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WHAT HAS ETHICS TO LEARN FROM MEDICAL ETHICS?

by

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Ethics is a well-established part of the philosophical curriculum; several thousand courses are given on it every year in the United States and there is a general academic consensus on what texts ought to be read, what the central issues and problems are and on the place of the subject within philosophical enquiry and teaching. Medical ethics by contrast is small-scale, riddled with contentiousness, open to every kind of innovation and simultaneously outspoken and tentative in its claims upon the academic world. It is scarcely surprising therefore that many philosophers and some physicians have seen moral philosophy as a soundly based, intellectually affluent discipline whose task it is to bring conceptual aid and comfort to the problem-ridden, uncertain enquiries of medical ethics. The philosophers on this view are to constitute a kind of intellectual peace corps, the medical profession a morally underdeveloped country. Or to alter the metaphor, the philosophers are the blood donors, the physicians, surgeons and nurses the patients badly in need of a transfusion.

I do not want to deny either that there is a crisis in medicine concerning medical ethics or that an important symptom of this crisis is the way in which philosophy is now, in a way and to an extent that would have been quite incomprehensible and unpredictable twenty years ago, being invited not merely into medical schools, but into hospitals. Nor could I deny that whereas many physicians and philosophers jointly recognize a point of crisis in medical ethics, almost no philosophers see anything like a crisis in philosophy, more particularly in moral philosophy. Yet I want to affirm in this paper a conviction that philosophy is in at least as grave a crisis as medicine. We have two crises not one. Should we be twice as pessimistic? The answer interestingly is 'No'. Two crises may on occasion be better than one and this, so I am going to argue, is one of these occasions. For a careful description of the crisis in medical ethics will, I shall suggest, throw a sharp and illuminating light on the crisis in ethics. I shall not be so silly as to ignore what moral philosophy does have to teach medical ethics; but I shall maintain that at this particular stage of their historical dialogue it is medical ethics that has in the main to be teacher, ethics the pupil.

I

I therefore have to begin with a description of the relevant features of the crisis in medicine. That crisis is the outcome of the rapid successive changes in medicine in the last eighty years. In 1900 the percentage of the total mortality in the United States due to the eleven major infectious conditions was over 40%; the percentage due to the three major chronic conditions - heart disease, cancer and stroke - was under 20%. In 1973 the percentage due to the eleven major infectious conditions was only 6%. The percentage due to the three major chronic conditions was 58%. This reversal was itself a major victory for medicine, if we include in medicine various preventive, sanitary and public health measures. Those who once died of diphtheria, tuberculosis or poliomyelitis now live long enough to contract cancer or heart disease. But the definition of the role of the physician in the period in which the battle was primarily with the major infectious diseases rests on assumptions which the victory over these diseases undermines. For it was very natural in that period to think of the physician as an applied scientist whose task was to identify certain chemical or physiological states in the patient and to change or prevent

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those states by chemical or biochemical agents. A patient becomes a locus for diseased or damaged tissue; a patient is nothing but an experimental subject in a hospital bed instead of on a laboratory bench. Consequently the division of labor among physicians is that appropriate to applied scientists and corresponds to the specialization of the sciences. A patient is only the particular instantiation of a set of law-like generalisations, and the physician is concerned only with those law-like generalisations which belong to his particular scientific discipline. There is consequently no more reason for there to be any personal element in the relationship between physician and patient, or rather those parts of the patient allocated to a particular type of specialist under this division of labor, than there is between a biochemist and the culture with which he is experimenting.

The physician thus defined naturally enough contrasts his role sharply with at least three other types of role. The first is that of the nurse. The nurse is concerned with care and effective care is in this type of medicine only a substructure; the patient must be cared for by the nurse, so that and only in the ways that will enable the physician to discharge his function effectively. The role of the nurse is, in this kind of medicine, rightly lower in the medical hierarchy than that of the physician. A second contrast is both with the medical sociologist and with the public health official. The physician, defining him or herself (and in the vast majority of cases in this period himself) as an applied scientist of one specialized type, is concerned with some causal chains, but not with others. The patient may have been infected with a microorganism that is carried by rats and the incidence of rats in a given geographical area may be due to specific social conditions, but the physician thus defined has no concern with social structures and therefore no concern with causal chains which pass beyond the chemical and the bacteriological to the social.

The physician's role was on this view to be contrasted not only with that of the nurse and that of the sociologist, but also with that of the moralist. Qua private person of course the physician may pose moral dilemmas, give moral advice, seek moral guidance; but qua physician he was no more to be concerned with such matters than is the biochemist. He was of course professionally committed to certain values - that of his patient's health for example - in a way which the biochemist was not. But these values rarely needed to be made explicit.

This view of the physician's role never of course completely usurped older conceptions of what a physician was, especially in such areas as paediatrics and family medicine. But between 1920 and 1970 it was enormously influential. Its failure to maintain its ascendancy - and it is important to remember how influential it still is - has only partly been due to the changes in treatment ~~reflected~~ in the large changes in the causes of mortality during this century. It is also of great importance that the implicit values taken for granted in so much modern medicine had to be spelled out and could no longer be taken for granted as a result of the improvements in medical technology.

To put matters oversimply: from Hippocrates until almost the present the three ends of medical practice were highly congruent with each other. To pursue any one of the three generally involved pursuing the other two also. What were those three ends? First to stave off the patient's death for as long as possible; secondly to prevent the patient's suffering pain or physical disability as far as possible; and thirdly to promote the patient's general health and physical well-being. The physician or surgeon presides at our birth and cares for our nutrition, attempts to cure our diseases and to mend our broken bones, and in so doing gives us expectations of a longer life. But with contemporary medicine these ends fall apart. The chronic conditions which require treatment and the technology available as the

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instrument for treatment allows us to continue life in such a way as to prolong suffering or to extend disability. There may be no way to promote my well-being which does not involve bringing about my death at a certain point; it may even be better for me if I had not been born. The physician or surgeon, therefore, pledged by his oath and the tradition of his profession to pursue all three ends now is forced, especially with the chronic conditions, to make choices, choices sufficiently frequent in occurrence and sufficiently harsh in character for moral choice to have become a central medical task.

This thrusting of choice between morally significant alternatives upon the physician has been accompanied by two other changes. First the medical tasks in relation to the chronic condition of the incurable patient reverse the order appropriate to treatment of the infectious diseases. Whereas care used to provide the substructure for treatment, treatment is now a series of episodes within the total pattern of care. Whereas death used to be unambiguously the last enemy, the incurable patient's transitions from one stage to another now have to be viewed as part of his or her total approach to death. And this is not just a reversal for the physician, it is a reversal for modern man. "The free man," said Spinoza, "thinks about nothing less than about dying" and in so saying he was the prophet of those perhaps rather less than free men who removed the skull from the mantelpiece, who ceased to walk in graveyards, who spoke not of "my parents' death" but of "our loved one's passing on", hoping to exorcise the fear of death by euphemism. Medicine, and not only medicine, has been forced to recognize that the incurable patient is a dying man or woman, that many of us are incurable now and that we are all incurable in the end.

Moreover the physician has been compelled to take a wider view of causal chains. Consider for example the role of stress in heart conditions. It turns out that not only the amount of stress but the way in which stress is addressed has a significant effect upon the heart. The physician cannot escape tracing the causes of stress in both the psychological and the social environment.

The morally self-conscious physician therefore finds him or herself immersed in contradiction and incompatibility; for central features of his or her medical situation are at odds with the inherited role which he or she is called upon to inhabit. And this immersion has been largely brought about by the way in which the problems of the incurable patient have become central to medicine. Because the relationship of treatment to care is not what it was, the relationship of nurse to physician cannot be justified in the way that it was. Because the relationship of medicine to moral and social questions is not what it was, the relationship of either nurse or physician to patient cannot be justified in the way that it was. The physician has partly lost a well-defined and clearly legitimated rule and status and has done so just at the time when the moral dimensions of his enterprise can no longer be taken care of by some version of the Hippocratic Oath and the constraints of professional and legal norms. This disruption of the physician's role and the fact that the ends the physician pursues are now often mutually incongruent compel the physician to make important moral choices just when he has been deprived of any well-defined standpoint from which to make them.

It is not surprising that medicine in this state should become overtly and explicitly philosophical. Such questions as those concerning the difference between the relationship of cure and care or what place causal chains have in scientific explanations or what we ought to mean by 'death' have a long philosophical ancestry and these questions are now internal to medicine. Every physician is bound to embody in his practice, whether he likes it or not, whether he knows it or

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not, an implicit answer to at least some of them. Medical men and women have as much chance of not being philosophers as M. Jourdain had of not speaking prose. And the area in which this is likely to be recognized, because of the immediacy of the problems, is that of medical ethics. How unsurprising it is then that recognizing the crisis in his own theory and practice the morally concerned physician should look in the direction of professional philosophy and more specifically of ethics. Alas, what does he find?

II

Twenty years ago philosophy seemed full of promise. The impact of Wittgenstein's later writings was being felt; at Oxford H.L.A. Hart and J.L. Austin seemed to be mining new veins; phenomenology had the achievements of Merleau-Ponty and a quite new impact of Husserl reread; Hegel was being rediscussed; Quine and Sellars had opened up new perspectives; Chomsky had published his first book; in Belgrade and Warsaw and Budapest there was the promise of revisionist Marxism; Sartre was about to synthesize existentialism and Marxism; Goldman and Strawson were both at work on Kant. The only problem for someone of my generation was how to choose between such a dazzling variety of approaches and whether or not all the great work might not have been completed before one had a chance to share in it.

And where are we now twenty years later? Almost in precisely the same place. It is not that a good deal of fine philosophy has not been done, but in nearly all the key problems of the discipline things remain substantially as they were. And this is equally true for very different schools of thought. Analytical philosophy, phenomenology, neoMarxism, the new Hegelianism, the semitechnical programs of modern semantics all share a failure to make good on their earlier promises, even if we judge each project on its own terms.

What is true of philosophy in general is also true of ethics. Analytical, semantic or phenomenological approaches have provided for the most part new vocabularies to express old contentions, old contentions that remain as or more vulnerable than they always were. Our contemporary utilitarians mark little advance, if any, on Sidgwick; our universalisability theorists have provided no answer to Kant's acutest critics; and the two most fashionable and publicity-winning books recently published in the area turned out to be reissues of the most advanced thought of the seventeenth century. The terms one is tempted to use to describe the situation derive from art history: pastiche, eclecticism, mannerism. The sophistication of contemporary vocabulary and technique fail to disguise the fact that a very limited and familiar array of concepts, assertions and problems are being deployed. It is therefore perhaps worthwhile to identify these historically, to ask what is specific to modern moral philosophy (as contrasted with some of its predecessors in other and earlier cultures) in order to discover the source of its poverty. What is it that the diverse points of view in contemporary ethics share?

First of all, there is a certain conception of the moral agent embodying in turn a certain conception of morality. This conception of morality requires that the moral agent be able to free him or herself from all positivity, to stand back from any particular norm-governed institution or practice or tradition, so as to be able to pass judgment upon it from an independent point of view. Qua moral agent therefore the individual is detached from all social memberships, loyalties and circumstances. The moral agent's identity is pre-social; it cannot derive from any social role which he or she happens to fill. For of any alleged moral authority

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embodied in social rules, practices or communities - such as those of church, state, family, school, city, profession - the individual may and must enquire "But do its pronouncements and practices have any genuine moral worth?" Hence the standard of moral worth must be found outside and beyond any concrete human community. The standpoint of morality is, on this view, detached from all social particularity. The moral agent thus has a ghostly, abstract and largely disembodied existence. Like the self in Sartre's philosophy, he or she inhabits any social role only accidentally and contingently, as a visitor, so to speak. He or she can have no ultimately binding social or institutional loyalties. The only desires ascribed to him or her are, or at least are intended to be, culturally non-specific.

A second distinctive characteristic of contemporary and recent moral philosophy is its preoccupation with rules and their justification and status. Modern Kantians, utilitarians and contract theorists differ as to how rules are to be justified and as to what their import and authority may be. But they never seem to doubt that the intellectual content of morality is just a set of universal rules or that moral judgment consists in the application of such a rule to a particular case. Moral problems are conceived as problems of how to arrive at correct or at least justifiable moral judgments, namely which rule to apply in some particular situation where there are competing and conflicting rules. The moral agent is thus both legislator and judge, himself creating by the content of his legislation the dilemmas, the solution of which provide him with his judicial task.

It is important to notice that both the conception of the moral agent as an abstract, non-social universal legislator and the conception of morality as centrally concerned with rules are distinctively modern. Aristotle, for example, is in the Ethics concerned with the good for man as such; but any particular man fails to be man as such if he is not, actually or potentially, the citizen of a polis, that institution without which a man becomes either a god or a beast. Likewise Aristotle in his account of practical reasoning never mentions rules at all. We learn how to make particular judgments by acquiring a grasp of the virtues so that we come to recognize what a courageous or just or generous man would do in a particular type of situation; and the capacity so to judge can never be reduced to the application of any set of rules. This perspective is of course not merely Aristotle's; in his understanding of the general structure of ethics he speaks for his whole culture. And there is yet a third respect in which that culture contrasts relevantly with our own.

Morality is on the distinctively modern view concerned with the question of what particular actions we should perform; to be moral is to accept certain rule-prescribed constraints upon the type of particular action that we undertake. Whereas for Aristotle, as for the ancient and medieval worlds in general, morality is concerned with the character of a whole human life and individual actions are important as they express and as they contribute to that character. Hence for those earlier cultures the question of the relative place of various goods in a whole human life had to be raised, if not answered, whereas this question is scarcely touched on at all in contemporary writing.

Individual agents, rules, individual actions - this triad provides the conceptual iron rations of recent moral philosophy. To this conceptual triad we need to add a thesis: that no satisfactory account of the status of the rules thus conceived appears to be possible. Accounts admittedly abound; but no shared rational criteria appear to exist by appeal to which a verdict on their disputed claims might be delivered. Rule-utilitarians contend with act-utilitarians and both with the heirs of Kant; contract theorists of one kind contend with natural rights theorists of another;

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conflicting syntheses of rival views are not in short supply. It would be a substantial undertaking to go from the simple sociological observation that this is the case to any explanation of why it is so; therefore for the moment I shall only hazard a brief hypothesis. It is that the concepts which inform the crucial major premises of each of the conflicting parties in contemporary moral philosophy are fragments torn from a variety of historical contexts in which they were once at home. In those contexts each - concepts of happiness, of rights, of justice, of rationality - was the part of some larger metaphysical scheme which was left behind as a condition of entering the domain of modern moral philosophy. Utilitarians no longer appeal to Bentham's psychology or theory of knowledge, Kantians do not affirm the existence of a noumenal realm, the notion of justice has been detached from that of a hierarchy of desert. It is, if this hypothesis is correct, small wonder that there is no commonly accepted court of appeal in moral philosophy, for the metaphysical background required to supply it has become unavailable. Yet even if this suggestion of mine is false, it remains a de facto truth that disputes about the status and authority of rules do not seem capable of satisfactory resolution within the self-set limits of recent moral philosophy. It is perhaps a consequence of this that disputes between rival and conflicting rules in morality seem, on the account given of morality within such moral philosophy, to be equally unsusceptible of rational settlement. In debates about the morality of war rules enjoining obedience to the ultimately medieval conception of a just war are contraposed to rules from the Italian Renaissance instructing us to break the first set of rules in order to preserve the state; in debates about abortion claims about the rights of women over their own bodies deriving from Mary Wolstonecraft and beyond her John Locke are met with claims about the taking of innocent embryonic life constituting murder deriving from the Bible. On both sides some rule makes a claim upon us which we have no rational means of weighing against the rival claims of other rules. Thus it seems to be a consequence of the way in which moral problems are characterized by recent moral philosophy that they are in fact rationally insoluble. Some recent moral philosophers, C.L. Stevenson, for example, have accepted this conclusion; others - most others - have resisted it. Here I shall simply have to assert briefly and dogmatically that I do not think that any of them have found the resources to resist it successfully.

III

In the first part of this paper I characterized the present crisis in moral thinking about medicine; in the second part I described the unacknowledged crisis in philosophical ethics. I hope that it will now be clear why medical ethics has very little to learn from ethics. For my claims about medical ethics amounted to this: that the way in which the role of the physician had been put in question by recent developments within medicine and the way in which simultaneously the once congruent goods pursued by medical practice had become incongruent had left the physician with a set of inherited rules which turned out on many types of important occasions to enjoin incompatible types of action. Hence the problems of medical ethics appear as a series of dilemmas in which moral agents look for good reasons to give weight and authority to one rule rather than another in situations of conflict. Consider three familiar types of example.

(1) A physician has a patient whose condition is slowly and steadily deteriorating and who requires treatment to keep him alive. The patient is in quite considerable pain and has a life of very limited activity. The patient foresees a time

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when as a result of further deterioration he will no longer be treated as a fully responsible and rational being, although still conscious and to some degree active. He asks his physician in advance to discontinue treatment when that time arrives. What ought the physician to do?

(2) A physician, for some reason that seems good to him, has instructed a nurse that a particular patient is not to be told that he is dying. The physician sees the patient only for short periods at intervals of some days. The nurse spends several hours close to the patient every day and the patient has come to trust him. The patient becomes increasingly anxious about his own future and asks the nurse whether he is going to recover or not. What ought the nurse to do?

(3) A retired impoverished widower, whose only remaining interest in life is his job as driver of a school bus, goes to his physician for his annual check-up and learns that he has a heart condition of some seriousness. The physician tells him that there is a high chance that he will have a heart-attack and that he must stop driving the school bus. The patient refuses to do this. What should the physician do?

Each of these three types of problems can easily be presented, and usually is presented in the form of a dilemma, that is a problem of choice between contingently rival and competing rules. In the first type of case the physician has to choose between the authority of the rules that prescribe that the physician do everything in his power to prevent death and the authority of the rule that enjoins upon the physician the promotion of the general well-being of his patient. In the second type of case the nurse has a similar choice between the rule that enjoins a nurse to obey a physician's instructions and the rule that upholds honesty in important human relationships. In the third type of case the physician has to choose between respecting the rule that ordains confidentiality between physician and patient and the rule that prescribes whatever action will prevent possible imminent harm to innocent human life, especially that of children.

For each of the six rules concerned it is possible to adduce excellent Kantian-type justification and excellent utilitarian justifications. What we cannot discover, however, within the stock of justifications advanced within recent moral philosophy are any grounds for giving some rules preference over others in any situation in which two or more rules provide conflicting injunctions. We therefore are left with genuine dilemmas: an agent in each type of case considers what to do on a particular occasion and has no means of deciding between rules. This is the form in which such problems are presented in most books and articles on medical ethics. Presented in this form the problems appear rationally insoluble. Presented in this form the problems are rationally insoluble. So the student of medical ethics turns to moral philosophy. What does he learn, if my account of the state of that discipline is correct? That this dilemmatic form is the necessary and essential form of all moral problems as such; that the conceptual resources of moral philosophy can provide no further and more illuminating characterisation of the problems; and hence that the problems are indeed rationally insoluble. Ethics turns out to be barren of insight not already possessed by medical ethics, except insofar as it suggests that the conceptual scheme which dominates it is deeply inadequate. And interestingly in suggesting this it confirms what would also be suggested by considering how these three types of problem have been generated within medicine. For in the all too cursory history with which I began it emerged that such problems had two related sources: they arise partly because the goods pursued by the physician have become to some degree mutually incongruent; and they arise partly because the inherited roles and relationships of medicine have been put in

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question or partially disrupted. Goods, roles, relationships: are these the missing concepts without which the notions of agent choice and rule become morally powerless? This is the question to which the whole argument directs us.

IV

Begin from what must seem at first an almost trivial observation about the third type of example of a problem. If the local School Board insisted on mandatory annual medical examinations by a physician appointed by it for all its bus drivers, the problem for the physician would never arise. A simple change in institutional arrangements would so alter the relationship of physician to patient, would so alter the physician's role, that the circumstances which created the conflict of rules would be eliminated. This suggests two theses in favor of which I shall argue for the rest of this paper. The first is that wherever we are confronted with an insoluble dilemma we should not try to solve it; we should try to prevent it arising. If we do not know how to choose between rules, it does not follow that we do not know how to choose between types of institutional arrangement. We cannot eliminate moral problems, but by altering our institutional arrangements we can choose what types of problem to have. Politics - in the Aristotelian sense - precedes ethics, just as Aristotle said it did.

The second thesis is that rules are less fundamental than roles and relationships and that it is the context which roles and relationships provide which alone makes sense of rules. But roles and relationships themselves require elucidation in terms of goods. Medicine is after all an ordered form of human practice and it involves the pursuit of at least two kinds of good. There is the good of the patient whose health, life and general well-being are at stake. And there are those goods achieved by that extension of human creative powers which the history of medicine embodies. For medicine pursues excellence in its activity, just as natural science does or the visual arts or athletics. But clearly the first of these goods has priority over the second; for the measure of excellence in medical achievement lies in the end in the good of the patient. The key question thus becomes: in what relationship must the patient stand to the physician in order for the goods of medicine to be rightly ordered? Two things at once become clear, when this question is posed. The first is that to answer it at all we need to bring upon the scene additional concepts to specify types of possible relationship. The second is that it turns out that there may be more than one satisfactory answer to it.

For my additional concepts once again I turn to Aristotle's thought as a resource. Modern readers of Aristotle scanning his account of the virtues are unsurprised by the prominence given to such virtues as courage of self-restraint, but very surprised when friendship turns out, on his view, to be a virtue and a virtue as fundamental as justice. Aristotle argues that both the relationship between free citizens in a city-state and the relationship of husband and wife need to be elucidated in terms of the notion of friendship. Not only according to Aristotle, but according to classical Greek thought generally, at the opposite pole to the friend is the stranger. To a friend you are tied by your concern for goods that are both his and yours and his concern for the same goods (Aristotle treats as inferior forms of friendship those that are based only on pleasure in each other's company or on mutual utility). To a stranger you have no ties at all; you do not even necessarily share any conception of goods. With a friend you share the duties, obligations and

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other moral constraints imposed by the authority of the goods you mutually recognize. With a stranger you share initially nothing; and whatever arises between you will necessarily rest, if you are prudent, on enforceable contracts and if you are imprudent, on force or seduction.

Modern moral philosophy books never mention friends or strangers. They are indeed categories excluded by the abstract characterisation of the moral agent. Nor do we find friends and strangers mentioned by the immediate progenitors of modern moral philosophy, Kant and Mill. But if we make notions of roles and relationships central, then at once we have to think in terms of friends and strangers. For Aristotle was right in recognizing that roles and relationships must all be characterized in terms of this dimension of human existence. Let us return to the question: in what relationship to each other should the physician and the patient stand?

I now answer: either as friends or as strangers. What would be involved in each of these answers? Consider the first example of a problem, that concerning a certain type of incurable patient. The question is: who is to make the decisions about the life or death of such a patient. There are very strong reasons for initially giving the answer: the patient himself. It is after all his and no one else's good that is at stake. But the problem is that as a patient moves towards the state described in the example, the patient tends to lose autonomy to become dependent and, in the eyes of others and perhaps in his own eyes, to become less capable of making decisions that should be respected. The sick role returns us all in some ways to childhood, and never more so than in the case of the incurable patient. We therefore might be inclined to amend our first attempt at an answer as follows: the patient must decide, but not the patient as he is now, once he has become incurable and distressed and weakened and dependent. The potentially incurable patient - and that is all of us, physicians as well as laymen - must exercise his rational will in advance, must say, in binding form, perhaps the form of a sworn document, what he would have others do in this type of situation. While I am still autonomous, I must speak for myself when I shall no longer be so. The difficulty with this answer is one that arises for many types of attempt to bind myself in advance. So great is the unpredictable character of ourselves to ourselves, that at fifty I would be very reluctant to consent to being whatever I willed that I should be when I was twenty. It therefore would seem that any earlier expressions of my will for myself when I am incurable and distressed need to be supplemented by someone who is able to speak for me in the present, about what I would have wished. The patient in other words needs a friend, someone who has long since made the patient's good his own. Who is this friend to be?

We can recognize at once that in some times and places this role of the patient's friend has been filled by the physician. Two conditions had to be satisfied for this to be so. The first was that the physician stood in a long-term relationship to the patient and the patient's family, a presence at births and deaths. The second was that physician and patient shared in essentially the same moral point of view. When both these conditions are satisfied the physician is able genuinely to speak for the patient as well as to him. Where either or both cannot be satisfied, as they usually cannot be satisfied in contemporary medical practice, then the physician cannot be in an Aristotelian sense the patient's friend.

But if physician and patient cannot be related as friend to friend, they must be related as stranger to stranger. Their relationship, that is, ought to become purely

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and only contractual. The physician becomes no more and no less than the patient's agent in the patient's pursuit of his own well-being. A physician would on this view stand to a patient precisely as a lawyer stands to a client. The lawyer's duty is to advise his client of all the alternative courses of action open to the client and of the legal consequences of each; there his duty terminates. He makes no decisions; those are reserved for the client. The consequences for examples of the first type are clear. The physician, if a stranger, has no problem. If a friend, he will have to exercise a sensitive judgment on his friend the patient's behalf, but whatever he does to the best of that judgment will be acceptable. What is outstandingly clear however is that without some specification of the physician-patient relationship in terms of the friend-stranger dimension, we have an insoluble dilemma, where any choice is arbitrary.

Are physicians thus to be friends or strangers? The question is of course one about the forms of organization of health care. The emotive overtones of the words 'friend' and 'stranger' may too easily suggest that it is better for physicians to be friends than to be strangers, if this is at all possible. But I am not suggesting this. There are some types of relationship in which it is clearly better, or at least is good, to deal with strangers as with friends. One's relationship to one's legal advisor may well be a case in point. What I am contending is that until we systematically choose to define the physician's role in terms of one alternative form of relationship or the other, we shall have no way of putting the variety of moral rules which contend for our allegiance in any sort of order.

As with the first example, so also with the second. The triadic physician-nurse-patient relationship can be specified either in terms of friends or of strangers. If the relationship is of the first kind, then the problem posed in the second example could not arise, because between friends the kind of instruction given in the example by the physician to the nurse could not be given. But if the relationship is to be one between strangers, then it will have to be defined by a new contract between the physicians and surgeons on the one hand and the nurses on the other and that contract, like all merely contractual relationships, will express the relationship of force and influence between the contracting parties at the time the contract is signed, whether literally or metaphorically. For contracts between strangers are made when one party cannot or cannot any longer enforce their will upon the other.

Problems of medical ethics therefore are secondary to problems of medical organization; and problems of medical organization turn out to have a crucial moral dimension. For insofar as choices between forms of organization have implications for role-definition, they at least partially determine moral problems we will encounter.

V

It is now possible to summarize what ethics has to learn from medical ethics. The first lesson is that no one is ever an abstract moral agent. Moral agency is embodied in roles such as that of the physician, the patient or the nurse; and roles are mutually interdefined in terms of types of relationship. Secondly it is clear that the place of rules in moral life is secondary to the place of goods, roles and relationships. There is no way to answer the question: "Which moral rules ought I to respect in this situation?" until I have first answered the question "Who am I and what is my concrete relationship to the other people involved in this situation?" Thirdly the focus of our moral choice ought to be not upon alternative actions in

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particular situation, but on whole forms of life, on whole alternative ways of organizing our roles and relationships in such contexts as those of medical practice and on the goods to be achieved by such ways of life. Fourthly the argument has cast some doubt on whether there ought to be such a subject as ethics or moral philosophy as such. For if moral agency is exercised through roles, then the questions that ought to be addressed are much more specific than those with which moral philosophy is conventionally concerned. The questions I have touched on today are specific to medicine; but there are parallel questions specific to family life, to politics, to life in schools and universities and so on. The moral agent turns out to be no more and no less than both the sum and the unity of his roles embodied in a single person. The abstract ghost of conventional ethics, man as such, with his impoverished conceptual existence has to be replaced by this much more interesting figure.

Whether ethics will be able to learn what medical ethics has to teach it remains to be seen. We have at the moment grounds for both optimism and pessimism. But if ethics as it is studied in this country is ever to be reformed, it will, I am quite certain, be because medical ethics will have led the way. And this should not surprise us; Hippocrates said long ago that philosophy has more to learn from medicine than medicine from philosophy.