate the importance of the dimension of time in caring for patients and subtle but important distinctions in caring for patients as persons, not things. In distinguishing disease from illness, we found there were people who experienced illness for whom no disease could be found. These people, identified as "hysterics," often seek dependency gratification and find that as patients they are able to appeal to the nurturing inclinations of family and physicians in ways that they (unconsciously) feel would not be possible for them if they were not "sick". Another group of patients is equally confounding for physicians, the group for whom disease is discovered, but illness is not experienced and who deny any need for help. The following case is representative:

A 42-year-old business executive is diagnosed as having hypertension at a routine physical examination. The executive is a vigorous and successful person for whom everything has gone well, he feels because of his diligence and hard work. He was a successful student and athlete at an Ivy League college and rose to a major position in his company in a short period of time. He values self-reliance and industry. Though his work is stressful, he feels it causes him no undue problems and has been handling the responsibilities of his promotion without apparent difficulty.

The physician discusses with him the need to "slow down" and to change his lifestyle, and prescribes for him an antihypertensive medication, which he must take twice a day. They agree to a follow-up appointment six weeks later.

The executive does not keep the appointment, but four months later, he returns with increasingly severe headaches. The hypertension has become worse as manifested by both a higher blood pressure and perceptible symptoms.

This situation is common and perplexing to physicians and epidemiologists and there is a vast literature about the "non-compliant patient," which shows interestingly that there is no single personality-type that can be identified as a non-compliant patient.<sup>4</sup> The 42-year-old executive is in many ways the opposite of the hysteric seeking dependency gratification through illness. He denies whatever dependency needs he has including the very real need for help in "managing" or treating his life-threatening disease/illness. The fact that non-compliance is so widespread suggests that it is not a manifestation of a particular psychopathology but something universal in human experience. Again the presumption of human rationality is called into question, because if it were simply a rational matter, then the epidemiological arguments of the decreased longevity which accompanies hypertension and the relatively straightforward pharmacological means of treating it should make an impact on at least sophisticated patients like the executive and should be within the intellectual grasp of most people.

Obviously this is not simply a matter of rationality. The treatment of hypertension is a physiologically straightforward matter, but the treatment of a person with hypertension is much more complex. The decision of the patient to comply

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<sup>4</sup>J. Houpt, C. Orleans, L. George, and H.K.H. Brodie, The Importance of Mental Health Services for General Health Care. (Cambridge, MA: Ballinger Press, 1979), p. 203.

or not to comply with the physician's recommendations is not a decision that is made at any given instant, but a decision which is made time and again as the patient remembers or forgets to take the medicine. It is a temporally enduring series of decisions which involves not only epidemiological data and concerns about health and longevity, possibility of symptoms and ultimately death, but also perception of oneself, a perception which may be altered by the physician's act of disclosing a diagnosis: "You are no longer a healthy person."

Thus the diagnoses of disease, even if not perceived as an illness may involve a sense of loss for the patient, the loss of one's identity as a healthy person. Following such a diagnosis the patient may have to grieve the loss of the former self, following stages similar to those someone might pass through after the death of a spouse: denial, anger, possibly depression, before coming to accept the loss.<sup>5</sup>

We can see that the 42-year-old executive with hypertension may be grieving the loss of his identity as a healthy, self-reliant, young man. The first stage of that grief is denial, probably at an irrational and unconscious level, reinforced by the fact that initially he experiences no symptoms. Were the physician sufficiently attuned to the biological-anthropological medical model, he might schedule an early return visit, anticipate the denial, and be prepared to help the patient voice his anger and frustration. Too often physicians (and nurses)

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<sup>5</sup>George Engel is also helpful on this point in his discussion of when grief is an illness. See Engel, *Ibid.*

discourage expressions of anger, which may be unfairly, or at least unreasonably, directed at them and their efforts to be helpful, and too often patients are reluctant to express anger, particularly towards someone on whom they may be dependent, for fear of being rejected. It is then that depression may become manifest, if the nature of the human experience of loss has not been discussed and clarified. Only then is it possible for the patient to accept the unpleasant reality and take whatever steps with the physician-partner which may be necessary to control the disease.

I offer this example in rather elaborate detail in order to demonstrate the richness and complexity of events which may develop in the doctor-patient relationship over time. Even so straightforward a problem as hypertension cannot rest on a treatment approach determined a priori because both the disease and the patient who suffers with it are uniquely unpredictable. The physician must participate in the history of the patient and share it with the patient, hopefully changing it for the better in the progression of time. Any suggestion of a contractual model for the doctor-patient relationship, based on patient-autonomy, however desirable this is as a partial ideal, is ultimately misleading and limiting.<sup>6</sup> Any attempt to specify the particulars

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<sup>6</sup>See Robert Veatch, "The Medical Model: Its Nature and Problems," The Hastings Center Studies 3 (1973):59-76.

of a contract in advance, however much we are so tempted by our characteristic reliance on the Cartesian demand for explicitness, must inevitably fail because it ignores the richer, more complex, and more encompassing tacit dimension, on which explicitness ultimately depends.

Ethics may be conceived teleologically in terms of the articulation of certain principles which should underly actions, and the effort must be made to attempt to articulate such principles. Ethics may also be conceived deontologically in terms of adherence to certain laws and rules, and certainly laws cannot be flaunted if any stability in civilization is to be maintained. But both the principles and rules arise from a cultural situation, and this must also be understood, acknowledged, and accounted for in any attempt at right conduct.

H. Richard Niebuhr formulates this alternative approach to ethics under the concept of responsibility, which he points out includes the element of response, a response to the actions upon an individual in the cultural situation over time, so that ultimately responsibility involves a dialogue with others in a relationship which changes and develops over time. In summary of his argument he notes that

purposiveness seeks to answer the question: 'What is my goal, ideal, or telos?' Deontology tries to answer the moral query by asking, first of all: 'What is the law and what is the first law of my life?' Responsibility,

however, proceeds in every moment of decision and choice to inquire: 'What is going on?' If we use value terms then the differences among the three approaches may be indicated by the terms, the good, the right, and the fitting; for teleology is concerned always with the highest good to which it subordinates the right; consistent deontology is concerned with the right, no matter what may happen to our goods; but for the ethics of responsibility the fitting action, the one that fits into a total interaction as response and as anticipation of further response, is alone conducive to the good and alone is right.<sup>7</sup>

Neibuhr notes, as I have already suggested, that the question of responsibility is implied in the "primordial action of parental guidance: 'What is the fitting thing? What is going on in the life of the child?'"<sup>8</sup> Similarly the physician must ask at each stage of treatment, "What is going on in the life of the patient? How is this person experiencing his illness and what is his response to my prescriptions?"

Neither the physiologic-technologic approach to medicine nor the regnant approach to ethics fully accredits this personal, responsible, and ultimately moral approach to knowing and doing, to the cultural affairs of human beings including the practice of medicine, the ethical reflection on that practice, as well as the various civic institutions of a culture, science, religion, morality, art, politics, marriage, family, caring for children, any of the affairs of life which bring people into contact and interaction with one another.

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<sup>7</sup> H. Richard Niebuhr, The Responsible Self: An Essay in Christian Moral Philosophy (New York: Harper and Row, 1963), pp. 60-61.

<sup>8</sup> *Ibid.*, p. 60.

Descartes suggested that it might be possible to avoid all ambiguity that such human interaction entails and avoid affective unpleasantness and avoid all dependence on others. It was a false promise, but a wish which mankind was so eager to accept that it was willing to sacrifice, at least from time to time, its sense of historical consciousness, and its sense of self as a moral agent capable of acting in history. The Cartesian outlook, a philosophical abbreviation for all those traditions sharing similar ideals, has never been unopposed. From the laments of Descartes' contemporary, Blaise Pascal, to modern phenomenology, psychoanalysis, epistemological revisionists such as Polanyi, and moral philosophers, such as Gilbert Ryle, John Macmurray, ethicists such as H. Richard Niebuhr, Stanley Hauerwas, there has been a vigorous opposition movement insisting that man continues to occupy a special place in the universe, if not as an extension of God or pinnacle of creation, then certainly as a locus of self-awareness and source of responsible action.

The analysis of medical ethics in terms of the relationship between the doctor and the patient suggests analogous considerations for other of our civic institutions and for other relationships between people, including sexual relationships, marriage, family, and childrearing or parenting, where focus on the rights of individuals without adequate attention to personal responsibility engenders an adversarial stance, which

belies the narcissistic expectations of self-gratification. This departure from a fiduciary partnership substitutes an appeal to "ethics" for a demand made on another. We have come to recognize that not every appeal to ethics is necessarily ethical, and morality can be inverted in the name of morality.

Thus ethics as a discipline shares with medicine as a profession and any citizen of our culture striving to be moral, allegiances to standards which no human being can possibly live up to. This does not mean that anything goes, or that values are just relative. It may be concluded, however, that one should practice ethics, just as one should practice medicine, not with a sense of self-satisfaction, but with a sense of respect for the limitations inherent in the human condition and its accomplishments, and with a sense of humility.

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## BIOGRAPHY

Allen Ralph Dyer was born November 10, 1944, in Bangor, Maine, grew up in Newport, Maine, and graduated from Maine Central Institute in Pittsfield, Maine. He attended Brown University, where he received the A.B. degree in 1967 and the Master of Medical Science in 1970. At Brown he was a recipient of a Noyes Fellowship and was elected to membership in Sigma Xi. He attended the Pacific School of Religion, and was awarded a Certificate of Theological Studies in 1969. He received his M.D. degree from Duke University in 1972 and served as an intern in family medicine, resident and chief resident in psychiatry at Duke. He received psychoanalytic training at the University of North Carolina-Duke Psychoanalytic Institute. He is certified in psychiatry by the American Board of Psychiatry and Neurology (1977). In 1976 he was appointed Assistant Professor of Psychiatry and Assistant Professor of Community Health Sciences (now Community and Family Medicine). He teaches medical ethics and teaches and practices psychiatry at the Duke University Medical Center. He has been involved in activities of the American Medical Association, serving on its Council on Mental Health, and the American Psychiatric Association, serving on its Ethics Committee, as well as the Society for Health and Human Values and the Polanyi Society of the American Academy of Religion.

He is the recipient of the following fellowships and awards: The Kent Fellowship of the Danforth Foundation; The Noyes Fellowship; Halstead; Institute of Human Values in Medical Fellowship; National Fellowship for Medical Education Fellowship; and grants from the Hunt, Biddle, Macy, Commonwealth Foundations and the National Fund for Medical Education. He has published articles on ethics, medical ethics and philosophy of medicine, which include the following: "The Role of Psychiatry in Pediatrics; An Appraisal," Rhode Island Journal of Medicine, September, 1968, pp. 566-569; "Weather Symbolism of the Hopi and Navajo," Archives of the Museum of Northern Arizona, Summer, 1964; "R. D. Laing in Post-Critical Perspective," British Journal of Psychiatry, May 1974, pp. 252-259; "Humanizing Medical Education: Ethical Conflict in Patient Care," addressed to the AMA Congress on Medical Education, Chicago, February 2, 1974, published in Selected Papers of 70th Congress of Medical Education, Chicago, AMA, 1974; "Medical Ethics, the Art and Science of Medicine," Connecticut Medicine, July 1976, pp. 467-470; "Can Informed Consent be Obtained from a Psychiatric Patient? Reflections on the Doctor-Patient Relationship" In Controversy in Psychiatry, W. B. Saunders, 1978; "Is Social Evolution a Moral Inversion?" American Psychologist. August 1978, pp. 768-772; and "Natural Death in Medical Practice," (with William B. Bunn) North Carolina Medical Journal, March 1980, pp. 147-151.

He is the co-editor of two books: The Physician and Child Mental Health (with Herbert Grossman, James Simmons and Henry Work), American Medical Association, Chicago, 1979; and Ethical Dimensions of Biomedicine (with Dennis A. Robbins) to be published by Charles Thomas Publishers, Springfield, Illinois.

DISSERTATION PROSPECTUS

Allen R. Dyer

ALTRUISM AND THE DYNAMICS OF THE MORAL INVERSION

The overall purpose of the dissertation will be (1) to show how the traditions of critical thought have handicapped moral thinking (moral thinking/action) and (2) to call attention anew to the personal dimension of ethics: The conscience of the individual cannot be obliterated by our (collective individual) tendency to objectify thought including ethical thought. I believe this can best be accomplished by focusing on moral development of the individual particularly in adolescence. Here one can see the fusion of cognitive philosophical ideas and ideals with individual personality dynamics in the formation of values.

Ethics is a problematic discipline in contemporary civilization. It is confused and confusing. It has no unifying method--nor could it. It is as diverse as are the people who have thoughts and values and make decisions and take actions. There are as many approaches to ethics as there are systematic disciplines ranging from philosophical analysis through religious doctrine through political action to introspection. In the United States ethical problems are often translated into legal problems, which then become constitutional issues. As necessary as this often is, much is obscured and the very perplexity occasioned by moral

dilemmas suggests a methodological problem. How does one go about doing ethics?

This methodological problem is one that I believe to be central to an understanding of our contemporary world, hence to self-understanding of an individual living in our contemporary world. It goes back to the origins of the critical tradition--perhaps best focused for us by Descartes in what has come to be known as the Cartesian method. Although critical objectivity has become for several centuries a social imperative as a criterion for valid knowledge, it leaves the individual person at something of a loss in grappling with moral alternatives. From the perspective of the individual, the critical tradition has left two very divergent approaches to ethics--neither one entirely complete or satisfactory: 1) the systematic articulation of beliefs or values, such things as creeds, catechism, rules and laws; and 2) the critical analysis of such beliefs--either as they are articulated or as the articulation is implied in action.

Both of these approaches are incomplete and inadequate as a methodology for ethics and both for reasons which go back to the tension between inner experience and external reality--made more difficult for the individual by the force of the critical tradition. Both Polanyi and Freud in their own ways have tried to remedy the excesses of critical thought and point the way for a methodology of ethics. Polanyi<sup>1,2,3</sup> by calling attention to the tacit dimension of thought and Freud<sup>4</sup> by calling attention to the unconscious have both indicated that there is more to ethics than can be apprehended by the critical tradition.

The workings of the individual human mind are, of course, very subtle and may seem very obscure when compared with broad social and political issues even though such public affairs are comprised of the actions of many individuals in aggregate. This point, though obvious, needs to be stressed because it is difficult to keep such diverse perspectives, individual and social, in focus simultaneously. Therefore some device is necessary to call attention to much of the utter madness which passes for social debate and ethical discourse in quasi-objectivist fashion. Here again both Polanyi and Freud offer useful conceptual tools for understanding how ethics can go awry in an objectivist age.

First Polanyi--In describing to the moral inversion, Polanyi has called attention to a uniquely modern phenomenon by which moral passions may actually be channeled into immoral actions. This comes about he observes when an individual is unable to meet the high ideals of (Christian) morality. Such an individual imbued with the demands of critical objectivity sees such moral perfectionism as hypocritical (literally less than critical) and repudiates it in the name of something honest, authentic or real. Often this may be some social cause which derives its merit from simplification of a complex situation or it may be an utterly gratuitous act, which has nothing more to commend it than the fact that it is indeed chosen.

The list of examples is long and illustrative and may serve as a sensitization to the presence of the moral inversion and the complexity of the ethical issues our society faces--Polanyi's key example is the dynamo-objective coupling of Soviet Marxism, which he uses to illustrate

the proximity of morality and politics and the close and reciprocal workings of moral passions and an objective view of reality. Existentialist literature offers numerous examples in which gratuitous acts affirm the reality of the individual who would otherwise be or feel dehumanized in an objectivist world. Dostoevsky's Raskolnokoff is a prime example. By murdering the old woman for no reason he can order his otherwise senseless existence. Gide's Laffadio similarly vindicates himself by pushing a man off the train, thereby killing someone who has offended him. The moral inversion is so prevalent in American cinema as to be commonplace. Unlike television where the forces of good must triumph punctually for commercial sponsorship, the cinema extols its anti-heroes; the good guys are the bad guys, who are admired for their audacious defiance of seemingly hypocritical social convention. Butch Cassidy and the Sundance Kid rob banks for the sheer fun of it. Bonnie and Clyde perform the same crimes to overcome impotence. In Clockwork Orange, an honestly self-serving psychopath is attractive when compared to the morality of the behavior modifiers for whom behavioral ends justify cruel means. In The Godfather we tolerate ruthlessness and violence for a view of intimate--rather than stereotyped--family life.

Two further examples, perhaps more subtle and complex, illustrate the workings of the moral inversion and the subtle complexity of modern moral and social life. These two examples are 1) the anti-psychiatry movement and 2) the sociobiology movement.

1) The anti-psychiatry movement. R. D. Laing,<sup>5</sup> David Cooper,<sup>6</sup> Thomas Szasz,<sup>7</sup> and others have criticized psychiatry for its failure to give attention to moral values. Psychiatry they say has become a repressive

social agent as may be witnessed by such things as enforced treatment and involuntary hospitalization, which should be done away with. The anti-psychiatry movement is an example of a critical approach to ethics, the criticism of an articulated or implied moral position. Psychiatry as a profession is vulnerable to this criticism because its ethics are implicit, tacit, sometimes unconscious, and usually tied up with social consensus of how much deviant behavior is tolerable in a given community. Civil rights, human rights, and personal rights are often the vehicles of calling attention to such value controversies. The Soviet treatment of political dissenters by psychiatric detention is an extreme example of the interconnections of shared social beliefs and psychiatric practice, but probably has more in common epistemologically with American psychiatry than advocates of human rights would care to acknowledge. Both are thoroughly modern in their camouflaging of social beliefs with scientifically objective facts. Neither system fully accredits individual responsibility in decisionmaking nor attempts a systematic articulation of moral principles. The moral passions of the antipsychiatrists, however, become inverted in a passionate therapeutic nihilism which would destroy anything short of perfection and along with it the possibility of genuine moral enrichment.

2) The sociobiology movement. Sociobiology<sup>8,9,10</sup> attempts to account for altruistic behavior on the grounds of species survival and adaptation--natural selection. It thus argues--primarily by analogy to social insects and entirely by analogy to non-human species--that morality is explainable in terms of biology--not individual choice. In essence altruistic behavior

(i.e., that behavior in which an individual risks himself for the survival of the species) is substituted for what we usually call "altruism"--a process which Polanyi calls a "pseudo substitution". Hence any manifestation of altruistic behavior we see is behavior which has survived and hence furthers the ends of social evolution. This tautology would be moot and trivial except for the very real and present confusion it engenders in moral thought. We might just distinguish the two altruisms: altruism I = old-fashioned moral self sacrifice and altruism II = behavioral altruism, the former explainable only in terms of complex processes of human thought, the latter in terms of nucleic acid metabolism. The sociobiological confusion of beliefs and actions is too ominous, however, by its implication that there is no other justification for moral action (moral behavior) than species survival. Donald Campbell<sup>11</sup> suggests that sociobiology provides scientific justification for traditional moral values. I maintain that such circumlocutions obscure rather than justify moral values. (See attached paper.<sup>12</sup>)

Both the anti-psychiatry movement and the sociobiology movement provide a useful service. They call attention to the way critical thought has shackled moral thinking and made it almost necessary to stand on one's head to raise a moral question. Sociobiology makes another contribution. It reminds us that it is essentially the values of altruism that are inverted in the process of the moral inversion and that altruism is not what it appears to be or claims to be.

What altruism is should be stated and stressed. Altruism is an ideal, a standard of human moral perfection, which can be approached but seldom attained. Critical thought shackles morality by making this appear hypocritical and hence hinders individual moral development.

A review of the place of altruism in ethical tradition would be useful here--Louis Budd's excellent history would be one source. Freud's<sup>14</sup> critique in Civilization and Its Discontents is another. Reinhold Neibuhr recognizes this tension in Christian Ethics when he speaks of the law of love as an impossible possibility.<sup>15</sup>

It is here that Freud's contribution may be helpful in his contribution of a methodology. His scientific language of dynamics is problematic, but his rigorous insistence on the importance of pre-rational experience of children on the development of the adult mind is indispensable to the understanding of moral decision-making in general and the moral inversion in particular.

Three lines of development may be seen at operation in the dynamics of the moral inversion: 1) The libidinal or object-relational. 2) The narcissistic (self), and 3) the cognitive. These developmental forces are not mutually exclusive, but rather mutually reinforcing accounting for the overdetermined complexity of moral actions.

1) Libidinal or object-relations development:<sup>16</sup> This line of development explains the reversal or inversion itself. Such reversals of impulse are common in relation to other persons (called object relations). One impulse may serve as a defense against its opposite and often occur

in pairs such as sadism--masochism; scotophilia-scotophobia; leaving (rejecting) before one can be left or rejected; counter-phobic activities as a defense against or denial of the fear itself; and particularly phallic assertive activities as a defense against the fear of castration. However, such defensive reversals are usually mastered and overcome in the process of normal development, and particularly the development of the superego should prevent any inversion of morality unless there is some underlying problem.

2) The narcissistic line of development<sup>17,18,19,20</sup>--development of the self. Impediments for this line of development explain how the superego could be impaired sufficiently to tolerate a moral inversion. Even before the infant perceives himself as separate from his mother--and hence able to relate to her as a separate person (object), he is beginning to form an experience of self. The self of the young infant is egocentric and based on the satisfaction of basic biological urges--hunger, attention and the like. As long as these urges are gratified, the infant perceives himself as omnipotent, i.e., having the power to influence the world around him. This state is referred to as primary narcissism. As the individual separates and individuates from his mother, he realizes that it is not he but she who has the power to satisfy his every want. She is then seen as omnipotent, but the reality principle gradually dispels this notion. Realizing that his mother is not always available to him, the infant now forms an ideal of what he would like to be (i.e., omnipotent like his parents.) The love he had originally invested in himself, then

toward his parents, he now turns toward this new and better possibility of self, the ego ideal. This state is referred to as secondary narcissism.

It is the vulnerability occasioned by the discrepancy between the ego ideal and one's actual strengths and attributes, intensified by the demand for perfection, that gives rise to the frustration and rage which reinforces the moral inversion.

How this happens requires an understanding of cognitive development and the impact of the critical tradition and an individual's concepts of morality. Reason itself may be understood as an ego idea--never in fact quite attainable and only approximated at the cost of isolation from the self, i.e., from the feelings and passions which are as much a part of human actions as abstract ideas, never completely explicit; never completely conscious.

The dreams and ideals of Descartes<sup>21</sup> may themselves reveal certain narcissistic themes as well as certain obsessive-compulsive themes and the impact of these striving on subsequent generations bears close scrutiny for preservation of moral health.

3) Cognitive development. The development of ideas of right and wrong has been carefully studied by Piaget<sup>22</sup> and applied to moral development by Kohlberg.<sup>23</sup> According to Piaget a process of social control through critical sensibility occurs about twelve years of age,

At this time

the child achieves the [Cartesian] cogito and reaches the truths of rationalism. At this stage...he discovers himself both as a point of view on the world and also as called upon to transcend that point of view, and to construct an objectivity at the level of judgement.

The cogito thus becomes the child's passport to adult society. As he learns the rules of his culture by living them, he develops a critical sense. Thus supported by the norms of his group, he acquires a sure standard for judgement. And as a self-assured judge, one is, of course, less vulnerable oneself to a critical assault, which may be perceived as a narcissistic injury thus mobilizing narcissistic defenses and anything which will preserve self esteem--even reversing the judgement itself. "It is not I that am imperfect but those judging me."<sup>25</sup>

Towards a Post-critical Morality of Self-Understanding: Just as we must realize and accept our own limitations we must accept that our social standards will be less than perfect even as we strive for such perfection. We must recognize that even as it is helpful, critical thought is limiting; it cuts with a double edge sword. Our ethics requires not only an understanding of alternative courses of action but also an understanding of ourselves. This task requires an atmosphere of interpersonal trust and conviviality, which is not fostered by the rigid demands of critical thought. It is a task which is familiar to psychiatrist and his collaboration in undertaking psychotherapy and a task which must be addressed by anyone attempting to do ethics.

## Procedures for Approval of Dissertation Topic and Guidance

### I. Approval of Dissertation Topic

Each student writing a dissertation must receive his doctoral committee's approval for the proposed study. The following steps should be taken.

1. Consultation with principal advisor regarding dissertation topic.
2. Presentation in writing to the advisor of a proposal for a dissertation topic. Where possible the proposal should include:
  - a. A tentative title.
  - b. A statement of the problem to which the dissertation will be addressed.
  - c. A brief statement justifying the topic on the basis of both its significance and its feasibility.
  - d. A tentative outline.
  - e. A brief statement regarding the methodology.
  - f. A basic bibliography.
3. When the advisor approves the proposal, the student submits a clean typewritten copy to the Director of Graduate Studies.
4. The Director of Graduate Studies circulates the proposal to all members of the committee.
5. The committee meets with student to discuss the proposal.
6. If the student for any reason should radically change his dissertation proposal from the one originally approved, he must take the above steps for the approval of a new proposal.

### II. Dissertation Guidance

While the dissertation advisor has principal responsibility for advice and guidance, it is understood that any member of the committee is available for guidance. Each student is urged, and his advisor may require the student, to submit sections of his dissertation while it is still in the process of preparation to various committee members for criticism. Any member may request that certain sections or chapters of the dissertation be submitted to him before they reach the stage of final draft.

Duke University  
DURHAM  
NORTH CAROLINA

AUG 25 RECD

DEPARTMENT OF RELIGION

August 24, 1977

POSTAL CODE 27706  
TELEPHONE 919-684-3301

Mr. Allen R. Dyer  
Department of Psychiatry  
P. O. Box 3838  
Duke Medical Center

Dear Allen:

I enjoyed reading the materials you sent me, especially the article on R. D. Laing. As regards your dissertation proposal, I warm to your project, however, I feel I need to see how your "prospectus" translates into a dissertation outline, or at least, a line of argument.

I have certain concerns. First, Polanyi's reflections on morality are rather scanty, and his discussion of moral inversion needs thorough, critical scrutiny. I for one am scarcely persuaded of his indictment of Marx. What I am concerned for, if you will allow me, is a "critical" use of Polanyi. What do you make, for instance, of the relatively bizarre expression--"moral passion." S. K. would be distressed, would he not, by the suggested confusion of the moral and the aesthetic. In any event, Polanyi's position must be clearly and critically analyzed before engaged in dialogue with psychological analysis of adolescence.

Secondly, I feel you must render some account of the literature in the area of what Harmon Smith would call "moral theology." You need to document your claims that discussions of morality have been crippled by critical thought. Polanyi is not a certified moral philosopher or theologian. You are engaging him at the margin of his competence. Since you are working in "religion," I suggest you focus on "moral theology" as opposed to moral philosophy. Given the scope of your proposed thesis, it would be reasonable that you deal with limited and therefore the most significant representatives of moral theology in the critical period. Evidence of responsibility for this literature is crucial, I feel. A basic bibliography would seem, therefore, to be in order.

Mr. Allen R. Dyer  
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In conclusion I see, more or less, three substantial sections to your dissertation, though not in this order necessarily: 1) Polanyi's views, critically analyzed and presented, 2) illustrations of the limitations of moral theology in the critical period; i.e., a Polanyian critique, 3) Polanyi and psychoanalytic perspectives. Or, are you saying and suggesting something different?

Sincerely,

A handwritten signature in blue ink, appearing to read "Bob Osborn", written in a cursive style.

Robert T. Osborn

RTO:wc

Ethics and morality are pivotal because morality is oriented toward society, either in small one-to-one, family, or tribe combinations, or those reaching outward toward the universal "others". The focus of an individual's sense of obligation may be anywhere from himself (expressing himself as an artist, existentialist, etc.) to the ambitious ideal of the Communist theorists who expect to change the way the world is run. In the latter huge focus, even thousands or more individuals, such as dissenters, do not matter.

Do the ends justify the means or the means justify the ends? The semantic terminology of ethics implies rules which are accepted or rejected in a game-theory of human existence. A common religion might enunciate standards for ethics. A Nihilist movement might establish the lack of morality as an ethic. In a country where organized religion is considered "opium of the people", other explicit standards might become established, such as seeing insanity in non-conformism and disobedience. However there might eventually be a reversal to new standards of what is conformity and insanity in this same country, and this increases suspiciousness and anxiety and therefore repression. The ethical or moral vocabulary has been used for the worst and best of purposes. The concept of the "Superego" is not really a value-judgment but rather a concept of dynamics. It is an attempt to see how things work for individuals and groups. The Superego as Freud conceived it could be at the same time dangerous and salutary, simple and complicated, constructive and destructive, weak and tyrannical. Any further insight into the dynamics of the Superego interacting with current social forces and individual morality would open up new fields of contribution from psychoanalysis.

Milton Miller's response to  
Dynamics of the Moral Immersion  
16 Nov 1977