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Doctors' Experiences of Work Related Moral Problems: Responsibility without Clear Boundaries

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Abstract

For as far back as the history of the medical profession can be traced, it has been assumed that doctors learn professional moral knowledge together with medical knowledge. From the sixties, internal professional morality has publicly changed to external morality, described with vocabulary and concepts, connected to philosophical branches. Although now incorporated in medical ethics teaching, it is not known how well they cover the problems of the clinical world.

The main purpose of this thesis is to study doctors' experiences of moral problems in their everyday working life. The most prominent schools of modern medical ethics with their assumptions regarding e.g. human nature and fact/value relations are also studied and their impact (by focusing on some issues and omitting others) on our public, shared 'reality' is described.

According to a social constructionist approach (based on ideas from Alfred Schütz, Peter Berger and Thomas Luckmann) individuals perceive, interpret and act within a *social life-world* where things and events in every-day life have a self-evident meaning. Within a person's life-world, moral life is a form of societal participation where experience is connected to *moral concepts* as loyalty, deception and (un-) fairness. To find a concept relevant one must have a standard (e.g. regarding social roles and other aspects of human life).

Fourteen experienced doctors provide accounts of everyday work related moral problems. The interview analysis is carried out with a phenomenological method. A moral problem occurs in a situation when, according to the professional *standard* related to being a doctor, *values* – discussed in the thesis – are violated to such an extent that the doctors obtain an insight of an existing *moral problem*. What counts as relevant in each situation (what makes *the context),* depends on how the doctors experience features within social and institutional settings in relation to the assignment they have internalised as being theirs.

For the interviewed doctors, morality is allied with the question: *How shall I live my life as a responsible professional?* The medical assignment with its inevitable risk of hurting fellow human beings, makes for the doctors, medicine and morality inseparably intertwined. Reflecting on the boundaries of the profession's standard, is, for the doctors, different than working in concrete, practical situations where they often find themselves forced to take responsibility for political issues.

Many of the doctors' problems involve social and economic aspects and cannot be discussed merely from the framework of philosophically founded medical ethics' theories. The doctors' experienced problems are related to their comprehension of what kind of society, what kind of human relations, and what kind of health care we desire. In discussing these issues – negotiating about the contents of our value concepts – non-professionals' experience as well as healthcare workers' praxis-bound experience are necessary elements.

Key words: *Morality, doctors' work related moral problems, responsibility, social constructionism, social life world, fact/values, standard, context*

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PREFACE

Towards the end of the sixties I had my first summer job as a doctor in a Swedish rural district. The patients often talked about their regular doctor (who was on a badly needed vacation). They told me that they were lucky to have a *good doctor* in the district. As I understood it, to be a *good doctor* seemed to mean being reliable, which could mean being able to pay a prompt visit in case of an emergency. As I also understood it, a good doctor ought to have medical knowledge and discernment, which could mean both giving a referral to a hospital in time and also, not telling someone's very old mother that her yellow skin was caused by pancreatic cancer. Patients occasionally asked for a specific medication, which I knew to have no significant effect. Was it cheating to prescribe a simple vitamin tonic? I remembered that my mother received such a bottle from her doctor once and found it very effective; she measured out the prescribed dose of the tonic carefully.

This was around the time of the birth of the modern philosophical *medical ethics*, however at that time I could not imagine that in a few years' time medical-ethical teaching would to large extent be taught with vocabulary and concepts from academic philosophy. Today it often seems to be *the* way: In September the last three years a five-day course on medical ethics for health care personnel has been held at Imperial Collage School of Medicine, London. Every year, the first day's lectures have been: *Introduction to Philosophical Medical Ethics, Theories of Ethics Concerned with Rights and Duties ("Deontological" Theories)* and *Theories of Ethics Concerned with Maximising Welfare ("Utilitarian" Theories)*. Immanuel Kant, born 1724, will probably be named as the founder of deontological ethics. Jeremy Bentham, born 1748, whose political philosophy became a cornerstone to different utilitarian ethical theory-schools, will also probably be mentioned. The doctors, whom I heard about, were, as professionals, not taught to use ethical theories. I do not know if these doctors, who later came to be regarded as paternalistic, thought about moral issues in a more superficial way than the doctors of today, who have attended a course to learn a very small part of moral philosophy.

During recent decades in which modern academic medical ethics has existed, the focus has narrowed to only a few issues. Other important problems, dealt with in clinical praxis, have been overlooked. So, for instance, focusing on patients' autonomy over doctors' paternalism has overshadowed the fact that we are all dependent on others in different ways and that a person's illness or age-related symptoms often add to the work burden of his/her relatives (Hughes et al. 2002).

During the eighties while reading newspaper articles about medical ethics issues, I began to feel more and more uneasy; the issues brought up were not the same as the ones that patients talked about, nor friends nor neighbours. I could not discern whether this change towards highlighting only a few issues was due to the fact that the theories and principles were connected with Western philosophical traditions which in turn were used to dealing with a special kind of questions suiting distanced, abstract reasoning (Baier 1986). However, I could well imagine other developments of medical ethics during the recent decades. To give a concrete example: in this new era of medical ethics the closest family member became a *proxy*, an interpreter of the will of the family member who could no longer talk for himself. The old paternalistic doctor was no longer governing the situation, but instead the *ethics* was now asking the question:

"Should tube feeding have been initiated for this aged patient against the will of her daughter?" (Hansson 2002) possibly forcing health care personnel to consider measures to keep an old person alive for just a short time more. Another moral foundation (also within a Western democracy's borders) where the daughter took part in the discussion in a more equal way seemed to be a better solution in my opinion.

In a similar way to how I now had come to question the established academic medical ethics, I had also looked at the whole medical enterprise when I was a medical student. During the last terms of my clinical student years at the Sahlgrenska Hospital in Gothenburg, I discussed a doctor's role in society with some fellow students. Accompanying many working doctors, we reflected on what a *good doctor* was. We noticed that many of the patients' problems did not seem to be medical, and hypothesised that perhaps their lives in fact became worse in the long run by meeting a nice doctor, who happily medicalised problems? We did not speak about reducing doctors' paternalism (the word was not on the agenda in those days), we merely talked about a society where health care and doctors would not be so important. We spoke about how being able to help an individual patient but unable to change social structures, we would easily be tools against changes in society (Waitzkin 1989). At that time we used the concept 'class'. We moved to different places and grew into health care communions: the everyday working-world of doctors with its conscious and unconscious rules. Now and then, I have thought about our talks in Pompe's Café, especially during recent years when there are more doctors than ever and yet people (including doctors) are on sick-leave more than ever before.

These issues have not been up to a broader discussion in recent years, in fact our vocabulary, mirroring our construction of the world, seems obsolete today. Of course the medical ethics born in the late sixties was also a political movement, stemming from an American liberal tradition, which focused on the individual rights and interests of those who were in the system at the expense of those who did not have the economic possibility of getting health care. In the beginning this was not apparent. Outside health care was a growing awareness that we live in a world of differences and multiculturalism, inside – as medical ethics showed – there was a striving towards achieving autonomy and universal rights.

I have read that medical ethics is meant to teach physicians to think in a structured way about ethical matters and to make them learn that there are other things than biology alone (Svenaeus 2001). I could not help but thinking that things were often made too simple and that important issues were left out. I found that complicated issues outside health care were discussed in a more modulated way: with the awareness that there exists such big differences in the value systems of individuals and groups that often an agreeable solution acceptable to everybody lies out of reach. To give a practical example from the 1970s: the local inhabitants of a street in the city centre of Gothenburg were tired of the traffic caused by 'johns', cars driving past to pick up prostituted girls and women. After negotiations with the police, the prostitutes moved to another street with their own office building. Here is just one of many questions in modern society with no apparent standard being visibly applied while solving the problem. Regardless of whether you feel it is a traffic problem, no problem at all, a moral problem or a class problem you need to find a solution that is as acceptable as possible for as many as possible.

In medical ethics, the negotiation regarding if a problem can be seen as something other than a moral problem and respect for standards other than your own was not

prominent. The medical ethics problems were typically studied from distance, whether or not they would look in the same way at a closer sight was not considered.

Having read through a great deal of medical ethics literature and many newspapers I have found doctors' empirical experience of professional moral problems to be virtually absent. In order to get a better knowledge about clinicians' professional moral world I talked with other doctors. In carrying out this qualitative study, it was not my task to take sides regarding which group of academic philosophic medical ethics I had most sympathy for. Nor did I try to give a conclusive answer to the question: "How did bioethics come to supplant literature, law and religion as a source of moral instruction and arbitration in all matters medical?"(DeVries & Subedi 1998a, p. xii) but underlying my writing was a belief that the actual development of moral matters in health care turning to a high specialised one-field matter was not the only possible development.

THE AIMS AND THE MAIN STRUCTURE OF THE BOOK

AIMS

- To describe theory-bound medical ethics approaches to problems in medical praxis today, which are also used when teaching medical ethics
- To study doctors' experiences of moral problems in everyday working life and their comprehension of doctors' assignment
- To point to complementary ways of discussing moral problems in clinical practice

THE MAIN STRUCTURE

As I write today, at the turn of the millennium, I can not rely on the meaning the terms *ethics* and *moral* had several hundreds of years BC. Today these words are used synonymously by many. The term e*thics* is also used when referring to the theory of morals (confounded by e.g. the widely accepted concept *moral philosophy).* In accordance with some of the most prominent contemporary books on medical ethics, I have tried to use the term *ethics* when writing about medical ethics with apparent theory connection. When writing about the doctors and the non-professionals' experiences, I use both *moral* and *ethics*.

I will use the terms *clinical ethics, medical ethics, bioethics, and care ethics,* as these terms are already established and I will not try to find a non-theoretical equivalent. At the back of the book, there will be a glossary, but I am aware that definitions are definitions within a world of accepted concepts: that the explanation on the right hand side of the '=' use words that do not always have the same meaning for every individual. It is well known that definitions open up the way for new obscurities (von Wright 1965, pp. 116-117;Polanyi 1962, pp. 249-257;Wittgenstein 1967, p.69). Although I will deal with moral matters in clinical practice, this is not always referred to as *clinical ethics* in literature. Instead, it is quite common that the terms *medical ethics* or *bioethics* are used when dealing with issues regarding *clinical ethics.*

In this book, the term *Ethical theory* will be used (according to the custom today) when referring to systems built up around:

- What should I do to achieve the best possible result according to the designated goal? These are consequence-based theories, among which 'utilitarianism' is one. This ethics theory-group is to a great deal grounded on Jeremy Bentham's and John Stuart Mill's ideas. Morality means that the desired end-state is achieved

- Which action is the right one? This group is called ‘deontological ethics’ and the group is based on a modern reading of Immanuel Kant’s philosophy. Morality implies that one follows the moral law (acts according to one’s duty)
- What kind of a person shall I be? This group is called ‘virtue ethics’, and is founded mainly on Aristotle’s writings. Morality implies that you are a prudent person

These theories have a normative content regarding what we ought to do, what goal we ought to strive for, or what kind of persons we ought to be, that is: what morality is. During recent decades the ideas of philosophers have been used as a foundation when, for instance, describing a good medical encounter. When saying that a good medical encounter, as described with the help of a philosopher’s theory, is *the* goal for medicine, this is also a normative utterance, although not an elaborated ethical theory about morality in health care.

The medical ethics’ ‘Four Principles’ as edited by Tom Beauchamp and James Childress will be referred to as *principles* (although the authors themselves call them an outline of a theory) (Beauchamp & Childress 1994, pp. 44-47).

Since this is not a piece of writing that aims at finding *the* best theory and it is not clear *whether* the ethical theory approach to clinical problems covers the moral problems that clinicians experience, I will not go deeper than necessary, when describing the different theories and the divergences between a theoretical and non-theoretical approach. However, in chapter two, I will mention some differences between the theories used in natural science and the theories used in social science. With the kind permission of the Harvard University Press, I will reprint figures from Randall Collins: *The Sociology of Philosophies* (Collins 1998), showing the networks around e.g. the philosophers: Jeremy Bentham, Immanuel Kant, and Emmanuel Lévinas. These men are mentioned in chapter one (and in later chapters) as authorities in modern medical ethics. I try to keep to the net-work view of the philosophers throughout the book, seeing them as time-bound human beings, working with related questions, producing unsolved controversies (Hartmann 1935, p. 43).

Throughout the book, besides written scientific material, I also use non-scientific publications such as newspapers and journals, e.g. *Aftonbladet* (social democratic), *Arbetaren* (syndicalistic) *Dagens Nyheter* (independent liberal), *Göteborgs-Posten* (liberal), *Uppsala Nya Tidning* (liberal), and the Danish newspaper *Dagbladet Information* (independent of political parties). The quotations from these newspapers are not statistically based; instead, they exemplify a special way of discussing the subject. By focusing on some problems and making the public aware of them, attention from the media has an impact on *how* the problems are understood publicly (Gusfield 1981;Conrad 2001). While discussing the political colours of newspapers, I want to point out that I fully agree with Charles Rosenberg: “A decontextualilized approach in bioethics is not simply a matter of disciplinary style; it is a political act” (Rosenberg 1999, p 41).

Those who teach and write with ethical theories as a starting point are usually: philosophers, theologians, and health care workers. From chapter two onwards, I will refer to those that I know have a one-ethical-theory-approach as *ethicists*, in order to distinguish them from other writers, who will be called sociologists, teachers, nurses, theologians, philosophers, physicians/doctors and so on.

In *Chapter one* I will describe both the birth and the growth of modern medical ethics based on theories, in addition to this, the birth and the increase in numbers of the *medical ethicists* (now possessing almost all the attributes of a profession) (Greenwood 1957) will also be discussed. The ethical theories are of different kinds, dealing with the goals of actions, the human character etc.

At the same time as these theories became established, criticism emerged towards theory-based approaches in general, and sometimes only towards particular theories. By reporting some of the criticism, I want to show that believing in one established truth implies disregarding other points of views that in the long run may have public significance. Inclined to keep the text readable, I have tried to limit the number of names in the text to better-known names, but some writers (who may have good reasons) are not in the public spotlight today.

These theories will be grouped together later on. However, in chapter one, I want to shed light upon the confusing mass of Enlightenment theories, care tradition theories (e.g.'Hippocratian'), cultural theories (e.g. religious), and mixed theories (Enlightenment ideas of, e.g. 'autonomy' together with traditional ideas of, e.g. 'benevolence'), which were suddenly used to define the problems and the solutions in the health care sector. Some of them are used in the education of medical students and doctors and they are now incorporated as accepted background knowledge in moral reasoning.

In *Chapter two* I will discuss the relations between facts and values, in order to demonstrate the key differences between the different groups mentioned in chapter one. I will also focus on *the open-texture of moral concepts* (Brennan 1977), which is of major importance in understanding the doctors' experiences of moral problems in this particular study.

In *Chapter three* I will discuss methodological considerations when planning my study. Because I write in a medical faculty, where quantitative methods are mostly abundant, I will give an outline of some different qualitative methods. I will also describe the selection process of the fourteen doctors who were interviewed in the study, as well as how those interviews were analysed.

In *Chapter four* I will describe work related moral problems, as they appear for fourteen experienced doctors from a social life-world perspective (Bengtsson 1999). I will focus on presenting *the structure* of the experienced moral problems, not on describing *what kind of* moral problems that the doctors encounter.

In *Chapter five* there will be a discussion about the results. They will be seen in the light of theory-bound medical ethics. Questions relating to the doctors' role and how to discuss moral matters in a democracy (Rorty 1991) will also be dealt with.

CHAPTER ONE

THE BIRTH OF THE MEDICAL ETHICISTS

> There is current among those who philosophize the conviction that, while past thinkers have reflected in their systems the conditions and perplexities of their own day, present-day philosophy in general, and one's own philosophy in particular, is emancipated from the influence of that complex of institutions which forms culture. Bacon, Descartes, Kant each thought with fervor that he was founding philosophy anew because he was placing it securely upon an exclusive intellectual basis, exclusive, that is, of everything but intellect. The movement of time has revealed the illusion; it exhibits as the work of philosophy the old and ever new undertaking of adjusting that body of traditions which constitute the actual mind of man to scientific tendencies and political aspirations which are novel and incompatible with received authorities. Philosophers are parts of history, caught in its movement; creators perhaps in some measure of its future, but also assuredly creatures of its past (Dewey 1968, pp. 3-4/1931).

1.1 OUTLINE OF THE CHAPTER

- In this chapter I will sketch out the birth of modern medical ethics, dealing with problems in clinical praxis
- I will describe prominent medical ethics' schools without taking side myself, but I will show that serious arguments can be found against most expressed ideas: there are many co-existing medical ethics realities. How a balanced survey looks depends on which reality one belongs to
- The beginning of the medical ethics movement can be traced back to the late sixties, but most writings have been produced in later decades when the movement has grown strong, and ideas from some dead philosophers have been incorporated in medical ethics branches, causing a big time spread of the texts referred to
- In the end of the chapter there will partly be a clinical focus

1.2 INTRODUCTION

To learn to be a good doctor has, for as long as one can follow the history of the profession, been assumed to take time and need practice rather than theory. With the praxis-internal moral knowledge inseparable from the medical knowledge it was

assumed that a skilled doctor had learnt much ethics without being able to name the knowledge (Gillet 1995).

In the sixties there was a growing philosophical interest in ethical questions with implications for medical practice. Compared with the philosophical interest in other societal fields, philosophers' interest in health care questions can be described as tremendous. *Applied ethics* from philosophical sources gained a prominent place in public life. Internal medical professional morality seemed to change to external morality (ten Have 1994). The language and methods of discussing those questions changed. Some philosophers claimed that they were the best suited to reason about ethical matters (Singer 1982). As the discussions have proceeded during the last three decades, it has been impossible for people with an interest in ethical questions but without specialist knowledge to understand what it all is about. Behind apparently practical discussions is a broad divergence in philosophers' views from theoretical (meta-ethical) matters (Smith 1994) to the nature of the good or just society. Is there an objective, single 'true' morality? (Nagel 1986). Is the praxis of medicine a kind of moral enterprise with its own norms, in other words do we live in communitarian relativities, or if not, ought we not strive back to such living? (MacIntyre 1985). Should we rely on hermeneutic interpretations besides (or perhaps beyond) objectivism and relativism? (Bernstein 1983). If this new, philosophical way of discussing clinical problems, was only an advantage came out of focus.

At the end of the chapter I will summarise what I see has come out of the last decade's way of equating ethics in medicine with (different schools of) philosophical ethics. I try to outline how in only a few decades, branches of philosophy have obtained the status of self-evident foundations in discussions. There is a growing criticism among others sociologists and anthropologists (Callahan 1999; DeVries & Subedi 1998a) but so far there has been very little self-criticism by moral philosophers regarding the ethics enterprise or the ethics of philosophising (Örs 1996). In order to show that in our minds today the established medical ethics is 'natural' I explore the way in which frequently debated issues, such as abortion and euthanasia, have been approached in recent decades.

1.3 A GLANCE BACK IN TIME: PHILOSOPHY AND THE PRINTED WORD WORKING TOGETHER

Moral issues have of course been discussed, in terms of duties and consequences, even before moral theories from Immanuel Kant (1724-1804) and Jeremy Bentham (1748-1832) were known. A well-documented period of moral reasoning is the century 1550-1650 when casuistics were much used by theologians and civil and canon lawyers interested in practical moral problems (Jonsen 1986; Jonsen & Toulmin 1988, p.70). The casuists' interpreting did not adhere to any philosophical system of linked ideas like today's ethical theories (which did not then exist). Aristotle's virtues, Plato's ideals, Augustine's charity and Aquinas' natural law were sources for examples and maxims (i.e. familiar, widely accepted but inconclusive statements). In only a few years in the middle of the seventeenth century it was all changed. Blaise Pascal, a mathematical and literary genius deeply devoted to the ideas of the Jansenist Catholic

group was engaged in the struggle against what the group saw as a lax treatment of penitents. The easiness to be absolved in the casuists' way of reasoning was ridiculed by Pascal's writings, which were so brilliant that even Voltaire is said to praise them as satire at its best (Jonsen & Toulmin 1988, p. 234).

According to Jonsen and Toulmin one man's skilled rhetoric and opportunities to be published brought the casuistic moral reasoning into disrepute. Since that time, it has on many occasions become apparent that access to a printing house is vitally important in getting out new ideas. Journals like *The Economist* and the utilitarian *Westminster Review* and editorial houses like *Bloomsbury* and *Gallimard* have had key roles spreading ideas (Collins 1998, pp. 530-531). Young Sartre, despite writing intensively for a long period of time, only became famous when Gallimard started to publish his writings (Collins 1998, p. 776).

1.4 HOW ETHICS BECAME PUBLIC AND SEEMED TO BE SIMPLE

Applied ethics, born in the late sixties, received a prominent space in newspapers as it suited journalistic conventions. Now – only a few years after the bloodshed of World War II -philosophers brought out examples from the philosophical seminar rooms to newspapers' debate articles: "Why not kill the anaesthetised man with the broken leg and give his organs to four or five patients?" This example, which was used by the philosopher Gilbert Harman to show that one can not sacrifice an innocent to save another individual (Harman 1977), has been presented as an ethical problem many times in Swedish newspapers over the past few decades (Genberg 1997;Genberg & Wahlberg 1997). This way of debating in a highly theoretical way (in this case, without considering fundamental democratic principles), was recently called 'a white boy's game' by the British writer Bea Campbell (Catherwood 2000). It came to be open for philosophers like some kind of *enfants terrible.* Other professionals, for example lawyers or teachers, could not realistically expect to have their considerations on actively killing innocent people published and even if they could, they would most likely suffer from some form of negative consequences in their normal work environment.

The psychiatrist and philosopher Karl Jaspers names situations where we meet our inevitable fate of demise and death as *existential limit situations* where reason alone is not enough (Jaspers 1971/1937, 1994a). This knowledge that in the end of our life we may try to get our lives right instead of striving for individual rights has not been the most highly focused upon issue in the media. A pattern of presenting issues as *news* has crystallised. The key ingredients are *a problem* and *an enemy* (e.g. 'health care', 'physicians', 'a political party', 'religion'); the enemy is often presented like *a disclosure.* A rational principle or rule, sometimes confirmed as a law is shown as a solution. In this way a *medical ethics* medial discourse with its own logic and mode of articulation has been born (Miller 1997, pp. 26-27) and held in public life. Both ritual and spectacular, the question of how we can get peace at the end of our lives has been hammered to a matter of euthanasia. In 2001 (Debatt SVT2 April 3) there was a telephone vote at the beginning and end of a TV debate regarding the public's opinion on euthanasia ("Are you for or against euthanasia, call this number to vote…"). Such a

debate, coming only one week after a vote regarding the legalisation of narcotics has worn out the discussion regarding complicated issues in clinical practice (Brannigan 1996; Rosenberg 1999, p. 40). The problems debated have often been edited to an extreme simplicity. At first sight easily apprehended as debates concerning concrete topics, however, the ideas behind the main contributions have distinct ideological foundations implying assertions about the nature of man, the nature of morality *et cetera.* The public altercation, if looking more closely, bears a strong resemblance to old academic disputes like the fight between the old and the new philosophies (the Cartesianism against Aristotelianism) held for instance in Uppsala 1687 (Bring 1754). Although of unclear significance regarding changing the opinions of either newspaper readers or TV-viewers, it is apparent when talking with people both within and outside health care services that this kind of one-question ethical debate has formed a view regarding what *medical ethics* is.

1.5 SHOULD WE ALL COMMIT OURSELVES TO AN ETHICAL THEORY?

With a great appeal in media, a modern medical ethics was created. Some of the topics from the philosophical seminar rooms were not apparently highly ranked in importance by a broad group of laymen; these included, for instance, infanticide (Singer 1982, p. 10; Tooley 1986) and killing people by lottery to get organs (Harris 1986). Ethical theories unproved on a larger scale were now applied to what were seen as problems in the medical world. These theories were untested outside seminar rooms and not designed to be teachable to children or non-intellectuals (Baier 1985, p. 219). Those with an academic background (given some guidance) were assumed to be able to reach the new moral world but it was still very hard to understand it all. The theories seemed not only to be meant as help in analysing moral problems, but on the contrary there were philosophers who actually presented the ideas as *the* right way of thinking. “It does show that we very swiftly arrive at an initially utilitarian position once we apply the universal aspect of ethics to simple, pre-ethical decision making. This, I believe, places the onus of proof on those who seek to go beyond utilitarianism“ (Singer 1993, p 14).

As these ethical theories, now used to solve problems in health care and taught to health care workers (as named in preface) were built, morality was thought of as being superimposed on social life rather than as inseparable from it (Noble 1982, p. 8). Problems were often presented as being abstract from their social settings. Presented so, it looked like the question of whether abortion is morally permissible was a separate issue from its consequences for women in different social classes or the historical roots of different attitudes (Noble 1982, p. 8). There was a right answer to be found, and when one had found it with the help of an ethical theory, the problem was solved. With this kind of reasoning the solution would not lead to new problems later on.

In the moral discussions present around the 1600s one could use the arguments one found important. In the applied ethics era from the 1960s onwards things were rather different: there were now ethical theories with in-built assumptions about human nature, goals and problem solving. Jeremy Bentham was engaged in practical problems:

legislative questions and practical questions about the supervision of prisoners. While he was living his *Utilitarian theory* was not an abstract intellectual theory but a political weapon for his own time (Jonsen & Toulmin 1988, p. 288;Foucault 1977;Sen & Williams 1982, p. 21). Philosophers after Bentham developed his ideas in different directions. With time most people seemed to forget that the -isms descended from time-bound human thoughts with good, bad and blurred ideas mixed. 'Mother'-isms (as utilitarianism) had split into new branches as act- and rule- utilitarianism schools. One could be a supporter of one theory or another, and beside the many different utilitarian branches there were Kantian and neo-Kantian schools, social contract-schools and so on. Discussing this was of course difficult when the entrance test for discussion was so rigorous that only philosophers who had passed the exams in philosophy were seen as being able to manage the test (Singer 1982). The political prescriptive force of the theories can be seen by a philosopher's utterance that every reasonable theory was seen to oblige you to give 10% of your income to poorer countries' people (Singer 1993). So highranked were the ideas of the famous philosopher that when he changed the recommendation to give away 1% instead of the earlier tenfold sum, it was printed as cultural article without comment (Singer 2002).

1.6 WHY 'APPLIED ETHICS' OF THAT KIND AT THAT TIME? DIFFERENT EXPLANATIONS

Different writers point to different explanations as to why the modern medical ethics came into existence. I will name three recurrent explanations and add my personal reflection (with a glance some decades back in time).

New knowledge, new problems:
The rapid post-World War II technical and scientific innovations showed up to give new problems, the knowledge of overpopulation, famine and unequal distribution spread (Pellegrino, Siegler, & Singer 1991;Wilkinson 1993;Örs 1996, p. 451). The first atomic bombs and revelation of the unethical experiments by doctors and others created a demand for ethical guidance (Wilkinson 1993).

Ongoing societal changes
The societal consensus on moral issues, largely based on the teaching of the Christian faith was lost (Wilkinson 1993, p. 496). Civil rights movements pointed at the possibility of a world with new empowered groups (Singer 1986, p. 3). The litigious spirit of the time and the reconceptualisation of medicine as a business are named (Pellegrino, Siegler & Singer 1991).

Analytic philosophy in crisis
In the middle of the twentieth century analytic moral philosophy was in a deep crisis. The study of meta-ethical questions like the meaning of moral judgements and the nature of morality had come to a deadlock (Singer 1986;Toulmin 1986). So, in the sixties philosophers became involved in problems from the real, physical world, some

of which were social questions with implications for medicine, ‘applied ethics’ or ‘medical ethics’, and the ‘medical ethicists’ were born (Singer 1986).

A glance some decades back in time

There certainly must have been many factors that cleared the way for the birth and rise of modern medical ethics. This revolutionary change into discussing problems, which in one way or another affects everybody, in an academic way, evidently has roots regarding certain issues in societal conditions back in time. So when philosophers in the front-line of this early applied ethics movement started to show an intensive interest in questions regarding control of dying and death, personal acquaintance with the subject of death and dying had for many decades been more and more rare among individuals in many Western societies. In a society with repression of the fact that we all are going to die and where most people no longer had personal acquaintance with death, medical ethics’ promise of controlling death seemed like a dream. As early as the fifties the ‘hiding’ of death was described by the anthropologist Geoffrey Gorer. In an article “The Pornography of Death” he claimed that death had become as shameful and unmentionable as sex was in the Victorian era (Gorer 1955). He later developed his ideas further regarding his observation about modern death having been removed to a distance (Gorer 1965). Also the historian Philippe Ariès describes in a chapter named “Death Denied” (Ariès 1981) how mentality changes came before scientific inventions had changed the medical world in a revolutionary way. In this way – which seems most plausible for me – some American court cases (like Karen Ann Quinlan) have paid much attention to, and even possibly became famous as a result of, issues regarding death having become highly loaded subjects, not only because medical science had developed dying in an unnatural way. Such cultural phenomena must have influenced philosophers as well as laymen but when medical ethics came one had ‘ethical problems’, not ‘ethical problems connected with societal/mental changes’. After decades of writing concerning the painful death, studies show that the desire to control circumstances of death is the most important reason for requesting a prescription for lethal medication (Ganzini et al. 2002).

1.7 WHAT FOLLOWED THE FIRST APPLIED ETHICS PERIOD?

The applied ethics, born in the late sixties originated from analytical school branches. Other philosophical schools had their own assumptions, categories, logic and modes of articulation, forming their own views of reality and belief systems (Foucault 1980, p. 77;Miller 1997, pp. 26-27). Analytical school branches were presented as practical tools in moral problem solving. The position of other philosophical schools has been less clear; Continental philosophers’ writings possible to be read as literary texts to be reflected upon (Jaspers 1994b, p. 7) could now also be seen to be of use as a foundation for a better medical encounter (Svenaeus 1999, pp. 287, 295).

For many non-philosophers as well as philosophers it quickly became clear that the applied ethics of any one theory model was very oversimplified and solid criticism exposed weaknesses (Noble 1979,1982;Scheffler 1988;Sen & Williams 1982). Looking at what had gone on for some years, the philosopher Michel Brannigan saw a risk of

"tabloid professionalism which capitalises on the more exotic life and death issues which stem from high-tech medicine, while it lures attention away from the more common, day-to-day ethical issues such as those surrounding both chronic illness and nursing practice" (Brannigan 1996). This written critique stayed inside professional journals and books (DeVries & Subedi 1998b;Hoffmaster 1992, 2001). When new issues came up in the medical field journalists turned to medical ethicists (who often changed name to bioethicists) to get an interpretation. When reading carefully it was often possible to see that the answers could be a combination of historical observation and personal opinion (DeVries & Conrad 1998).

Whichever philosophical branch, the emphasis regarding problems in health care came to lie on individual rights: those individuals who had gained access to health care had the right to demand resources, understanding and empathy. The big issues: if the medicalisation of Western lives made our lives better or worse and secondly, problems of the inequality of accessibility to medical treatment, food and clean water were not prominent. Although the history of modern applied ethics birth's writing had brought in societal issues (see 1.6), the development of medical ethics became conventional and often conservative (Fox & Swazey 1984) without calling into question the society, which produced the individual rights a patient could claim. In this modern medical ethics *good life* questions were not prominent. I will return to this issue when discussing the results of my interviews. In this present chapter I only give short descriptions of prominent lines on ethics with implications for medicine.

1.8 ETHICS IN THE HEALTH CARE SECTOR, DIFFERENT DISCOURSES

Suddenly, in recent decades, there were many different views on which moral problems in the health care sector were the most important and which solutions were the best. Clinical ethics was seen to have similarities with Jean Baudrillard's description of America where everything was seen to exist at the same time (Baudrillard 1988;ten Have 1994). Despite this enormous range in ideas and the relevance of society, the solution rested upon the health care personnel's actions or behaviour.

1.8.1 The one-theory period

As a student of philosophy one learnt to discuss whether to save a drowning person if it will make you late to an appointment (Clouser 1989, p. 175). Students also had to choose between saving Mother Theresa (who was doing much good for the world) and their own grandmas (with some dubious affection value for a few) when they were both drowning before your eyes. Which ethical theory, i.e. entity connected with a philosopher, had the right answer?

Now after the birth of modern medical ethics the problems came from the health care sector. The old highly abstract or detached way of reasoning was often preserved. Albert Jonsen remembers the days when agents A and B now became "…this young Dr

Smith and that elderly, very sick Mrs. Jones. Act M became 'turning off the respirator,' or was it 'allowing to die' or was it 'killing'?" (Jonsen 1986, p. 67). Issues, which had been outside newspaper's and medical staff's everyday discussions, were brought to the agenda by philosophers, for instance infanticide (Singer 1993;Tooley 1986). Utilitarian philosophers calculated the amount of produced happiness in different situations, for instance the happiness produced by killing a handicapped infant and later giving birth to a healthy child compared with other outcomes (Singer 1993).

So here in the new period when developments in medicine and biological sciences were said to "throw up ethical questions which have few precedents" (Singer 1986, p. 4), a new, detached way of discussing difficult human ethical questions was spreading. I aim to show the way of discussing the questions in the analytic-philosophic discourse by outlining two of the most quoted texts from the childhood of applied ethics.

1.8.1.1 A way to write about abortion/the rights of the unborn:

Judith Jarvis Thomson's text (Thomson 1986) (first in print 1971) is in spite of the title" In Defence of Abortion" a defence of the rights of the foetus. The title perhaps alludes that Thomson in the end of the article says: "[...] a sick and desperately frightened fourteen- year-old school-girl, pregnant due to rape, may *of course* choose abortion"(Thomson 1986, p. 55). To exemplify the spread of the text, I can mention that it has been translated into Swedish in a book meant for non-philosophers (Thomson 1987), and quoted as a kind of ground-text on abortion in an Estonian anthology, written by Estonian philosophers 1995 (Parve 1995). It is still often referred to in medical ethics articles (Alward 2002;Hansson 2002) and reprinted in an anthology 1999 (Kuhse & Singer 1999). Judith Jarvis Thomson writes a text filled with loaded metaphors. You have been kidnapped and connected to violinist, who needs your kidneys for nine months:

> You wake up in the morning and find yourself back to back in bed with an unconscious violinist. A famous unconscious violinist […]. Suppose you find yourself trapped in a tiny house with a growing child. I mean a very tiny house and a rapidly growing child – you are already up against the wall of the house and in a few minutes you will be crushed to death […]. Suppose a boy and his small brother are jointly given a box of chocolates for Christmas. If the older brother takes the box and[…]. If Jones has found and fastened on a certain coat, which he needs to keep him from freezing, but which Smith also needs to keep him from freezing […] when Smith owns the coat (Thomson 1986, pp. 38,42,46,43).

On the last page (of twenty) something is said about what may happen to the child after birth (it can be adopted). This text will be further commented in chapter two (2.4.1), as seen from laymen's point of view (situated in their social life). I will there also bring out criticism from the philosopher Hilary Putnam (Putnam 1983), who discusses the Thomson's text as *proving too much* and compares her way of debating with the Supreme Court's "wise adjudication"(Putnam 1983, p. 5) of a difficult dispute.

1.8.1.2 A way to try to discuss euthanasia (or doctors seem to be responsible for every death)

In James Rachels' text (Rachels 1986a) (first published 1975) "Active and Passive Euthanasia", the concept *passive euthanasia* is used in a way which had an enormous impact on euthanasia discussions to follow (Hope 2000).

> James Rachels tells us about Smith, who will gain money if his six-year-old cousin dies. One day, when the child takes a bath, Smith goes to the bathroom and drowns the child and arranges it to look like an accident. Jones also stands to inherit his six-year-old cousin. He too plans to kill his cousin but when arriving at the bathroom he sees the child hit his head and fall under the water. Jones stands by and sees the child die. Rachels concludes: there is no moral difference between killing and letting die, to say that letting die is less bad than killing "can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defence at all" (Rachels 1986 a, pp 32-33).

The euthanasia question returns with Rachelsian concepts later in this chapter (1.11).

1.8.2 Around 'Four Principles'

In 1979 a basic book in medical ethics was written by Tom Beauchamp and James Childress, one of them a Christian deontologist, the other a secular utilitarian (Beauchamp & Childress 1994). In editing the book they used four principles: Autonomy, Nonmaleficence, Beneficence and Justice. The principles were seen belonging to a hierarchy where *particular judgements* are covered by *rules*, which in turn are covered by *principles*, which in turn are covered by *an ethical theory*. Occasionally the authors themselves refer to their system of principles as a theory. They mean that a theory ought to have (1) abstract reflection and argument, (2) systematic reflection and argument and (3) an integrated body of coherent and well-developed principles. They assume that they pass the demands of (1) and (2) but only present some elements of (3). I will come back to theory constructions in chapter two (2.3.2)

The book became very widespread, in later editions some changes occurred in the content of the book but the core principles that had no specific frame remained. For a number of years they were seen by many as being *the* medical ethics principles. In practice the principles came to be used as free-floating from ethical theories: the Four Principles ethics was not treated as a sub-division of the ethical-theory group but as the modern way of doing medical ethics.

Together with the popularity there also came a hard and bearing criticism of the Four Principles, sometimes called 'the Georgetown Mantra' (after the place of origin, Georgetown University). It was remarked that the principles could not be guides for action but rather names for a collection of sometimes superficially related matters for consideration. The principles were found to lack any systematic relationship to each other and often seen to conflict in an irresolvable way (Clouser & Gert 1990, p. 219). It is remarked that two persons using the principles correctly can reach very different

conclusions depending on if they get there via a utilitarian or a deontological way (Green, Gert, & Clouser 1993, p. 483).

In justifying the use of the principles one of course ought to have one's own idea why they are to be chosen (Holm 1994). To say that Tom Beauchamp and James Childress found them to be good principles is not enough.

The obscurity of the meaning of each principle has been noted. For instance *Autonomy* which now is seen as a key concept in many medical ethical discussions has many definitions (Dworkin 1988). The autonomy concept can be traced to Immanuel Kant (Kant 1948/1785). Kant wrote about autonomy as a kind of self-control. He considered individuals to act autonomously if they acted according to their ideals. They were said to act heteronomously if they acted against their own ideals (or if they did not have any). Liars who fail to live up to their own ideals can be seen to act heteronomously. Nowadays, anything infringing a patient's desires or wishes is seen as infringing the patient's autonomy: today autonomy is self-fulfilment instead of self-control (Baker 1989, pp. 32-33).

One interesting comment on the issue comes from Marjore Kagawa Singer (Kagawa Singer 1988). Studying Japanese-American and Anglo-American patients' adaptations to cancer she found differences between the groups. One major difference that emerged was not seen between the two cultural groups but between the study groups and what she calls the professional values of the American health care system. The health care system was seen to reflect the cultural ideals of individualism: independence, autonomy and rationality. Kagawa Singer notes that those values of autonomy and individualism were not compatible with the style of coping exhibited by members of either patient group. She means that the American health care system neither incorporates the strengths that a sense of community provides, nor provides for the needs of nurturance and social participation that appeared to be essential for the studied patients (Kagawa Singer, pp. 295-296). Kagawa Singer is an anthropologist and I have stated her research results here to show that there exists knowledge in other academic fields that has had little influence upon the evolution of medical ethics.

Mostly, however, the Four Principles were not seen as indicators of societal values but as neutral practical tools in health care, as such they have spread to many official health care documents as medical ethical grounds. In the Swedish physicians' scientific journal *Läkartidningen*, the Beauchamp and Childress' book and the principles are often referred to as a self-evident foundation. I mention two examples here: (Ottosson 2003;Wijma et al. 2002).

Used in this practical way, real philosophers could find that medical ethics had now become superficial when *ethics* among many doctors had come to mean '*the Four Principles ethics'* (Beaufort 1996). After all, that kind of medical ethics was given to the medical world from outside. The risk of oversimplifying complicated human health care situations with concepts and ways of analysing borrowed from philosophy is now apparent.

1.8.3 The ethics of traditions

Alasdair MacIntyre (MacIntyre 1985) Charles Taylor (Taylor 1989), Michael Waltzer (Waltzer 1987) and Michael Sandel (Sandel 1982) have, from different political and

religious backgrounds, focused on human beings as belonging to a society with its own history and tradition, family members and members of a society. MacIntyre looks back from our days with 'the Rich Aesthete', 'the Manager' and 'the Therapist' (MacIntyre 1985, p. 30) to the Aristotelian moral community. The Communitarians, not writing directly about health care, have been much studied by some groups within the sector.

Critics have pointed at the fact that MacIntyre has not justified the claim that the Aristotelian-Thomistic tradition of justice and practical rationality is rationally superior to its rivals – even the limited number of rival traditions he has analysed (Bernstein 1991, p. 64). According to the philosopher Richard Rorty, another weakness is that it is not clear how the Communitarian visions can be realised in democracies where people have post-Enlightenment selves (Rorty 1991). (I will comment on Rorty's writings about democracy and philosophy in chapter five).

With an awareness of the fact that we live in a multicultural society the practical use of the Communitarians thoughts in health care of today is obscure (Turner 2001). After all, the Aristotelian virtues were virtues in a society of a very different kind compared to societies of today. It is also unclear which role a health care with communitarian internal virtues plays in a society where, for instance, helpfulness and generosity are not encouraged.

1.8.3.1 Ideas from Aristotle and from Continental philosophers into medical praxis

David Thomasma and Edmund Pellegrino assume that the concept: "It is good to be healthy"(Thomasma & Pellegrino 1981, p. 8) could function as a norm in medical ethical decisions. They find that the primary ethical and medical questions coincide in their reasoning. According to them, the principle and primary value that "it is good to be healthy" is based upon the most ancient axiom: "To help or at least to do no harm" (Thomasma & Pellegrino, p. 9). Their second principle of medicine is that individual persons have intrinsic value leading to the axiom: "Care must be taken for the susceptible individual" (Thomasma & Pellegrino, p. 9). As a third value-principle of medicine they see that the intrinsic value of individuals also includes their representation as a class-instance of human bodies. This leads to an axiom: "The common good of living bodies is an altruism expressing the common notes of individual living bodies" (Thomasma & Pellegrino, p. 10). The authors say: "Ethical axioms may be relative in their formulations, that is relative to different situations and conditions, while simultaneously being absolute in their ground – the ontological basis of medicine" (Thomasma & Pellegrino, p. 11).

Pellegrino and Thomasma (Pellegrino & Thomasma 1993) are following the history of virtue ethics from Plato and Aristotle. They acclaim that if there is any meaning to professional ethics, it must revolve around an ethic of trust, which must go beyond principle- and duty-based ethics to an ethics of virtue and character. According to them, the nature of illness, the non-proprietary nature of medical knowledge and the nature and circumstances of the medical oath makes medicine a moral enterprise that imposes collective responsibilities on its practitioners. They distinguish features characterising the special human relationship in medicine like the vulnerability of the sick person. They point to the fact that medical decisions have both technical and moral components. According to them, the characteristics of medical knowledge involves

obligations from those who own the knowledge and the moral complicity in a caring situation means that the physician is the final safeguard of the patient's well-being (Pellegrino & Thomasma, pp. 42-44).

1.8.4 The situation-based ethics (The ethics in the personal meeting)

Knud Løgstrup (Løgstrup 1997/1956) writes about the ethical demand: as human beings we have a responsibility for our fellow-beings, we are each other's world and fate.

Martin Buber, an interpreter of the *dialogue philosophy*, according to which we are created in the meeting with another human being, sees the ethics in our way of answering (Buber 1970/1923). Buber says that 'I can choose between meeting a You and an It'.

Emmanuel Lévinas describes ethics as coming before ontology (Lévinas 1969):

> The strangeness of the Other, his irreducibility to the I, to my thoughts and my possessions, is precisely accomplished as a calling into question of my spontaneity, as ethics. Metaphysics, transcendence, the welcoming of the other by the same, of the Other by me, is concretely produced as the calling into question of the same by the other, that is, as the ethics that accomplishes the critical essence of knowledge (Lévinas 1969, p. 43).

I quote this text to show on its exclusive or abstruse tone, a fellow human being is a threatening stranger: the Other. The breadth of the ideas, brought out to help the physician, with the natural scientific gaze has been tremendous. The philosophers named in this section are regularly used as authorities in various medical ethical writings, critical to the mainstream applied ethics. Lévinas and Løgstrup are mentioned as a possible base when working out an ethics of clinical practice (Svenaeus 1999, p. 287). I will return to Løgstrup in chapter two (2.3.2.2).

1.8.5 Ethics bound to gender (and perhaps, profession)

Thomasma, quoted above, was an immensely productive authority in medical-ethical issues (Thomasma et al. 1998, p. xv). He described nursing ethics as a separate discipline with its own patterns and development (Thomasma 1994).

Carol Gilligan studied how people solve moral conflicts (Gilligan 1982). She found that men had a justice orientation and women a more relational-oriented perspective. Her theory was a challenge to Lawrence Kohlbergs moral development theory (Kohlberg & Hersh 1991).

In *ethics of care*, Nel Noddings denies universal or generalizable moral norms (Noddings 1984). She means that care involves an indwelling relationship, an engrossment and motivational displacement derived from feminine emotional qualities.

Lawrence Blum reviews the theories of *care ethics* (Blum 1994). He finds that in Gilligan's use of 'care' as a first-order value she misses relationships with other values such as honesty. "If I am honest to Jim only because I care about him, then I have failed

to grasp the full significance of honesty, which is a good for its own sake" (Blum , p. 256). In discussing the *care orientation,* Blum also emphasizes that if the *care orientation* is person-oriented, it will be directed towards all persons towards whom caring would be appropriate; you either possess a caring orientation or not. Blum points out that the caring virtue in Gilligan's way may help sustain harmful relationships (Blum, p. 262). He says that if care is seen as a virtue, it must mean that all virtues constituting the care orientation refers to one single moral capacity. As there are tensions between the qualities, counted as care qualities by Gilligan, Blum assumes that this care orientation cannot exist.

The *ethics of care* concept has been much debated. It's meaning has been found to be hopelessly vague and lacking both normative and descriptive components (Allmark 1995, 1996). There also exists a view that an *ethics of care* must be grounded in Christian faith (Bradshaw 1996).

1.9 CLINICAL ETHICS (THREE STORIES)

> A GP reflects on a patient he treated for many years (Nørrelund 1998). She had a manic-depressive illness. When she got ill her relatives called for a home visit by a doctor. Many times the doctor had to involve the police in bringing the woman against her will to institutional psychiatric care. He remembers that she shouted at him: "I will never forgive you." In periods she seemed to live well. Eventually she committed suicide. The doctor knows that his license would have been withdrawn if he had not brought her to the hospital. The patient's parents and children were satisfied with what he had done. The doctor still wonders what he has done against a fellow being, and if he had acted right.
>
> An elderly woman was brought to a hospital after several episodes of weakness at home (Ackerman 1989). On the whole the woman was mostly in bed and her old and tired husband was doing the chores. The physiotherapists found the woman uninterested in performing exercises. The daughter arranged for a nursing home, but the woman wanted to go home. She simply seemed satisfied to be entirely dependent on her husband dealing with her personal needs. The author asks: "Is it morally permissible to insist that she complete her daily rehabilitation exercises? Can the staff force her to talk about the matter when she asks to be left alone? Can they threaten to discharge her to a nursing home?" (Ackerman 1989, p. 144).
>
> A man with back pain following a scoliosis-operation visits a young doctor (Hensel & Rasco 1992). The doctor feels that she has a warm and talkative meeting with the patient. As the patient is new to the area, his papers have not arrived yet, but he needs his narcotic medication, which he used to get from his old doctor. He is allergic to a lot of preparations and the narcotic seems to be the one he can take. The next day the local pharmacist calls: Our doctor has prescribed narcotics to a narcotic addict, who is at the moment undergoing consultation as an in-patient at a psychiatric ward.

Doctors tell two of the stories, a philosopher, critical of the medical ethics' school approaches, provides the third account. It is not self-evident which story which

professional tells; they are all modulated with everyday social complexity and show how everyone's life is surrounded by legal regulations. Neither health care workers nor philosophers are the exclusive detectors of the problems in the clinical world. If we look back at the Thomasma-Pellegrino principles in 1.8.3.1, it is hard to see how those principles can really help to solve those clinical problem situations.

1.10 A REMINDER ABOUT THE SOCIETY OUTSIDE HEALTH CARE

Here I will briefly show that another way to work with the problems seen in medical praxis has existed during the era of the modern philosophical ethics. This way of looking at problems from a sociological point of view has hardly had any impact on the mainstream modern medical ethics. The sociologist Anthony Weston (Weston 1991) criticises the way of teaching bioethics with a standard list of issues, common in bioethics literature of today (Kopelman 1995, p. 796). According to Weston bioethics has a tendency to marginalise larger social questions, as many of the familiar bioethics problems depend on much deeper social tensions. He means that our standards for what might count as a reasonable answer even within the immediate 'dilemma' may change once we take a larger perspective on the source of the dilemma itself. He names the well-known *decision scenarios*, for example about a victim of a traffic accident who is in an Intensive Care Unit. Weston points to the conundrum that despite these situations only seeming to regard the patient, the relatives of the patient and the personnel, there are in fact other important questions like why accidents of this kind actually happen in the first place: car safety, traffic systems and so on should be discussed (Weston, pp. 109-110).

Weston tells a story about a mother of four, with two previous abortions, who wants a third abortion. There are three physicians serving in her isolated rural area, one of them refuses on religious grounds to perform abortion. One doctor refuses to take her as his patient because the pregnant woman is on welfare and the doctor finds the paperwork with the (Medicaid) payment system so time-consuming that he decides to provide care for other patients instead of filling in forms. The third doctor helps the woman to get an abortion. Has this third doctor a right to tell her that he will not perform an abortion if she does not at the same time accept sterilisation? Why does the woman make herself dependent on doctors? Would there be a moral problem if, through political decisions, there were lots of doctors in the area or if midwives were allowed to perform abortions? Is the religious doctor's refusal, and not the paper-hating doctor's refusal, morally acceptable? (Weston, pp. 110-111). Weston concludes: "[…] only given a set of background political choices does abortion become a *medical* 'dilemma' at all" (Weston, p. 111).

1.11 TWO WAYS OF WRITING ABOUT MORAL MATTERS

The modern medical ethics was born in philosophy seminar rooms in the sixties. The content, with its highly abstract, academic foundation was partly spread through articles in newspapers the following decade. With time it seemed quite natural that a

philosopher teaches a clinician that performing active euthanasia is not much different from doctors' ordinary work:

The machine-fixated doctors, to be afraid of

> In Sweden's largest morning paper a philosopher (Anderberg 1996) makes comments on a debate about euthanasia. He says that the boundary between passive and active euthanasia is blurred and probably morally insignificant. He claims that most people's death in Sweden is caused by euthanasia because sooner or later the doctors decide to leave the medicine and machines (sic) in the cabinet. And how far will the opponents of euthanasia go to prevent dying people from committing suicide outside hospitals? Will they by coercive measures try to hinder such suicides? Perhaps even with such partly insidious methods used by American 'suicide prevention centres', or for a long-term lock-in of rational people who show an above average risk of committing suicide?

In this newspaper article, a theory from philosophy has been used as an accepted piece of knowledge. The Rachelsian active and passive euthanasia concepts (see 1.8.1.2) (Rachels 1986a) are used as a foundation. Reading this article, it seems as though patients always die secondary to something a doctor prescribes: that people would live forever if doctors were not, somewhere in their vicinity, withdrawing medication.

Clinical knowledge is that it is mostly impossible to predict the time of a patient's death (Christakis 1999) and also that when the dying process has begun, it is apparent and no medical activity (including heart resuscitation) can change the outcome. The clinical uncertainty may be hidden in the documentation, which is apparent from a doctor, performing euthanasia:

> I find myself shading my description of the case in more serious tones than are completely accurate.[…] Outside the legal framework, if I were asked about my decision-making, I would indicate the variety of choices that were available, "I could have done X, but I believed there were better reasons to do Y, but I am not 100% sure"(Thomasma et al. 1998, p. 290).

The clinical uncertainty and ambiguity is not always known from outside. This is apparent when a philosopher-ethicist gives advise in a newspaper: "Everything that happens must be carefully documented" (Tännsjö 1998). With such a difference in understanding between clinicians and medical ethicists, who use the Rachels' article as an argument of what the presuppositions are, meaningful discussions are not taking place. To point at one more concrete detail in the reasoning: it is known that doctors often experience sleeping-problems and need to consult a colleague after performing euthanasia (Thomasma et al. 1998, pp. 316-317, 451). This knowledge does not appear in an article like the one referred to above in this section. Seen from outside, performing euthanasia has been compared to performing abortion, played down as "something which may be felt as not perfectly good to perform" (Åkerblom 2003).

Patient autonomy released from scientific knowledge

I will give one more example of how public knowledge about problems in health care is built up. A newspaper article brings up a problem of doctors as defaulters, describing how patients with MS are forced to go to other districts to get their medication. The title of the article is "Patients with MS must travel to other county councils in order to get

treatment" (Jansson 2003). The same issue is at the same time debated in the Swedish professional paper *Läkartidningen*, showing that there today exists no definite agreement regarding the use of the most modern treatment (Fagius 2003;Hillert 2003). Most laymen do not read scientific journals or books. Media builds up the shared public knowledge. Very often, as here, the doctor is made out to be the problem.

Although *medical ethics*-issues have been extensively discussed in newspapers in recent decades the debate has been edited according to journalistic conventions. Medical ethics, so constructed, has not dealt with problems lasting in time and not thrown light on the influence of law on individual's views and expectations. This issue will be further discussed in chapter two. Here I will merely point out that *medical ethics* is not something fixed but has been built up through bringing in and leaving out. The following summary is of an article about how the abortion law in Denmark may have changed life for women and men.

A peaceful reflection (extremely rare)

> In a Danish daily newspaper a Ph.D. student (Esbensen 1998) reflects on the 25 year-old Danish abortion law; how the law moved away abortion as a question outside the ethical field and in what way the law may have affected women's opinion of themselves as women, relations between women and men and society in other ways. The author's view is that the law has had unforeseeable consequences.

The sociologist Joseph Gusfield describes how issues get a public shape:

> Public problems have a shape which is understood in a larger context of a social structure in which some versions of "reality" have greater power and authority to define and describe that " reality" than do others. In this sense – of responsibility – the structure of public problems has a political dimension to it. […]Acceptance of a factual reality often hides the conflicts and alternative potentialities possible. Ignoring the multiplicity of realities hides the political choice that has taken place (Gusfield 1981, p. 13).

Gusfield himself shows how a focus only on the drunken driver (who can never as long as cars exist be totally eradicated) works against minimising accidents. To do so, one must also work with car safety and road safety. According to Gusfield, such measures were for many years virtually absent, compared with the activity to find drivers with high blood alcohol levels. In the same way, if the doctor is always seen as the primary problem, the incitement to search for other issues that are possible to change for the better fades away. I will return to Gusfield's ideas when discussing our public reality of today.

1.12 MY PERSONAL INTERPRETATION

Being a member of the doctors' community meant to me that I was a member of a praxis with predominantly inductive moral reasoning: searching for solutions with the help of previous experience. This meant not simply always acting but also biding time, and trying to find compromises, occasionally asking someone else to talk to the patient

and family: the social worker or someone else if no one in the ward's working-team seemed suitable. In situations like those I can understand that in the USA today an ethicist is required (DeVries & Conrad 1998, p. 247). Whether or not this is a better solution for patients is unknown.

1.12.1 About philosophies and philosophers or Four (of many) reasons to be humble

When *applied ethics* and *ethicists* from the analytic philosophic school were born, doctors were taught to think in a deductive way, with theory-bound principles applied to (what were seen as) medical facts. After a few decades one can wonder if we are in risk of changing the moral practice of medicine by using concepts of philosophy which do not fit: the risk of discussing problems that can be expressed not knowing if the problems in need of being discussed suit this new model. I will return to this question when discussing the results of my study.

Philosophers and theologians with other foundations than the analytical philosophy branch taught health care personnel about Aristotelian virtues and Continental philosophers' thoughts. That was stimulating for health care personnel who were interested in ethics but also showed new problems. When the language, categories and frameworks of one culture (as ours) are used to interpret and understand alien cultures – as pre-Christian Greek where a male elite (without competition) formulated their truth in a homogenous society (Flyvbjerg 1991, p. 86) – there is always a risk of simplification. The belief systems, social/cultural values and the general way in which the subculture or subsystem we are studying works, are not in themselves intelligible without interpretation. Our own language and thought forms are not always adapted to fit them and therefore interpretation is always problematic and maybe accompanied by distortion (Hesse 1973, p. 4). The same problem appears when using concepts, used in philosophy, about what *understanding* foreign cultures is. If one knows about the fusion of horizons after having read continental philosophers (Gadamer 1989/1967) – this picture has been used as a picture of a good medical meeting with gradual fusion of the patient's perspective of unhomelikess and the doctor's of medical expertise (Svenaeus 1999) – one does not manage to understand another person better. No patient has an unequivocal reason to her unhomelikeness. The clinical uncertainty remains clinical uncertainty: there are always "horizons" left out regarding understanding (Bernstein 1991), and there are always practical concrete issues to consider.

1.12.1.1 Time for thinking does not necessarily lead every philosopher to the same conclusion

In 1647 René Descartes visited young Blaise Pascal (Marc-Wogau 1992). Both were philosophers and mathematicians. Today Descartes is in much seen as the philosopher with the mind-body dualism, Pascal as the author of *Pensées* (Pascal 1962/1662). Pascal wrote "Descartes inutile et incertain" (Pascal 1962, p. 99). Two highly gifted men who possessed the time to philosophise deeply on all matters, yet who looked at the world in different ways: philosophy is not the way to the Truth.

Svante Nordin describes how brilliant philosophers in Europe during the First World War came to different points of view: Ludwig Wittgenstein volunteering, Bertrand Russell working actively against the War (Nordin 1998).

Descartes, named above, describes why he thinks it is so that we can love someone rather than another before we know the person's worth. If not knowing that this philosopher is seen as the one who made a division of mind and body one could not get to know it by this utterance either. He says: things get a meaning through earlier significant experience:

> The objects which strike our senses move parts of our brain by means of the nerves, and there make, as it were folds, which undo themselves when the object ceases to operate; but afterwards the place where they were made has a tendency to be folded again in the same manner by another object resembling even incompletely the original object. For instance, when I was a child I loved a little girl of my age who had a slight squint. The impression made by sight in my brain when I looked at her cross-eyes became so closely connected to the simultaneous impression which aroused in me the passion of love that for a long time afterwards when I saw persons with a squint I felt a special inclination to love them simply because they had that defect (Descartes 1991, p. 322/6 June 1647).

Peter Singer assumes that we are good at ethics if we have philosophical education and time to philosophise (Singer 1982). We may, however, get to different conclusions because we all (using the Descartian description) *have brains folded in different ways.*

1.12.1.2 Philosophers historically formed preunderstanding of morality

Immanuel Kant's writing can be interpreted as marking off *moral* reasons for acting from desires, wishes and other 'inclinations': thinking and writing as a man of his time when the standard account of human motivation was "psychological egoism" (Jonsen & Toulmin 1988, p 287;Kant 1866/1798).

In the same way, Jeremy Bentham, when writing *Principles of Morals and Legislation*, writes as a member of the society of his own time, trying to remove 'the King's wish' as law (Jonsen & Toulmin 1988, p. 289). Today Bentham's thoughts are often seen as the foundation of a timeless moral theory.

Jonsen and Toulmin claim that in the same way that we cannot define the term 'justice' from Plato's Republic alone, we can neither see Bentham's writings and John Rawls' *Theory of Justice* as being timeless and universal. Their written work must rather be understood as answers to the social and political questions and needs of their own times. Jonsen and Toulmin remind us that the theories of Bentham and Rawls do not throw direct light on problems of justice that arise between people who already know each other well (Jonsen & Toulmin 1988, p. 293).

1.12.1.3 Readers historically formed preunderstanding of philosophers' texts

Aristotle reflects on if the soul relates to the body as the seaman to the ship (Aristotle 1998a, p. 47). Many of our contemporary philosophers, among others Lili Alanen and Richard Zaner (Alanen 1989;Zaner 1988) have objections to seeing Descartes as *the* original divider of body and soul. Alanen means that there are resemblances between

the dualism of Descartes' origin and the dualism in Aristotle's system. It is easy to understand Alanen's viewpoint after reading some of Descartes' letters, for instance one written to princess Elisabeth, (daughter to Fredrik V) who asked him questions about body and soul:

> […] and finally what belongs to the union of the soul and the body is known only obscurely by the intellect alone or even by the intellect aided by the imagination; but it is known very clearly by the senses. That is why people who never philosophize and use only their senses have no doubt that the soul moves the body and the body acts on the soul. They regard both of them as a single thing; that is to say, they conceive their union; because to conceive the union between two things is to conceive them as one single thing (Descartes 1991, p. 227/28 June 1643).

Quite likely, Descartes' contemporaries understood him in a much less stereotyped way than later generations.

1.12.1.4 Everything may not be understandable

The philosophers Dewi Zephaniah Phillips and Howard Owen Mounce discuss Abraham's intended sacrifice of Isaac (Phillips & Mounce 1969). They conclude that even if someone today would make the same physical motions as Abraham it would be logically impossible to perform the same act today because of differences in cultural background.

1.12.2 Turning this writing back to medical ethics

Somehow, in clinical ethics there often seemed to be no real difference regardless of the school one consulted: both the questions brought up and the goal to strive for were also often the same. Much interest was focused on questions regarding the beginning and the end of life. The individual values of respect for the uniqueness and dignity of the individual self determination and privacy seemed to be the key goals. Often physicians were described as not sharing a similar system of relevance in understanding the patients' illnesses – they were seen as having gone into the world of science, categorising in terms of scientific constructs (Toombs 1993, p. 10). The doctors were now taught to think in new ways and with concepts not belonging to their old pre-doctor world or natural clinical-doctor world.

1.12.2.1 Looking to the past in order to see the present more clearly

A recurrent theme in writing about medical ethics seemed to be that science had somehow destroyed the mind of the doctor so that he lost his view of the patient as a whole person. The *whole person* as it is constructed and used as a concept in the health care of today (Armstrong 1982, p. 119) was certainly not seen by the doctor visiting a blacksmith or crofter 200 years ago; psychological concepts regarding individuality differ. The doctor certainly saw the crofter as a culturally anchored crofter but that did not hinder the crofter's children dying of malnourishment. Most people in Sweden

lived their lives without talking to a doctor two hundred years ago: when there was a proposal from the county governor in Södermanland (6000 km²) to employ a district medical officer in the middle of the eighteenth century, the region's inhabitants refused. They had a barber surgeon who could bleed and treat external injuries. People did not need, nor could they afford, more. It was often difficult to get a message to the doctor. Roads were next to non-existent and the journeys sometimes took days (Hagberg 1937). When the doctor was sent for it was because people were in need of his specialised skills.

With only 7 million inhabitants, Sweden in the 1950s had more people living in the countryside than in towns. The rural population shared somewhat less than one thousand doctors. In urban areas there were about four thousand more physicians. For the most upper class urban families the doctor may have been a person one could talk with about smaller life events. For most inhabitants the doctor was a foreigner to consult when a catastrophe was appearing. The terrifying district nurse, who rinsed purulent ears, may have been better known.

In the year report from the districts one can read about rat extinction campaigns, contaminated water, problems with drainage and latrines in schools, scarlatina epidemics, and so on. Thanks to the new penicillin, the isolation time (to hinder transmission) could be reduced from six to two weeks. If the modern ethicists had been around at that time, they would hardly have helped the doctors to think in another, more personalistic, way, hindering them from isolating innocent, contagious patients to save the health of non-patients. Societal factors have an influence on the doctor's role but today the clinical examples are mostly of the format: one patient-one doctor without any surroundings.

Fifty years ago was a time of paternalistic teachers punishing school children by slapping them, sometimes using just the hands and sometimes with a specific instrument. Teachers have stopped slapping children now because our society has developed in that way: we think in another way about how to protect children, who are dependent on adult persons. In no article written about the school problems of today is the paternalistic behaviour in the fifties and sixties mentioned. Our reality is not an inevitable reality, but instead merely one of many different possible realities that was produced by different discourses at war. The *paternalistic doctors* is written into the self-evident knowledge of 'reality' in another way than paternalistic teachers and priests, colouring discussions in an often routine-like way.

At the time of the birth of the modern medical ethics there was also a societal discussion about the role of health care going on. The development of medical enterprise was criticised for instance by Ivan Illich who talked about the 'Medicalisation of Life' (Illich 1975). Other critics of health care (where physicians were seen to be incorporated in a societal power structure) were Thomas Szasz (Szasz 1974) and Vicente Navarro (Navarro 1976). The physician's new role as a life – event facilitator and normaliser of life stages (Young 1987, pp. 108-109), now 'managing' chronic patients from not only the most upper class, was in the medical ethics discussions mostly not called in question. The medical ethics' *paternalism* – to fight against – came to be more a bad individual behaviour than a manifestation of societal power. Here was disclosed an inevitable risk of physicians' failing when laymen (as patients) were stricken with the tragedies of life.

At the same time as the modern medical ethics was born, articles were published in the physicians' professional journals, written without philosophic foundations. In the

respected *Journal of American Medical Association* 1961 one can read Donald Oken's report entitled "What to Tell Cancer Patients: A Study on Medical Attitudes" (Oken 1961). Likewise, one can read an article co-written by a surgeon and psychiatrist in *Cancer*: "The patient with inoperable cancer from the psychiatric and social standpoints: A study of 101 cases." (Gerle, Lundén, & Sandblom 1960). Articles with clinical ethics content, written for ordinary clinicians, with concepts, used in ordinary language, have continued to appear in the medical journals. In a Lancet Editorial titled "The ethics industry" it is remarked that one does not require recourse to 18th century philosophers concerning concrete practical matters (Editorial The Lancet 1997, p. 897). It is not possible to say how clinical ethics would have looked today if not shown an immense philosophical interest. Probably the less dramatic issues had been highlighted.

If one can say that Swedish society in the fifties was in a lower developmental stage – that the modern medical ethics with its emphasis on individuality was not applicable – one can reflect on if in a future society there will be a need of a different set of *medical ethics* than we have today. One could, for instance, imagine a Western society with more influences from Japan or China, where medical morality is said to be grounded in the basic view of the relationship between self and others and between the individual and society (Lock 2001;Fox & Swazey 1984, p. 345).

1.12.2.2 Philosophers teaching doctors, how do patients' and other individuals' values count (= a hint of chapter two)?

As pointed out earlier, clinical philosophical ethics focuses on individual rights: respect for autonomy, integrity, privacy and personal values. At the same time, in modern medical ethics there has been an ongoing debate about the foundation of ethics. Although in Sweden we have had a law since the seventies that permits abortion, a law which the women themselves in their behaviour urged on, the question of abortion is one of the topics of "perennial concerns for bioethics as a field" (Crigger 1998, p. 196). The question is now meant to be discussed without presumption (Anderberg 1998). As I understand it, for philosophers of the analytic school this implies leaving religious value grounds outside the debate as something irrational (Singer 1993;Smith 1994). When looking at common Western people's lives, one can see that when illness comes the cultural meaning of 'good life' is often connected with religious tradition (Callahan 1999, p. 280;Churchill 1999, pp. 260-261). An American study showed that more than half of the population of America believed in angels (Lock 2001a, p. 59). In medical ethics of the modern kind inclined towards reason, believing in an established religion can be argued against but the beliefs and values of a non-established kind based upon a feeling do not have a prominent place in the medical ethics value systems. In this way it is not so much the doctors or other health care personnel who lose, but the patients themselves and their families.

As a doctor one must try to meet and soften one's patient's existential anxiety and respect her values. However, if the patient is anxious because she is pregnant and says that she would keep the child if she lived alone but is considering an abortion (permitted by law) because her husband gets fits of anger for no reason and has a tendency to hit the children, there are norm systems (sanctity of life and the rights of the unborn respectively, depending on philosophical school) which evaluate according to morality. Today, medical and ethical problems are by modern academic medical

ethics representatives formulated within the realm of philosophy, where 'pure' thought free from the constraints of economic and social necessities has been the foundation. Pierre Bourdieu calls this the scholastic tradition (Bourdieu 2000, p. 12) and the connections between a social moral view and philosophic moral view are obscure or nonexistent.

Apparently, individuals and cultural/religious groups must agree or at least accept reasonable compromises in law regulations. The opposite of 'moral' is not always 'immoral' but 'neutral'. A man may say: "A foetus of 3 or 5 weeks is not a human being and does not suffer, I do not see it as a moral matter to make an abortion at that time. However, I find it deeply immoral that so many assistant nurses have lost their jobs. People in the end of their lives need fellow human beings to talk with." The man's remark does not suit in the academic medical ethics of today but may all the same be moral talk.

1.12.3 Coming next

Two main questions reveal themselves.

1. Do the philosophical theories suit the problems of the clinical world? (And do they do so without distorting with their concepts, foreign for the clinical problems?)

I will illustrate what I mean. Tycho Brahe, born in 1546, studied astronomy. On the evening of 13 November 1577 "[…] he looked up from the agreeable task of fishing for his supper, and noticed another new object in the darkening western sky" (Russell 1991, p. 77). For the next two months he examined it with the best instruments available to astronomers at this time. He found that this new planet must lie in the region above the Moon and that the fixed stars could move. This had not been possible according to the philosophical theories of Aristotle. Here we had a scientist whose empirical observations could not be explained within the framework of accepted theories. I do not say that our hospitals are filled with Tycho Brahes but there may be issues that do not match with theories.

> Example: If staying within the borders of rights contra duties in the Judith Jarvis Thomson text about abortion (1.8.1.1), one cannot get sight on problems of injustice caused by insurance rules. Although Thomson claims that of course a raped teenager in great despair ought to get an abortion, the girl will not get an abortion if she lives in the USA and does not have an insurance payment (Kampmann 2002).

2. Are there other questions left outside in the laymen's world that do not fit?

An Italian friend told me that when Galileo Galilei was arrested, put on trial and accused of blasphemy against the Church, laymen had accepted the scientific knowledge that the earth moved around the sun: they had other problems than those fought between groups of power in the war for the right to define the world. With this I say in the shadow of the fight of prominent branches of modern medical ethics (for instance is the Sanctity-of-Life Principle an important foundation in Western

civilisation or an old religious prejudice?) there may be other important problems for laymen.

> Example: As modern medical ethics has been a project where very few have had possibility to be published this is not known.

1.13 SUMMARY

I have outlined some of the medical ethics' schools, which deal with problems in clinical praxis. It is apparent that they are built up around different assumptions regarding human nature, goals etc. Part of this ethical school knowledge has had a high medial appeal, forming a public comprehension of what medical ethics is. Social factors and economic constraints have seldom been focused on.

Empirical knowledge about how moral problems look from the point of view of actively working clinical physicians (whom I will call doctors) has been sparse. Evidently, there are differences regarding what individuals and groups see as facts of importance in a moral problem, that is: which facts are value-loaded in a situation. In order to supplement the last decades' clinical ethical discussions with clinicians' experience, I have talked with doctors. Before giving information about the doctors' experience of professional moral problems, I will illuminate value questions, which are of importance in understanding the situation of today where different schools of philosophical ethics disagree regarding morality. It is also of importance in understanding the interviewed doctors' work related moral problems. These problems are connected with what problems laymen experience and what role the doctors, as well as patients and patients' families, assume a contemporary doctor to have.

CHAPTER TWO

FACTS AND VALUES

2.1 OUTLINE OF THE CHAPTER

In this chapter, I will

- describe different views on how facts relate to values
- point out that problems exist when claiming one kind of (e.g. universalistic or religious/cultural) value ground
- assent to the idea that one can talk about moral matters without agreeing on moral foundation
- illustrate moral reasoning among persons outside medical ethics' domains, keeping the question, whether the modern medical ethics cover the problems of laymen, alive (and answering that laymen may speak of loyalty and commitments over time instead of moral and immoral problem solutions)
- bring up questions of law and morality
- present the idea of *the open-texture of moral concepts* in 2.3.5. This section is aimed to enhance deeper understanding of the interview analysis in chapter four

2.2 INTRODUCTION

I will here describe some different views on relationships between facts, values and norms. Much of modern medical ethics is founded on theories that make the assumption of an ordered world with differences between facts and values and between descriptive ethics and normative ethics. As described in chapter one, there is no congruence between problems dealt with in modern medical ethics and clinical moral praxis. By studying fact/value relationsships, I want to show how these differences come to exist. In the latter part of this chapter, I will illustrate how problems dealt with in medical ethics may look from a layman's point of view (i.e. today's patients and their families and future patients and families). In doing so, my intention is to expose weaknesses in both medical ethics and formalised clinical praxis. When problems are pointed to from outside, as in the public medical ethics debate of today, there may easily be issues of importance for health care workers, and/or patients and their families that are not yet discovered.

Very little public media coverage has been given to the fact that both health care personnel and patients live in a society governed by laws where e.g. a doctor may be in doubt about if something, although legal, is morally right (as the doctor in 1.9). There has been an intense attention to the (legal) sterilisations during the last century (for instance in the Swedish newspaper Dagens Nyheter August, September 1997 mainly as a search for the responsible professions and persons. In a Danish book by Lene Koch the same evens are written more as a historiography (Koch 2000)). What is seen as

legal today may be seen as immoral tomorrow. I will bring up a discussion of how legal frames may work today.

To describe moral problems in clinical praxis, as I do later in this book, is not to describe what I see as *the* right way of reasoning but *one* way, with its time-bound blindness and presumptions (as medical ethicists' and laymen's reasoning). The stories that I present in this chapter as laymen's stories are stories heard by myself in a range of contexts outside the hospital environment. The stories are about abortion and transplantation: issues dealt with in modern medical ethics and existing in real life. More than 30.000 abortions are performed every year in Sweden, making the topic a topic of concern (and possible moral significance) for many people. It is apparent that there are problems around organ transplantation as there is a decreasing number of organ donors (Wijnbladh 2003). There may be problems, not solved only by doctors learning how to inform. The details of the stories have been changed in order to protect the identities of those involved. The validity lies in whether the stories seem plausible for the reader or not.

Once again I will remind the reader that I do not claim: *Reiten lehrnt man nur durchs Reiten*. Regarding certain details, the conclusion may be that I have investigated what 'Classic School' and 'Western School' riding teachers teach lumberjacks about using horses in their forest work, and what the lumberjacks experience they need to know. If lumberjacks are meant to use the language of the Classic School to talk about their work then it is good to understand the Classic School language. If the Classic School and the Western School disagree about the basics, then it is an issue to be resolved between themselves and not one for the lumberjacks to be concerned with. In this lies the commonly recognised fact that it is probable that lumberjacks (as most other workers) could do their work in ways other than the standard recognised norm. If these new ways could be called better or worse depends on the standard of judgement; such as if only the amount of produced timber counts or also the treatment of horses and/or a very big risk of hurting a fellow worker when working at an intensified speed. It would be wise if the representatives of the different schools tried to learn what kind of help that was needed and to see if the best result would come out of co-operation with other Schools. Here is included the fact that the teachers must make a judgement if the lessons must include a flying change of gallop and also if the representatives of one of the schools find this exercise extremely important. (The question of if moral objectivism exists may not be necessary to discuss together with practical everyday problems in health care).

Language only works when one can take a person's intended meaning without constantly having to explain what one means (Phillips & Mounce 1969, p 62). This is possible when people share the same qualifications or life experiences. To use Wittgenstein's example (Wittgenstein 2001, p.192/1953) on judging something as not red, one must appeal to a shared meaning about what red actually is. Moral practices may be seen as a part of such shared thinking; if concepts from outside which do not fit the thinking tradition are used, one can end up with superficial talk or misunderstandings. It is probably the case that nothing will change in the world if you merely say to your friend as she gets in her car "be mindful and careful with your fellow road users." That intention is probably built into her life regardless. If deciding before talking with my interviewees that I would use a 'key' consisting of ethical theories or principles, brought from outside to clinical praxis, I would have been locked into seeing something that possibly was not translatable into those categories. It has, all

the same, not been an outstanding intention to keep outside Western philosophy and the question is if it is possible in this kind of academic writing, taking place within a form of knowledge (Hacking 1999).

The medical ethics' questions dealt with during recent decades have to a great part been in the mould of finding the *right/wrong* and *good/bad* actions in a (very often dramatic) medical situation. In many cases the medical situations have been described as consisting of neutral facts upon which to apply principles. A tremendous interest has been shown towards the control of death and dying in rich Western countries. Questions of individual rights have, for the moment, been more conspicuous than *good life*-questions, both among medical ethicists and in the media (where a much-simplified version of the philosophical medical ethics debate has appeared). Ideas, not anchored in society of today, have been brought up. As medical ethics has crystallised, only a small fraction of divergent ideas existing among contemporary individuals (among them philosophers, historians and anthropologists, not particularly inclined towards medical ethics) have come into focus when giving the doctors an ethical action guide.

To sum up the introduction (and at the same time, give some hints of the results):

- The branches of the modern medical ethics have different philosophical foundations. In order to understand the foundations of the philosophical theories taught during basic courses of medical ethics (see preface) and dealt with as self-evident foundation (1.8.2), I find it important to look at their premises.

In a later part I will focus on

- problems with universalistic acclaims (as used in mainstream medical ethics) in a multicultural world. I will also briefly focus on mainstream medical ethics' relation to religions and law and cultural differences
- As previously mentioned, I will also look at the relation between medical ethics and laymen's moral reasoning, revealing that medical ethics faces the risk of becoming an elitistic, paternalistic enterprise in a democracy

2.3 DIFFERENT PHILOSOPHICAL VIEWS REGARDING HOW FACTS RELATE TO VALUES

In the philosophy of today, ethics is often described as consisting of three parts. One separate *descriptive* part, in which observations and recordings of people's behaviour is made, a *normative* part, which considers questions of good and/or right conduct in the spheres of personal and social relationships and *meta-ethics* which handles questions of general character of moral judgements (Frankena 1973). Many prominent philosophers disagree about the possibility of such divisions. For instance, Georg Henrik von Wright, working within the analytic philosophy field, doubts that there is a sharp distinction between normative ethics seen as the part which covers the prescriptive and the evaluative (the 'ought') and non-normative ethics (the 'is') (von Wright 1963, pp. 2-3). Neither does he see a clear boundary between *normative ethics* and *meta-ethics,* which is a modern concept describing the activity of the conceptual or logical study of morals. Von Wright's interpretation of Aristotle's *Nichomanean Ethics* (Aristotle

1998b/c. 330 BC), Kant's *Grundlegung zur Metaphysik der Sitten* (Kant 1948/1785) or John Stuart Mill's *Utilitarianism* (Mill 1971/1861) means that the authors did not distinguish sharply between the normative and the meta-ethical content.

The world in moral philosophy can also be described in terms of *is, good* and *ought* covering *descriptive, evaluative and normative* terms and sentences. 'Values' as a concept is used as in ordinary language as something ascribed to situations, objects etc. One can talk about, for instance, moral, aesthetic or religious values. Normative terms are prescriptions of different kinds (for example permissions, recommendations and rights). Many discussions in meta-ethics deal with the question of if an objective moral exists, and if that is the case, in what way can we gain knowledge about that phenomenon. Among contemporary philosophers there is, at present, no big wing, which believes in moral utterances representing feelings or attitudes. This idea was much more philosophically *en vouge* in the beginning of the twentieth century. A claim regarding universal validity is often held today and ideas exist (among utilitarians) (Sen & Williams 1982) that when one calculates the outcome of an action, one must count with the outcome regarding infinite future.

One meta-ethical modern (analytical branch) 'truth of logic' is that no moral conclusions follow from factual premises (Smith 1994). It can be traced to David Hume who remarks:

> In every system of morality, which I have hitherto met with, I have always remark'd that the author proceeds for some time in the ordinary way of reasoning, and establishes the being of a God, or makes observations concerning human affairs; when of a sudden I am surpriz'd to find, that instead of the usual copulations of propositions, *is*, and *is not*, I meet with no proposition that is not connected with an *ought*, or an *ought not* […] that a reason should be given, for what seems altogether inconceivable, how this new relation can be a deduction from others, which are entirely different from it (Hume 1992, p. 469/1888).

For those within natural science who are accustomed to natural scientific proofs it probably seems to be no proof at all. Regardless of this, the above idea has a prominent place in moral philosophy of the analytic branch. If Hume could have been understood in different ways is outside this writing as within analytic philosophy, his words are interpreted as a "law" (broader descriptions of Hume's interpretation of moral concepts can be found e.g. in Hilary Putnam: *The Collapse of the Fact/Value Dichotomy and other Essays* (Putnam 2002, pp. 20-21) and Annette Baier's writings (Baier 1985)).

The everyday world is full of examples demonstrating that the fact-value distinction does not exist in a law-like way and that what counts as facts have normative implications. Alasdair MacIntyre points out that only naming that someone is a sea-captain or farmer implies what a good sea-captain or a farmer ought (and ought not) to do (MacIntyre 1985, pp. 56-57). In this way, by changing the philosopher being listened to, one changes from one ordered world with fact-value distinctions to a different kind of ordered world. Phillips and Mounce object to both kinds of order and give examples: a good farmer is a good farmer when the end is defined as being the producer of good crop. When cattle are involved it already is more complicated; questions arise such as does a good farmer keep cattle indoors? (Phillips & Mounce 1969, pp. 52-53).

My own conviction is that although the world is value-laden, it is not value-laden in the same way for all of us. If school teachers and health care workers always believe that the world is an ‘orderly’ place (as in the MacIntyre view), where parents have no wish to harm their children, then they will in due course betray those children who are abused (either physically, or in some other way) in their own homes.

2.3.1 A value-loaded world

The philosopher Fritjof Bergmann expresses his disbelief that values are ‘secondary’ to facts and that the world is ’neutral’ (Bergmann 1983, pp. 127,142). He says: “The world does not consist of neutral objects, which we disdain or value; the world is sad and alluring, horrible, magnificent and disgusting, attractive, splendid and mean in its own right” (Bergmann, p. 141). This is a description of the world using *thick concepts*. The concept ‘thick description’ can be traced to Gilbert Ryle. Behind this concept lies the understanding that we can communicate about a richer world than one consisting simply of right/wrong, good/bad and the like, these are later called thin descriptions (Ryle 1971). Clifford Geertz notices that there is an enormous difference between saying that *a boy is twitching his eye* and saying that *he gives malicious amusement to his cronies* (Geertz 1973, pp. 6-7). I give two examples:

In the first example we have facts at hand, a principle stated and a solution found. A philosopher from the analytic school uses thin conceptions in a radio programme:

> Talking about suicide, a philosopher declares that one should define when it is *right* to commit suicide. As an example he names that if someone who has a disease which makes life not worth living for that person, and the family (spouse, parents and children) accepts the suicide, a doctor ought to assist because then it is *right* to commit suicide.

As an example on thick concepts I will tell a friend’s story (somewhat changed, yet written with permission):

> Seeing his children grow up, a middle-aged man often reflects on his own years as a teenager. When he was 15 years old his mother died of cancer after years of illness. Her doctor had told him that she would die. For a while he came to some kind of acceptance of the family’s fate, however her last months became almost unbearable for him: she began to say that she did not want to live anymore. When she got fever she was, despite her terminal condition, eager to go to the hospital and get treatment. He started to feel repulsion: he realised that he was not so important to her as he had thought. He felt that she used her illness to act irresponsibly.

What counts as facts for one person may be values for another. Unsolvable problems are a part of life. Thick concepts are used in this story. No right/wrong or good/bad is used. A value-laden meaning regarding how a mother ought and ought not to behave is built into the story without translating to such concepts. Concepts like sincerity, honesty, courage and loyalty live their own life, as a message of something about human life without being connected with that which is perceived as *good* or *right* or *wrong*.

2.3.2 About ethical theories

2.3.2.1 Universal acclaim

At the moment it is common in the enterprise called medical ethics to refer to moral issues in the health care sector according to three key standards: virtue ethics, deontological ethics and consequentialism (of which utilitarianism is one). At first sight such a classification may look irreproachable, lifting up the mess of everyday life to a theoretic and possibly even scientific level. However the concepts do not describe the same state of things and are not interchangeable, in the same way as it is possible to name the length of a road in meters as well as yards. To use an example, although both deontology and utilitarianism answer the question: "What shall I do?" the former shows us to goals within morality and the latter assigns morality a purely instrumental role. While it is often said that a physician's ethics is a mix of consequentialism and deontological ethics, this in fact sets together irreconcilable entities (if the terms are seen as in philosophy grounded terms). The neglect of a person's attachments and ties are shared by utilitarianism and Kantianism (Sen & Williams 1982, p. 5), but the morality is seen as different, coupled to the end-state and duty respectively.

A *theory* can be seen as a group of assumptions or assertions, explaining different kinds of phenomena and systematising them. An activity is theoretic (in contrast to empiric) if it is founded in a theory and by that reason not only noticing facts but also explaining them and predicting new events. Theory is often used about a demarcated amount of knowledge, it may also in everyday language also be used about something hypothetic ("this is still just a theory").

Beauchamp and Childress (Beauchamp & Childress 1994, pp. 44-47) discuss criteria to separate theories from norms belonging to our pre-theoretic thinking. They name eight conditions for making a well-developed theory. They point out that no theory gets high scores on every criterion and a theory can get a high score on one and a low score on another criterion. Their criteria are clarity, internal coherence, completeness and comprehensiveness, simplicity, explanatory power, justificatory power, output power (producing data in excess of pre-theoretic beliefs) and practicability. According to them, the same general criteria as for a successful moral theory can be used for any type of theory. As examples they name scientific theories and political theories (Beauchamp & Childress p. 45).

The philosopher Richard Bernstein sees this search for order (although order does not exist) caused by the 'Cartesian anxiety' (Bernstein 1983, pp. 16-20). It is apparent that also if one may speak of some kind of order in natural sciences during a period of 'normal science' (Kuhn 1996/1962), in the study of social sciences one does not accumulate knowledge within a field of knowledge – episteme – as one does in e.g. physics. Most scientists in a natural science field can co-operate in research projects. Differences may occur in medical praxis, e.g. regarding what role bacteria plays in stomach ulcer formation and some neurologic diseases but such differences in view is not ordinarily a hindrance to working together at the same departments. Regarding

medical ethics theory field it is easy to see that basic agreements do not exist, on the contrary, the same abyss as was to be found between Pascal and Descartes still exists (1.12.1.1).

The study of human beings and society can be pictured as changing upon different fashions and power fluctuations (Flyvbjerg 1991, p. 45). Bent Flyvbjerg discussing what a theory is in social science refers to Hubert Dreyfus' manuscript from a lecture 1982 "Why Studies on Human Capacities Modeled on Ideal Natural Science can never Achieve their Goal". According to Flyvbjerg, Dreyfus makes a six-point criterion for a theory. The criterion is based on ideas from Socrates, Descartes, Kant and modern natural science. A theory is explicit (not founded on interpretation or intuition), universal, abstract, discrete (not using context-dependent elements), systematic (forming a whole), complete and predicting. With this definition, theories in some way dependent on context, can be seen as abstractions but not as theories.

Flyvbjerg has a discussion about the Aristotelian concepts *episteme* (scientific knowledge), *techne* (today known as technology, skill, know-how) and *phronesis*, translated to prudence and practical wisdom. This last concept can be seen as judgement of conduct, based on collected experience. Aristotle did not explicitly work with power questions, which may have been of minor importance, when belonging to a male elite in a small society. His ideas have been hard to translate to situations today, Flyvbjerg uses the term 'progressive phronesis' to mark out that when using the Aristotelian concept, he does not try to get back to the old Greek society.

Although the electrons move as they move (if they exist and if they move) independent of human theories, the theories made by the natural scientists are not independent of what they see as the relevant facts. Applying an ethical theory to human situation influences on what one sees and interferes with the recommended outcome. A situation can be described in different ways – a picture of a moment (a medical encounter) or lasting decades (as family conflicts may do). What situation one applies the theory to or interprets the situation with depends on if the theory can work with situations over a period of time. Peter Berger and Thomas Luckmann point out that if a psychological theory is recognised as an adequate interpretation of reality "it tends to realize itself forcefully in the phenomenona it purports to interpret" (Berger & Luckmann 1966, p. 178), regarding psychological theories through internalising working as identity forming.

The philosopher Annette Baier (Baier 1985, pp. 213-214) discusses the practical use of ethical theories in teaching. According to her, students attending moral philosophy courses, learn to defend their moral intuitions by subsuming them under some universal rule. She finds that they are taught that they must have been muddled if their intuitions are inarticulate or are not suitable to code. Baier says:

> There is no reason to believe that actual moralities mimic legal systems in the way they control or regulate action, and it is only a dogma that we would improve actual moralities by making them mimic legal systems (Baier 1985, p. 214).

> Yet the influence of our introductory classes in ethics may be fairly direct and immediate – exposure to a variety of moral theories, and the varieties of conflicting advice they generate when "applied" to business or medical decisions, is a very effective way to produce a moral skeptic. Our pluralist culture prepares a young

> person for moral skepticism, and a course or two in comparative moral theory (and application) is the perfect finishing school for such skepticism (Baier 1985, p. 234).

Some of the ethical theories used in medical ethics teaching are quite elaborated as theories and may be good in e.g. academic writing, starting from a foundation and when referring to known entities. This, however, is quite another dimension than teaching medical students, who are going to work in a practical field. Working in such praxis one meets an extremely wide variety of different problems, many of them with connections to e.g. economic constraints and many individuals' conflicting wills. Although I think that much wisdom is to be found in reading Aristotle, there are many problems of societal/political origin as unemployment and there are interpersonal problems, such as troublesome family situations where a doctor's practical wisdom is not enough or perhaps not the best help.

To say that physicians strive towards making decisions with good consequences, and fulfilling what they see as their duty can well be said without ethical theories. (My study object is not the solving of ethical problems but to describe what work related *moral problems* are seen to be by some doctors).

In the world of universal ethical theories every moral question seems to have a correct answer: that is dictated by the moral theory. Behind the theories lies the prerequisite that moral knowledge is theoretical, objective and grounded in some kind of foundationalism. This construction of medical ethics: that in a multicultural world (as ours of today) (Turner 2001) right solutions existed and could be reached (by thinking thoroughly and by discarding prevailing cultural values) is an idea that became popular in newspapers, where it met very little criticism by either professional philosophers or journalists. In a newspaper (Genberg 1997, p. 45) an ethicist says: "In praxis, we all take for granted that there exists a moral objectivism." If there would have been philosophers, working as medical ethicists in the first half of the twentieth century in Sweden the chance that they would have had a contrary idea about moral objectivism is great.

Outgoing from different philosophical views on the nature of morality, the same ethical problem and the same solution may be found. In this way the Swedish philosopher Ingemar Hedenius (Hedenius 1963a,b) and for instance the philosopher Peter Singer with quite different views on moral foundation have the same standpoint regarding euthanasia (Singer 1993). As apparent in liberal *Dagens Nyheter*'s editorial columns (Editors DN 2000) the editorials view is the same as both moral schools, calling into question the role of ethical theories in medical ethics' standpoints and, bringing back the issue from chapter one that media have an important role in shaping public problems (Gusfield 1981)).

The question of moral foundation, which is a requirement for the existence of those theories, is, as I see it, not essential for the discussion of moral matters. Clifford Geertz, tells an Indian story about an Englishman, who, having been told that the world rested on a platform which rested on the back of an elephant which rested in turn on the back of a turtle, asked: "What did the turtle rest on? Another turtle. And that turtle? 'Ah Sahib, after that it is turtles all the way down'"(Geertz 1973, pp. 28-29). One can talk without solving what the "all the way down" consists of. In fact, the question of if there is a firm moral layer at the bottom of the moral world is old: Bernstein (Bernstein 1983, p. 8) points out that the fight between objectivists and relativists can be traced to Plato's attack on the Sophists and on Protagoras' alleged relativism. Gilbert Harman and Judith

Jarvis Thomson (Harman & Thomson 1996) debate if there is an objective morality or not. This may be a good philosophical question, traceable to Plato's time, and unsolvable.

That the patients come from different cultures with different valuegrounds – a multiplicity of morals, having different expectations of health care and that not all values are to be accepted in health care is not easily discussed with an ethical theory approach. Although declaring a universalistic validity of a theory like utilitarianism an evaluation has been made to deal with securing death in Western countries more than work for relieving the suffering caused by basic life issues such as a lack of clean water or vaccinations. Neither has attention been paid to occupations and working environments that make people ill. The personal view of what is valuable also appears when professional ethicists express their analysis of some issue. In a Swedish journal (Carlsson 2002) philosophers of the analytic school come to divergent results concerning the legalisation of doping in sports and if doping would make sports more or less interesting. There is always an evaluation regarding *what* counts and *how* when bringing up health care problems but this personal and group/discourse related opinion has been shadowed in mainstream ethics of today. In fact there has been an evaluative process for the philosophers to choose philosophy of sports (Johansson 2001) and to choose animal rights but not children's rights, to show interest for questions regarding euthanasia but not showing interest in improving the risky short lives of prostituted children, women and men.

Sometimes apparently, medical ethics discussions, according to an ethical theory has no 'medical' content but very superficial details may locate a thought experiment suiting the theory into the medical world. In Gilbert Harman's book on ethics focusing on the subject as a basic philosophical issue he brings up a discussion about why we should not cut up the patient in room 306 and give his organs to five other patients. Harman calls this a "thought experiment" not meant to be a hypothesis to be compared with the world, but to compare an explicit principle with our feelings about certain imagined examples (Harman 1977, p. 4). This example of setting aside our right to live has been mentioned (as a calculation about some kind of utility) in Swedish newspaper articles during recent years (1.4). The reader of the changed Harmanian example is turned into a fool and left in a state of uncertainty regarding why such an example is brought up. New developments in medicine that throw up ethical questions with few precedents has been named as one of the causes to the birth of applied ethics (Singer 1986, p. 4). However, this killing example is invented outside health care and not by laymen or health care professionals, showing that the theory used brings in a valueground not anchored in society.

Gilbert Harman himself, the owner of an original organ-stealing example without naming it 'medical', peacefully discussing basic philosophical problems about morality assumes that observation always depends on theory. He states that if you can perceive that you have boys in front of you, then you have to know that people pass through the stage of infant, baby, child, adolescence and adulthood. In a situation involving children pouring gasoline on a cat and igniting it, you must know how a cat is different from other animals, and know what gasoline is etc. Harman says that what you see is is more than just a pattern of light on your retina. Here Harman is describing something like a *life-world*, you look at a world, which is filled with meaning beforehand (Husserl 1999/1931). The concept of life-world will be discussed in chapter three (3.2.1) but as ideas from a group of philosophers of the Continental philosophy branch have been

used as an alternative to the universalistic theories in medical ethics (1.8.4) I want to make some comments regarding such an approach.

2.3.2.2 Non-universal acclaim (?)

The ideas from a group of philosophers, working with phenomenology and/or the philosophy of existence have often been named in medical ethics of the late twentieth century (see chapter one). In medical ethics' praxis, ideas from those philosophers and theologians have been used as instruments to understand and meet human suffering (the suffering Other). This often has been called situation-based ethics, however the situations have been dealt with in an abstract way, decontextualised from family conflicts and time and economic constraints. As an example, the Danish theologian Knud Eiler Løgstrup finds an existing ethical demand (Løgstrup 1997/1956) in the encounter with one's fellow being. According to Løgstrup, the ethical act is self-evident in this situation, and it is to be found and then followed. "The deed which ought to be done" (Løgstrup, p. 155) is not to be neurotically avoided as there are demands in the situation. Named situation-based ethics, the situation has been self-evident, the ambiguity from real life is not prominent and that "the deed which ought to be done" may be problematic as many persons are involved or the long term result seems to be some other than the immediate result or that economic constraints make the problematic situation difficult to discuss with this approach. Behind this meeting the Other is an understanding of the Other as a stranger, often as a threat ("the strangeness of the Other" 1.8.4) (Lévinas 1969;Sartre 1984, pp. 301-400).

Every philosophical system is in some kind of competition against the previous system, the disadvantages with the forerunners' thoughts may be exaggerated. Every philosopher has indistinctnesses and ideas not thoroughly thought through, which will be solved in different ways by later philosophers. One philosopher's world of ideas consists of components of several other philosophers' reasoning, taken with or without their own awareness, over a long period of time. So, for instance, what we call philosophy of existence can be seen to have been influenced by many epochs and any two given philosophers do not have exactly the same masters. Looking superficially, one can get the impression that issues dealt with during different periods deal with the same issue. So, for instance, what came to be the core ideas among the twentieth century existential philosophers can be traced to many others, e.g.:

- Human existence is the starting point for philosophy (Socrates, ca. 470-399 B.C.)
- Human existence has limits, there exists the possibility to get in contact with something bigger (Auguste 354-430 AC)
- Human existence is characterised by fear of death (Blaise Pascal 1623-1662)
- Man is surrounded by emptiness, there is nothing to lean on (Max Stirner 1806-1856)

However, how much the individual from Socrates' days (Jaspers 1994c, p. 384) is like the individual of Stirner's days or our post-modern days is unclear.

In the same way, the meaning of concepts depends on the time they are used. *Intentionality*, a concept of great importance in Husserl's philosophy can be traced to the Middle Ages. However, the medieval intentionality, as used by Wilhelm of

Ockham (Hamlyn 1987, pp. 116-122) is far from the Brentono's nineteenth-century meaning (von Wright 1965).

An idea that we all should to strive after happiness or some other utilitarian assumed common goal is of course a political thought. Also the thought that the health care worker's obligation lies in the dealing with the suffering 'Other' is a normative or political thought by focusing on the patient being cared for and leaving other issues outside. A great deal of modern health care work is teamwork, taking care of patients who often have clouded consciousness upon arrival to the emergency department, as well as when leaving the hospital (Nilsson 2001). Other common problems are apparent of social/socetal origin as work overload or problems seconadry to insurance rules (Bengtsson 2003;Nykvist 2003) Problems connected with such common everyday work is not easily discussed within the framework of concepts and categories from Continental philosophy as a practical tool.

A theory may seem unproblematic from outside but these phenomenologists and existentialists), despite working with related questions, they worked in different ways and came to partly different solutions, changing views during their lifetimes. I find it useful to illustrate that they are human beings with human beings' thoughts, influenced by other human beings. They, as other human beings, change views over time, their lives are filled with accidental occurrences, sympathies and antipathies, in no way dealt with better than by other human beings.

Simone de Beauvoir tells a story about an evening, sitting with the philosophers Jean-Paul Sartre and Raymond Aron. Aron pointed at his glass and said to Sartre:

> "You see, my dear fellow, if you are a phenomenologist, you can talk about this cocktail and make philosophy out of it!" Sartre turned pale with emotion at this. Here was just the thing he had been longing to achieve for years – to describe objects just as he saw and touched them, and extract philosophy from the process. Aron convinced him that phenomenology exactly fitted in with his special preoccupations: bypassing the antithesis of idealism and realism, affirming simultaneously both the supremacy of reason and the reality of the visible world as it appears to our senses. On the Boulevard Saint-Michel Sartre purchased Lévinas's book on Husserl, and was so eager to inform himself on the subject that he leafed through the volume as he walked along, without even having cut the pages (Beauvoir 1992, p. 112/1960).

This accidental conversation at a café apparently made Sartre go to Berlin. He studied phenomenology there between 1933-1934. By that time the philosopher Edmund Husserl was an old man. Martin Heidegger was his successor in Freiburg. Husserl can be seen as the founder of transcendental phenomenology. Husserl's philosophy can be characterised as a Cartesian philosophy (and so is the philosophy of Sartre): there is a reflecting mind, an "I." Husserl's student Heidegger (Heidegger 1996/1927) made an ontologisation of the human being: 'Dasein' took the place of Husserl's 'I'.

In the foreword to the Danish version of *Cartesianische Meditationen* the translator tells a story that Husserl is said to have told Emmanuel Lévinas (Husserl 1999/1931): As a child Husserl received a knife as a present. He did not find the edge sharp enough and so he sharpened the knife, and continued to sharpen the knife until it eventually became too small. So Husserl, spending a great deal of time writing in privacy seldom

found his writings ready for publication. In *Logische Untersuchungen* (1900-1901) his ideas had a close relationship with his teacher Frans Brentano. Husserl could at that time be described as working with descriptive phenomenology. At the time of the publication of *Cartesiansche Meditationen*, a book written after his lectures in Paris 1929, his ideas have changed, perhaps he was now describing an idealistic philosophy (Lübcke 1987, p. 72; Ricoeur 1981). Husserl succeeded in developing old thoughts in a radically new way: bracketing the natural/taken-for-granted attitude one could study the acts of consciousness. Husserl's 'Lebenswelt' (life-world), coloured by our values, needs and feelings, influenced by social patterns and conventions is seen as being pre-theoretic and a precondition to science.

Jean-Paul Sartre, who studied phenomenology in Berlin in the early thirties, when Heidegger had stopped visiting the psychiatrist and philosopher Karl Jasper because he had a Jewish wife (Lilla 1999a,b). Sartre was later called an 'existential philosopher' or 'existentialist' seeing questions of human existence precede the questions of essence. From outside, many saw similarities between Heidegger, Sartre (called atheistic existentialists) and Gabriel Marcel, Kirkegaard and Karl Jaspers (called Christian/deistic existentialists). Although an elegant division from outside, from inside it looked in another way. Marcel, found his philosophy misunderstood by the grouping together in this way. He describes what could be behind the naming:

> For almost twenty years I have consistently rejected the label of "Christian existentialist" which was first applied to me by Sartre and then by countless popularizers. I have taken every opportunity to emphasize the difference between philosophical research which deals with existence and a doctrine which makes existence prior to essence. Indeed, for me "essence" constitutes the locus of a renewed meditation, and I would be wholly against subordinating it in any way to the notion of "existence"(Marcel 1973, pp xxxi-xxxii).

Also Maurice Merleau-Ponty refused to be called 'existentialist' during the last years of his life (Nordin 1995, p. 517). Thus, in ordering and labelling from the outside, simplifications and misunderstandings may occur and an idea or school begins to live its own life.

Some of the writings of the existentialist philosophers' are brilliant observations concerning human matters and contain much human wisdom. However to use the thoughts from a group of philosophers or a philosopher as a guiding tool for the ethical good or right in a situation (as the medical encounter) one must also bear in mind that one has moved to a social reality. The existentialists (if we can go on calling them that), many of them bred at the same elite school with tight, personal bonds, (Collins 1998, pp. 761, 775) could not co-operate in praxis and were no better human life practisers than anybody else. Heidegger showed also after World War II contempt for us ordinary people and for politics of the time. If Heidegger had studied for the medical profession when his most important philosophical writings were done: would his deep philosophical education have made him to a good doctor? (I will reveal my opinion in chapter five).

I will not scrutinise other philosophical theories as neo-Kantianism or critical rationalism, contractarianism, (to name a few). Neither will I comment on virtue ethics more than already done under 2.3.2.1. Virtue ethics is today not a prominent theory in doctors' teaching and as will be apparent in the end of the book, I do not see the moral

problems, experienced by doctors, possible to bring away with improvement of doctors' prudence. The philosopher Annette Baier remarks: "We certainly do not find some engineers building bridges or spaceships by application of one theory, while others at the same time are applying another different theory."(Baier 1985, p. 232). There must be a communication between philosophers and within society. This is primarily not a problem for health care workers to judge and choose between the theories.

2.3.3 About medical ethical principles

The Four Principles, named in chapter one (1.8.2) are a mixture of post-Enlightenment ideas (autonomy), ideas from the Hippocratic tradition (beneficence, nonmaleficience) and societally founded values, interpreted within the own culture (Justice). The principle of autonomy has come to be used most often as *the* content of medical ethics. The Justice principle has actually come to mean justice for those who can articulate, leaving aside for instance those who do not have insurancies in the USA, (Daniels, Kennedy, & Kawashi 1999).

Kenneth Gergen, professor in psychology, writes (in a social constructionist approach):

> The meaning of the principles of justice, honesty, and equality – in terms of behavioral applications – can vary. It is in this way that the abstract principles embodied in the Constitution, the courts, or the Bible can remain relevant; their meaning is under continous repair (Gergen 1994, p. 102).

A doctor, trying to follow principles in his work must have come to different conclusions depending on the existence of penicillin.

The ethical principle used turns some issues into problems and leaves other issues, which don't fit well into the boundaries of the principle, outside. When the emphasising of some issues (e.g. the principle of autonomy) or presentation of problems as only being situated in the consultation room get public, recurrent attention in the media, a new shared social reality is shaped.

It is sometimes easier to see patterns if looking at other issues. Joseph Gusfield (Gusfield 1981) demonstrates social problem formation by the repetition of facts (that, when making a control are not always true), by dramatisation and by the withholding of facts. In this way, he finds the Drunken Driver as the only cause of car accidents was born. Looking from a distance, the problems of clinical ethics share resemblance in structure with the above: both representing a selective process from multiple possible realities affecting accidents in traffic/problems in health care. Some groups are seen as the owners of a problem, others are actively disinterested in the ownership. In the last group one finds the automobile industry and the pharmaceutical industry. Failures of roads and of deficient hospital resources are not meant; instead the faults are attached to the individual (driver/healthcare worker). Gusfield quotes an apocalyptic tale about the American philosopher Morris Raphel Cohen, who is said to ask his students on a course in ethics a problem about an angel (Gusfield, pp. 2-3). The angel came down and promised something, which would bring families more together, decrease the time of transportation and create an easier life. However, the angel demanded that every year 5000 Americans be put to death on the steps of the Capitol. The risks of the modern

medical treatments are of the same kind: As a health care worker one knows that some will be killed.

Gusfield describes how, what he beforehand thought was a dull and hackneyed project on court cases came to look quite different. Without claiming to be a researcher of Gusfield's quality: the repetitions of the paternalistic physicians as the cause of most troubles in healthcare made me aware of a political formation; somehow here the normal political constraints moved away from the ordinary society and the paternalism of the doctor seemed to be the hindrance that prevented patients getting unlimited resources.

I will recall a story about *school ethics* in order to show how accidental, yet at the same time self-evident one's way of seeing the world might be. The intention behind this fictitious story is to show how problem analysis within a frame of fixed concepts and principles may be simplified and today impossible outside health care.

2.3.3.1 The Four School-Ethical Principles

In the sixties, philosophers started to show interest in ethical questions involving schools. For several years, in TV debates and newspapers, moral questions belonging to the school world seemed to be congruent with philosophical ethics. Because teachers from the old days were known to be patriarchal they were not seen as reliable and were not believed to have the will to change as much as other professionals such as nurses, physicians and priests were in those days.

So, the applied ethics branch of school ethics came to be philosophical ethics. It came to deal with a wide range of questions, matters of pedagogy, pupils' conduct problems and resource allocation problems to name but a few. Some philosophers assumed that everybody ought to strive towards specific goals and they could even specify these goals both within and outside the school world. Others used special school ethical principles when discussing problems. These principles were based on an assumption that the school children and their families had a joint interest in striving towards autonomy as opposed to the paternalistic teachers.

In the old days, questions such as how to distribute money in society were seen as political questions. Now, when families with many school children moved into a school area, it was seen as a question for school ethics. Seminars were arranged where teachers discussed 'one computer, sixty pupils' and had to decide which ethical theory solved the problem best. The teachers, however, had difficulties in learning to think in a new way and could still be heard during their own school conferences discussing the pupils' school problems saying things as: "I know his elder brother, I know that the children have problems at home." Such an old-fashioned comment could not be translated to the modern philosophical concepts.

After a few decades a new insight came from a group of philosophers: the four school-ethics principles were evidently American and some new principles better suiting the European culture were added. The teachers, who had attended courses where philosophers had taught them the Four Principles, were blamed for taking the principles too seriously; they were now taught that the principles were only meant to teach them think systematically.

One can reflect on the function of these *ethical principles*. In fact principles may be seen as creating problems rather than solving them and if you do not have a principle in a situation, then you may not even have a problem (Phillips & Mounce 1969, p. 86). Also, if you believe in principles but you do not notice a moral content in a situation, then you have no reason to apply a principle. You may even see a possible moral content in the situation but do not care (Blum 1994, pp. 32-33).

When my (fictitious) teachers speak, they can be said to negotiate about what counts in school situations, which have occurred during recent years. Also, much is dependent on what is known about the home situation and what teachers see as being their responsibilities. Teachers have individual, deeply rooted beliefs concerning religion, politics etc. What constitutes human good and harm differs for different individuals: a pacifist and a militarist What is seen as morally right and wrong depends on the individuals' understanding concerning these matters and this is derived from the moral practice to which she/he belongs (Phillips & Mounce 1969, p. 62). The teachers work at school, however, must be based on democratically decided goals and basic democratic values.

Rules and principles may be seen as manifestations or expressions of (more or less broadly) accepted standards. For many years, Swedish teachers have tried to get pupils to take their baseball caps off while indoors, but this has not been successful. A rule or a principle must somehow be plausible if it is to be obeyed and apparently the pupils have not found that the teachers have given a good enough reason for this principle. A teacher who holds the principle of always telling the truth may in certain situations find reasons to act against this principle if he/she wants to help a pupil who has parents that use very cruel methods of punishment for that pupil's short-comings. Another teacher possibly sees himself as following no particular principles at all, but may deal with each situation in the best way possible, which may mean that he takes exactly the same measures. One teacher, who is suffering from burnout, may see that he should interfere in a particular situation, but he can't find either the energy or the interest to do so.

The same as about ethical principles can be said about the *ethical theories*, when used in praxis. The philosopher Gilbert Harman talks about watching a group of boys set fire to a cat. What does an observer see, how does he find the boys' activity wrong, do moral facts exist? (Harman 1977, pp. 7-8).

As it turned out, a very similar occurrence happened in a schoolyard: a teacher saw two boys, not pouring gasoline on to a cat, as in the Harmanian example, but tormenting a schoolfellow. The investigations showed that the pupils came from extremely difficult home conditions, where neglect and corporal punishment were the rule. However the debate that followed in the media came to focus on what the teachers had done wrong. Owing to the fact that the autonomy-principle was of no apparent help in this case, there arose a discussion about whether the teachers had failed to treat the children fairly and if so, in what way. Two different philosophical schools, which both believed that there existed a culturally independent, objective morality, ridiculed each other's assumptions on the foundation of morality.

Most teachers, who had not attended courses in ethics, did not reflect on how they perceived the fight as wrong and for months there was an ongoing discussion in the teachers coffee-room as to what they as teachers could possibly have done to prevent the tormenting. Looking back, there had been some incidents with the boys before but these were no worse than several other incidents concerning other pupils. According to

some older teachers, who met many of these 'hopeless, problematic' boys in their adult life, they had often acquired steady jobs, nice wives and children. What was a teacher's duty? What was the duty of society, of neighbours etc.? Underlying these discussions was an unspoken idea that children should have a secure childhood, even if their parents could not manage to take care of their children.

One can reflect upon whether theoretical knowledge inevitably provides another 'better' type of behaviour. Our use of principles is not clear at all: do principles steer actions or are they used as a construction afterwards? Does one change after looking at a model or choose a model according to one's own beliefs? As I see it, by acclaiming what principles to use, one begins with one's level too high, not having discussed what basic issues to agree on.

Although aiming to be logical and to help clinicians think in a structured way, if reading carefully one can often find that philosophers' and ethicists' answers regarding new 'ethics' issues are often mixed with historical observation and personal opinion (DeVries & Conrad 1998, pp. 238-239) and not analyses on what different ethical theories would give as results. The personal view of what is valuable appears also when professional ethicists express their analyse (2.3.2).

2.3.4 How do we decide what is moral?

With the theories and principles, the healthcare had obtained a model where the moral came from above and cascaded down. However, in ordinary life, moral reasoning seems to go *up* from the specific and concrete, and not down – via deduction – from general criteria and standards (Bergmann 1983;Blum 1994). Frithiof Bergmann points out that the general proscription against lies has its base in the damaging result of individual deceptions (Bergmann 1983, p. 148) and that by looking at single cases of prisoners on death-row one can move towards the idea that the law must be changed (Bergmann, p.149). "Thinking what is the best thing to do" is impossible only in general terms (Hampshire 1983, p. 63).

2.3.5 The Open-Texture of Moral Concepts

Within analytic philosophy, as named, one distinguishes between the factual, the evaluative and the normative. One can also talk about 'thick evaluative terms' and distinguish *moral terms*: just, reliable, loyal, and *non-moral terms*: graceful, vigorous, serene, wholesome (Thomson 1994, p. 11). For the non-philosopher, a moral problem is not a problem of semantic classification but a problem of what is relevant in the situation and a problem of decision. Our different beliefs and assignments as neighbours, teachers etc. influence what we see as relevant and logically involved. One can never speak about the facts of a situation: no situation is finally described.

The British philosopher John Brennan has in his book *The Open-Texture of Moral Concepts* opened up an original and constructive way of discussing how moral concepts are formed (Brennan 1977). He assumes that we cannot understand moral

judgements until we realise that such judgements are comprehensive only within a context of meaning, giving significance to certain features of a situation, lifting them out of the neutral background (Brennan, p. 30). According to him, moral judgement is not the pinning of a normative label upon a uni-levelled, neutral array of facts: "moral questions arise only within a structured situation" (Brennan, p. 31). He argues that "there is a distinctive mode of moral understanding over and above, and irreducible to, any logical or factual considerations" (Brennan, p. 10). According to Brennan, implicit in the making of a moral judgement is the belief that anyone who considers the case properly should be in agreement with one's judgement. He also tries to show that disagreements can be settled in principle. Taking a step away from the controversy between naturalists and objectivists, Brennan says that he tries to do with the fact-value-problem what Kant did with the mind-world-problem: turning it upside down and making the factual content depend on moral judgement rather than vice versa. (Before Kant, one had knowledge depending on objects, Kant made the objects depending on knowledge). In this way Brennan sees his work as offering a possible means of reconciliation instead of making the old controversy bigger. He says that it is by means of our moral concepts that we recognise certain factual features as moral symptoms and accord them relevance and importance. A moral inquiry can be described as a collection and assessment of facts with reference to some hypothesis. This hypothesis in a moral inquiry is that a course of action can be seen as right or wrong because it is a member of a class of actions governed by a moral concept. A moral judgement in this way can be seen as an answer that is "raised only within a situation which has been structured by a moral concept, and it is of the form: 'Yes this is wrong because it is a murder'" (Brennan, pp. 34-35).

> Similarity between cases is clearly not morally neutral in this sense, because unless one sees the relevance of certain features in different cases one cannot see that they are similar cases. Shooting a man in order to marry his wife is, in many respects, like shooting a man in a hunting accident or shooting a man who is shooting at you and, in these respects, quite unlike poisoning someone in order to inherit his money. But if one knows which respects are relevant, one knows why the first and last are cases of murder and why they are similar to putting a person in a gas chamber because he is a Jew. 'Relevance' is not an absolute term, something which is 'relevant' must be 'relevant *to'* something else (Brennan 1977, p. 37).

With this way of reasoning a moral concept is not the classification of actions, in accordance with a morally neutral description, but in accordance with a morally relevant description. That is, they are similar because they are all judged to be right or wrong by appealing to the same standard. To refer to a standard for saying that some act is right or wrong is to give the reason for why it is right or wrong. For example, poisoning someone in order to inherit his money is wrong because it is a murder. Brennan says: "Therefore, we can define a moral concept as *the classification of actions which are judged to be right or wrong for the same reason"* (Brennan**,** p. 38). To detect similarities between actions one must have a prior grasp of the moral standard (Brennan, p. 39). If one does not know why a class of actions is right or wrong, one cannot identify the members of that class.

He also points to the fact that statistics are not the same as moral standards: statistics do not change the mind regarding capital punishment of someone who has the belief

that the State never has the right to take a human life (Brennan, p. 73). If one is engaged in an inquiry and doubts the standard yet accepts the factual results then one is not a participator in a moral inquiry but in a statistical inquiry. "Moral inquiry is a conceptual activity; it is a way of understanding and interpreting human behaviour" (Brennan, p. 79). If someone had no moral standards he would have no moral problems.

> To say that moral judgements make a claim to interpersonal validity is not to assert that moral judgements claim infallibility any more than the claim that a scientific explanation is correct in an assertion of infallibility. What is being asserted when we make a moral judgement is the *claim,* which may or may not be justified, that anyone who considers the case properly ought to agree that what we think to be right is right (Brennan 1977, p. 74).

We can study how people *can* and *do* reach agreement on moral categories, and follow their arguments when reasoning. In this way, moral terms are open-textured: their "explication is an incompletable process" (Brennan, p.121). Brennan says: "[…] a moral problem arises when, in the welter of factual circumstance, the agent suspects that he detects a pattern in which some of these facts stand out as relevant and significant" (Brennan, p.132).

Of course, moral disagreements do occur. D.Z. Phillips and H.O. Mounce give an example of a disagreement over how to deal with prisoners of war: a captured warrior may demand his right to die with his sword in his hand, while we may want to rehabilitate him: this is a clash between heroic morality and welfare conceptions (Phillips & Mounce 1969, p. 105). They also name the catholic house-wife, pointing at the honour of bringing children into the world and the scientific rationalists who have arguments rooted in different traditions within which there are underlying rules and no common evidence (Phillips & Mounce, pp. 58-59).

2.3.5.1 What counts as creating a moral problem (a social constructionist approach)

Today, social constructionism is an over-used concept, where the most divergent issues are written about as being socially constructed (Hacking 1999, p. 1). However, as I see it this kind of approach to moral problems gives a constructive opportunity to discuss moral questions without getting stuck in the unsolvable philosophical questions regarding the nature of morality. In ordinary life, knowledge systems are not only built up around inductive or deductive logic but also around analogies, metaphors, the presuppositions and premises from which a person reasons, the models used for generating explanations, the types of evidence seen as authoritative in those particular situations and so on (Shweder & Much 1987, p. 234). In everyday conversation and social interaction between adults and children one can find teaching of a moral order, expecting the children to uphold moral order and to care about upholding moral order. So, incidents like *The Foundation of Rights, or "I Had ItFirst and I'm Using It"* and *The Value of Friendliness* (Shweder & Much, pp. 204-205) can be distinguished. Within this frame, social events and actions can be said to have significance by way of the meanings people find in them: practical activity seen as intrinsically polysemous or ambiguous (Shweder & Much, p. 247).

In this way, moral reasoning can be seen as putting forward propositions about moral order. Whether this moral order is a glimpse of a partially hidden, already existing moral order or societal agreement or not is impossible to tell. In my opinion, one can discuss moral issues without taking sides between these two viewpoints.

Five-year-old children in India and in America agree on the fact that it is wrong to break a promise, destroy a picture drawn by another child or kick a harmless animal. (Shweder & Much, p. 202). However, other fields are areas of disagreement. The moral foundation is different: one of the countries links the rules to tradition, the other represents the obligations in terms of values associated with liberty and secular happiness.

Growing up we learn practical morality in many ways, for instance through fairy tales, soap operas and proverbs: “He who steals from his cousin gets warts on his hands” (Berger & Luckmann 1966, p. 94). As adult persons, we have collected large chunks of socially connected moral wisdom. In philosophical seminar rooms, there may be a discussion on *telling the truth* with reference for instance to Kant: “Are you allowed to lie if a Nazi rushes into your flat, asking if you have seen a Jew and the Jew is hiding in your wardrobe?” This detached way of looking at problems can be seen, for example, in Sissela Bok’s “Lying” where she compares the lies from physicians, car-salesmen and estate agents (Bok 1999, p. 227). One can easily see that a situation where a teacher chooses not to tell an extremely bad-tempered parent about something their son/daughter has done in school, is totally different from a situation where say, an estate agent hides something in order to benefit financially from the situation.

When asked about what time it is we answer without thinking of the Ten Commandments or the need for societal rules. All the same, when you notice that someone is *rude* or *immoral* you know that everybody does not agree with your view: there is always a personal perception and interpretation. The philosopher Norman Malcolm (Malcolm 2001/1958) describes a seminar where his friend Ludwig Wittgenstein became excited and interrupted G.E.Moore. Moore found Wittgenstein’s behaviour rude because he thought that good manners should always prevail. Wittgenstein believed that because philosophy was such a serious business, interrupting a philosophical discussion when you had something important to say could be discounted. Their standards of rudeness were influenced by wider beliefs. The same has happened with many of the chunks of moral knowledge that we have attained from our childhood. The difference between etiquette and ethics becomes blurred when taking into account the range of opinions we are exposed to and the different rules we are taught during our upbringings. For the one who early in childhood has learnt rules about who is allowed to talk to whom or sleep in the same room this shapes the world deeper than etiquette rules (Shweder & Much 1987, p. 199). Estonian fishermen, refugees in Sweden after the Second World War, found the Swedish men weak and lacking in masculinity, for example when they carried in water for their wives: from outside it could seem to be a matter of muscle strength but for the men who had learnt that it was a task for women it was also a task of male identity.

The medical ethics principles, aimed at helping to secure patients’ autonomy, are not tools for bringing into light the fact that not all foreign cultural norms (all social constructions of morality) are to be approved of in health care:

> A middle-aged married woman from a country with a patriarchal structure suffers from a chronic disease and after discharge from the hospital requires help at home.

> Both the woman and her unemployed husband do not want any help from the social services. A member of staff sees the husband sitting at a café. Their fourteen-year-old daughter has been forced to leave school prematurely in order to help her mother.

Social Constructionism and *Social Constructivism* are not normally used as synonyms: *Constructivism* is more connected with a psychological approach in the explanation of individuals' experience of the world. Both Constructivism and Constructionism schools, however, avoid foundationalist warrants for an empirical science and both stress the effect of the methods of science itself influencing knowledge. From a Constructionist's view, neither 'mind' nor 'world' is granted as it is from a Constructivist's view. I will use Social Constructionism when analysing the interviews with clinicians. I am aware of the overlapping of the terms named (Gergen 1994, pp. 67-68;Hacking 1999, pp. 47-49). Beside the two concepts named, there is also a *constructionalism* concept, used by the philosopher Nelson Goodman. Constructionalists leave social issues out of their interest field. This leaves Goodman's concept out of my interest in this context (Hacking 1999). The same is true here regarding the difference in view between Lawrence Kohlberg and (among others) Carol Gilligan and Nel Noddings about whether morality is learnt as developmental stages or focused on relations (see 1.8.5).

What one perceives can in this way be seen as a mix of personal traits and culturally taught traditions; what one assumes one ought to do in a situation depends on what role one presumes as being assigned from society. In court, the judge speaks as a judge (Berger & Luckmann 1966, p. 75). In this context, Harman's question regarding whether there exists an objective moral does not cover the situations when teachers, lawyers and doctors discuss which facts in a situation are morally relevant. Lawyers have the (changing) law as a fixed point when trying to make a decision, the priests talking with their parishioners have a (more or less) common foundation on moral issues. Contrast this with teachers, social workers and doctors who can open the newspaper and read complaints about what they have done in a situation as well as not done in the same situation.

To be a patient is also a role (Armstrong 1983): schoolchildren know which problems one discusses with a nurse and which one discusses with a doctor. Adult people know what to say to a lawyer and what to say to a doctor (it is presumed to be the best outcome of naming your investment problems to one of them) (Berger & Luckmann 1966). Sitting in a corner, looking through journal papers in a ward-room where a nurse is attaching a drip to a patient, I hear the patient tell an odd story about one of the doctors of the department (he happens to be the patient's doctor). Afterwards I ask the patient if she wants to change doctor. She says no, but she knows that she often falls into the behaviour of gossiping about doctors because nurses like it. This answer is of course not the final 'true' description about the atmosphere at that ward. The story shows that when a patient and her family members meet a doctor they have collected experiences, stories heard and not at least stories read in newspapers, about what a *doctor* is and how to talk with a *doctor* and how to talk with other professionals.

2.3.5.2 The social construction of patients' and doctors' premedical moral world

Those who were middle-aged during the middle of the last century grew up in a society with an active teaching of morality in school (Läsebok för folkskolan: A reading book for elemantary school 1899). They learned morality along with knowledge about our kings (who, according to the schoolbooks of those days, all happened to be highly gifted and brave). They also learned practical virtues to help them tolerate the difficulties that they may have to face later on in life in society or if hit by a serious illness. In the first 129 pages (of 1064 pages; the book was meant for all classes in elementary school) one could read about:

- Being the good neighbour (En god granne)
- The rewards of honesty (Ärlighetens lön)
- Perseverance pays (Trägen vinner)
- Self-sacrifice (Självuppoffring)
- Patience is a virtue (Den otåliga löfmasken)
- What do you pride yourself on (Hvad Yfves du öfver?)
- How do you thank your mother (Hur lönar du din moder?)

One hundred years ago boys and girls in Sweden read the story "Sanningskärlek" (The Love of Truth) about the boy George Washington who told the truth to his father about who had destroyed the pear-tree. This story was one about personal courage, not principles. At this time Sweden was a homogenous society with a common, Christian value system, but as I see it, the school-book's moral knowledge is not only concerning Christian values but also societal/relational: how shall I live as a responsible person? This is morality taught by thick concepts (2.3.1).

Schoolbooks of today do not consider these subjects, instead these discussions happen in day-care centres, schools and on TV soap operas. A translation to the good/bad right/wrong is not necessary outside the academic world where one need not say: "To swindle someone out of money is wrong". Outside the academic world one can say "She swindled him out of money" and the moral (or the immoral) lies within the sentence. There is a possibility that someone says: "Was it swindling? Was it her intention or was she simply lucky?" Advanced discussions, negotiations in order to understand each other are going on a kind of Brennan reasoning (see 2.3.5). In the following part (2.4.1) I will further show how non-philosophers may reason out an issue (much dealt with within medical ethics) and bring their (fictive) situations together with the thoughts of a (fictive) physician and a philosophical text, which in summarised form is reproduced in chapter one.

2.4 LAYPEOPLE

Peter Singer claims that a newborn baby has no more of a right to life than a foetus and that "a defective human being has no more of a right to life than a dog, or a pig at a similar mental level" (Singer 1982, p.10). He has been met by protests regarding his intentions to visit Germany and Austria (Singer 1993). So although starting in the radical sixties, medical ethics became no layperson's movement but rather an exclusive

enterprise, both regarding content and method, outgoing from abstract theories. When philosophers, in order to restore power to patients, took upon themselves the right to talk in the name of other individuals, they acted in a paternalistic way. Very rarely patient groups have used the new resources for a more powerful assertion of patient autonomy utilities (Bosk 1999, p. 63).

2.4.1 From ordinary life (before becoming a Patient)

Working in a political group, Anita attends seminars once a week for a term. One evening, she happens to sit beside a man she finds very attractive and later on they go home to her flat together. The man does not show up for the next few seminars. Then suddenly, he reappeares and sits down beside another very nice girl and Anita an see and to some extent hear that he is trying to charm this girl, with the same stories he had used on her. On the same day she takes a pregnancy test, which turns out to be positive. Anita had grown up with her mother. When she started to ask questions about her own father her mother refused to tell her who he was. It was an awful situation, something very important had gone wrong in her life. Anita often studied foreign men on the bus to see if they had a physical resemblance to her. She decided that she would not have a child if she did not have a father who was prepared and willing to carry out his role as a father. At this time, she is completing her university studies and is certain that she will be able to find a well-paid job so it was not a question of wanting financial support. Instead, she thought that it would be immoral to give birth to a child who was not welcome.

Berit, who is a teacher, and a mother of two children, has a feeling that her husband is going to leave her. She knows that he is having an affair with a woman at work. She gets an idea that if she gets pregnant her husband will stay with her. When she finds out that she is pregnant, she realises that she has been selfish and is about to use what she herself sees as an old-fashioned female trick. As she understands things, the morally correct thing to do, is to have a legal abortion. She believes that she has an obligation to set her husband free and doesn't want to force him to stay in the marriage.

Cecilia finds out from her gynaecologist that she is pregnant. She had arranged for the consultation in order to get contraceptive pills. She is still breast-feeding her youngest (fourth) child and had believed that she could not get pregnant, as she hadn't begun to have her periods after the birth of her last child yet. One of the children has eczema and the oldest child, a girl, has diabetes. Almost every night something happens at home, either the baby cries or the child with eczema cries or else the diabetic, weight-gaining teenager is eating and crying in the kitchen. Cecilia had started to dream about going back to her part-time job, after years of taking care of children. When she told her husband that she was pregnant and wanted an abortion he flew into a fit of rage. He travels a lot in his job and she gets the feeling that he finds it convenient to have her at home. She realises that if she has an abortion he will always throw it back in her face. Sometimes she has thought of divorcing him but when she sees him angry, she knows that she would not feel safe letting the children see him alone because of his outbursts. She decides to keep the baby but knows that if she ever gets pregnant again she will have an abortion, without telling her husband.

These three women attended a British-American discussion group. One evening their teacher, David, chose a text on abortion written by Judith Jarvis Thomson (Thomson 1986) (1.8.1.1).

Anita had worked as a volunteer in a warring African country where children had suffered greatly, including losing parents as a result of various acts of war. She questioned how anyone could perceive that the fate of cells without even a consciousness as being important compared to the horror of innocent children starving, not having clean water and losing limbs to mines that were manufactured in European countries. Berit felt that the tone in the essay was coarse. She thought that it seemed to be more about whether or not one should buy a new refrigerator rather than of issues of love, passion and dependence, where history bears witness to the fact that social circumstances can result in the mother either taking her own or her child's life. In fact, Berit and most of the women she knew had experienced pregnancy as a miracle, and she believed that the most important thing was her obligation to her husband and not to attempt blackmail with a child.

Cecilia thought that the text was arrogant and devoid of commitment to other human beings. What counted to her was the right of the child to be welcome and the pregnant mother's views on whether she could manage to take care of a child or not. She knew that when the possibility of having a legal abortion became available, women had abortions rather than giving up the child for adoption. It was also well known that in the times of pre-legal abortion, one out of ten fathers were not the biological fathers and that many women chose to give the child the most socially secure life.

Their teacher David described how when he was 19 years old in the early sixties his girl-friend and future wife worked as an au-pair in London (which was felt to be much further away at this time). One night he went out to a bar and then later on went home with a girl. One month later, the girl wrote to him and told him that she was pregnant and that she refused to go to a Swedish doctor with the risk of receiving a "no" from the doctor.

He could not stand the idea of being a father to a child with this girl, whom he did not want to see again. He was also keen not to destroy his relationship with his girlfriend so he scraped together 5.000 Swedish Kronor (which was a lot of money at that time) and gave it to the girl. She then said she went to Poland and had an abortion, but David was not sure. She could have gone out dancing, meeting more men to cheat them out of money. To this day, he still does not know what really happened.

A participant in the discussion group, Erik was a physician. He wondered what women would have told him as a doctor at the gynaecological department. If the women had been in this situation in the sixties they would have had to speak to two doctors who could certify that they were allowed to have an abortion, because they were presumed to have a weak constitution. Erik was sure that the three women would have emphasised other parts of their story: that there was and is an interplay between the law, the symptoms described by the patient and the doctor's perception of what he ought to do. The new law seemed to change women's health. They were no longer seen as 'weak' or 'presumed weak'. (The number of abortions was not changed by any considerable degree by the change in law (Sveriges officiella statistik, HS 1983:9). A great deal had been written about abortion: was the woman only to be seen as the carrier of an unborn child from a future generation? (Thomson 1986) or as an autonomous person deciding over her own life? or as a responsible person, deciding if she can manage to take care of a child for the next eighteen years?

I myself assume that many medical ethics questions are not *medical* if one does not look at them from an especially narrow point of view. The problems of the three women, named here cannot be solved by simply having time to think (Singer 1982). Their problems can not be discussed within the realm of the Thomsonian text without excluding most of what they see as important. The text does not cover the standpoint of women, who see themselves bound by other commitments or who find it to be immoral to give birth to a child who will not have a secure childhood.

With the autonomy of the patient so highly ranked in mainstream medical ethics it is not possible to explain that the Jarvis Thomson text is still in the centre. The legal right to ask for an abortion exists in most Western Countries where the text has a prominent position in philosophy.

When in Sweden more than 30.000 women a year have an abortion it is probable that a great many of them do not see the question of an early abortion belonging to the realm of morality (=that the early foetus does not own personhood) or, that other issues may have a greater importance. A physician treats individuals with different kinds of lives and problems. It is perfectly acceptable, as I see it, if a doctor simply decides wether or not doing abortions is a doctor's job and if it can be done with medical safety. In the end of this chapter I will illustrate difficulties with deciding what reasons may count as acceptable for doctors and patients in treatment decisions.

The Judith Jarvis Thomson text concentrates upon the unborn child. Pregnant women who receive the information that they risk giving birth to a child with a genetic disease make their decisions not on the probability of the outcome but on whether or not they can take care of a child if that "worst case scenario" came to happen; they see the problem not as probabilities but as commitment (Lippman-Hand & Fraser 1979). If women talk about social issues after the birth, and ethicists talk about rights contra obligations before the birth of the child, it is apparent that there is no agreement on what counts as a valid argument. Although extensively discussed in ethical journals (Crigger 1998), these articles often have a non-contextual, theoretic character as privacy contra sanctity of life, a woman's right to choose contra the moral character of the foetus or a woman's duties contra the rights of the foetus. The frame has been narrowed: neither "law" nor cultural beliefs nor personal problems nor ambiguity seem to exist. In fact, the child hardly seems to exist after birth.

Laymen's experiences of problems connected with unwanted pregnancy and academic medical ethics' way of working with the same problems have often been so far from each other regarding categories, logics and modes of articulation that one can say that they represent different discourses or reality constructions (Foucault 1980, p. 77;Miller 1997, pp. 26-27). The professor of philosophy at Harvard University, Hilary Putman, criticises moral philosophy practiononers. According to Putnam they continue arguing in a tradistional and aprioristic way. He remarks that "[…] when a philosopher 'solves' an ethical problem for one, one feels as if one had asked for a subway token and been given a passenger ticket valid for the first interplanetary passenger-carrying space ship instead"(Putnam 1983, p. 3). He points out that the Jarvis Thomson text proves too much. He is pleading for adjudications in cases like abortion where there is no possibility to find principles "solving the problem". He finds the Supreme Court adjudication: that a first trimester foetus does not have legal protection, that abortion of a second trimester foetus is to be regulated, primarily in the interest of the mother's

health and that a third trimester foetus must be legally protected. He calls this ”a reasonable stance in absence of a theory”(Putnam 1983, p. 5).

2.4.1.1 Today the public moral debate is too narrow for laymen

The philosopher Barry Hoffmaster tells a story about a young Indian woman in Canada who, while delivering her third child, accepted being sterilised. Later she regretted this and felt that she would have followed the advice from her mother and her aunts, however the doctor thought that he only needed her consent. Hoffmaster points out that philosophical ethics ignores the kinds of deep-seated cultural values that separated the woman and her doctor (Hoffmaster 1989).

A consciousness can be seen as ideologically false if it commits an epistemic mistake (Geuss 1981). Such epistemic mistakes are made in moral traditions, e.g. when presuming that additional scientific evidence will clarify when a foetus becomes a person. Another mistake is the false belief, that some social phenomenon is a natural phenomenon, for example that a woman's place is at home because so many women spend so much time doing housework (Hoffmaster 1989, pp. 220-221). As I see it, an epistemic mistake is made regarding abortion when assuming that women striving for autonomy is the most important point for women or that their decisions are always autonomous (Wijma et al. 2002).

Isaiah Berlin, philosopher and historian, does not believe in striving towards an ordered value-world. In many ways he finds a pluralism of values; he means that we cannot lean against any moral theory which will give the right answer (Berlin 1978). For him it is important, in respect of the truth, that we do not try to reduce and deny conflicts. If there are many and competing values in a society, values are suppressed if only a few or one value is allowed (Berlin, p. xix). Berlin says:

> The basic categories (with their corresponding concepts) in terms of which we define men – such notions as society, freedom, sense of time and change, suffering, happiness, productivity, good and bad, right and wrong, choice, effort, truth, illusion (to take them wholly at random) – are not matters of induction and hypothesis. To think of someone as a human being is *ipso facto* to bring all these notions into play: so that to say of someone that he is a man, but that choice, or the notion of truth, mean nothing to him, would be eccentric: it would clash with what we mean by 'man' not as a matter of verbal definition (which is alterable at will), but as intrinsic to the way in which we think, and (as a matter of 'brute' fact) evidently cannot but think (Berlin 1978, p. 166).

These are, I feel, wise words, which – in other words – could have been said by many people. As it is today, the public cultural history is edited as though the important thoughts are thought by only a few. If not having a philosophical basis as Berlin had, an utterance like the quoted would easily be seen as muddy. In chapter five I will return to the question of whether the public debate about medical ethics needs a philosophical foundation.

2.5 LAW INFLUENCES BOTH PATIENTS AND DOCTORS (AND IS SOMETIMES SEEN AS FAR AWAY FROM MORALITY)

One issue, which philosophers from different schools have agreed upon, is the brain-death concept and possibilities (or obligations) of donating organs. The conclusion has been reached in different ways – for instance with *utility* as a goal and *sanctity of life* as a foundation, respectively. It is hard to understand that philosophers, appealing to different theories, have come to a real agreement accepting the same conclusion. Seeing *law* as an official, societal ratification of a decided order (often intended to be moral order). I will use an example from a journal for the Swedish internists *Internisten* (Svensson 2002), I will show that health care workers both loyal to the law and approved of by philosophers of today are still at risk of using dying patients in an instrumental way and at risk of deceiving relatives.

A case story, used in the specialist examination for internists, tells about a 72-year-old woman brought into the emergency unit with a major intracerebral haemorrhage. She has no spontaneous breathing. Her pupils are dilated and un-reactive to light and her blood pressure is falling. After some discussion with the Intensive Care Unit (ICU) doctor on duty, the patient is put on a respirator to wait for the family to arrive. When they arrive they receive information about the mothers's bad prognosis. The tests are carried out as prescribed by the National Board of Health and Welfare. They show that the patient is brain-dead. The relatives are asked about the deceased's attitude to organ donation. They answer that the question has not been discussed in the family. The family themselves have nothing against organ donation. After a further seven hours the liver and kidneys are removed.

This story is described under the heading: "An ordinary day for an internist, test your knowledge." The test contains several questions regarding the appropriate measures but in the answers one learns that the previous summarised story was the right way to take care of a pateint who was dying on arrival to the emergency room.

It is presented as a medical story, every hint of a possible moral problem somewhere is left out (if the ICU doctor did not have objections of a moral kind– we never get to know in the story). In the answer key it is becomes a situation of the family's right to choose. One possible way of getting around a moral problem is to change it into a technical problem – take it out of the realm of values and put it into the realm of technique (Zussman 1992, pp. 141-142) and this is what happens here. My point here, however, is that even though different philosophical schools seem to be of the same opinion in the donation matter and the law permits the taking of organs from brain-dead people, legality and clinical decency may not be the same, neither today nor tomorrow.

Every clinician knows that out in society one hears stories not told in health care. Here is a story, which I overheard, and changed somewhat to be unidentifiable and to suit the previous case story. In chapter four I will report a similar story told by an interviewee. My point here is that while there is much attention paid to the importance of informed consent regarding research there are other fields left. It could be possible to show respect to citizens and ask them beforehand in a serious and decent way, taking away the possibility of offending the family and forcing them into making a serious decision in a short time.

2.5.1 Family with veto rights, but hardly any others

They called Hans from the hospital and told him that his mother had been brought to the emergency room in a critical condition. Hans called his wife Inger, and both managed to get away from work immediately. On their way to the hospital they passed their home and went in so that Hans could get a mobile number he needed. It was his turn to take his oldest son and some of his football teammates to training and he had to call another father to ask him to take them to the training. They searched for his mother's neighbour's number: was his name Lundqvist or Lundström? They found it and Hans asked him if he could help out and look for his mother's dog. Hans was told that it was the neighbour Lundqvist who had called in at his mother's house earlier in the morning and found her. They had planned to do the weekly shopping using his car but instead he found Hans' mother lying deeply unconscious on the kitchen floor. This was when he had called the ambulance. After they came and took her away, Lundqvist fed the cats and picked up the dog.

Inger wrote a message for the oldest son. In the car on the way to the hospital she called her daughter's teacher and left a message at the leisure centre saying that her daughter could go home with one of her friends and call the son at home later and tell him where she was. Then she made a telephone call to the nursery: one of the women working there promised to take their youngest daughter home with her. They lived only a few hundred meters away from each other. Hans, meanwhile, left a message on his sister Johanna's mobile (she was working as a tourist guide in Madrid). Inger had suggested staying at home but they had only one car and it was impossible to go later by bus and Hans wanted her to accompany him, she was the only relative in Sweden and he needed her.

They succeeded in finding a parking place but did not have change for the parking meter. At the ICU they were shown to Hans' mother. They were told that she had been deeply sleeping all the time and that she was now probably dead. So they felt that it did not matter that the telephone calls had made them late. They could not understand that she was dead as the nurses had said. The staff was extremely nice but they both felt that the ICU was a strange place. When Hans' father had died at an oncological department one year ago it had been peaceful and Hans had lost his fear of dying.

They asked about her standpoint regarding donating organs. He had to say that he did not know at all. He wondered if she could have received something in the mail, as he remembered he some years ago he had received a donor card that could be used to declare your intent to donate organs after your death. He thought that it had come together with advertising brochures. He remembered that she had a note on her mailbox saying that she did not want to receive advertisements. So, just as they asked him about his own standpoint his sister called from Madrid. She said that she did not know either what feeling their mother had about it but that if she was not really dead yet it must be better that she was left a long time before they did anything. She knew that they usually did too much, and that she would prefer that they did too little, otherwise they would have a parcel for a mother. Hans said that they had told him that she could not recover.

They told him that he had veto right but as he then came to think about how USA misused their veto right he said that he did not want to use his. Suddenly he remembered that his son's football shoes were in his car. They said that his mother

would stay on the respirator for some hours. They got a feeling that it all was over and went back to the parking place. They had got a parking fine.

Some months later Hans happened to talk with one of the fathers at football. His name was Karl and he was a doctor. Hans asked him what the hospital had intended to do with his mother since they put her on a respirator: was it possible to operate on a large brain haemorrhage? He gave Karl permission to look in the medical notes and Karl found out that no operation or hopes for survival were foreseeable. Hans felt that they had betrayed his mother: she would have preferred to die on the floor at home. He said to his wife that he did not want to go to the hospital before he was stone dead or at least had his 'no donation' card with him.

2.5.2 Law and moral

Seeing law as a device for the reconciliation of different views in the least painful way and including allowing ordered societal life to continue, it is evident that law and morality do not cover each other completely. Although law can ideally be said to be a formalised moral understanding it is at the same time possible to say: "Yes, this tax deduction is legal but I find it to be immoral."

In the medial debate there has mostly been a situation of unspoken identity between law and morals, striving at getting what seems to be right to be legal. How a law may interfere with people's expectations and behaviour has not been focused on. The abortion law may have changed a man's view on what he should do when his girlfriend tells him that she is pregnant: the contemporary 'myth of a decent man' as well as the contemporary 'myth of dying' are in communication with laws. Legal systems differ, in the USA there is a feedback to casuistry in another way than there is in Sweden. Lacking an established church in the USA, it is possible that many Americans expect the courts to implement certain values, and in a way this is central to the countries culture (Capron 1999, p. 296).

With judgements made in a court some innocent people are sentenced and some individuals, who have committed a crime, are set free. Medical matters are mostly built on probabilities and not on certainties. If one must have a physician's certification regarding one's state of illness in order to achieve a legal right one also builds in the possibility that two other physicians may interpret this medical matter in different ways and that patients may be dealt with in a wrong way. Such matters have not been focused on within modern medical ethics.

2.6 OTHER CULTURES AND RELIGION (NEITHER THE LAW, NOR PRINCIPLES TAKE PROBLEMS AWAY)

It is apparent that many relatives and health care personnel have found the brain-death concept both hard to understand and work with in practice. A suggestion has been offered that the law should be reviewed, and that it should be possible under certain

circumstances to accept a donation from a brain-dead person without actually declaring the person dead (Kerridge et al. 2002, pp. 92-93).

In a public letter the bishops of the Nordic Catholic Bishop's Conference declare themselves to be against terminal sedation, as such a step would violate the holiness of life, turning human beings into masters of life and death. The bishops agree with organ donation and declare that they accept the brain-death criterion and ensuing transplantation as it may be an act of compassion from the deceased. They acclaim that death is not a private matter (Ramel 2002). Also if seeing death as something other than a private matter one can reach other conclusions. Until now death and dying in Japan has been seen as a social matter, people seeing simply *death* more than *death of the brain,* and that a person is best understood as existing in the loci of human relationships (Lock 2001, p. 56). There has been a long-standing resistance to the brain-death concept. In Japan the modern ICU has been described as a prison: resembling Jeremy Bentham's invention Panopticon (Foucault 1977;Lock 2001, p. 56), patients being monitored closely and mostly separated from their relatives. When joining a detailed debate as the Catholic bishops do they must be prepared to be met by arguments of different kinds and cannot count on a special treatment because their opinion is founded in religious beliefs.

In 1995, half of all families in Australia refused transplantation, and in 1999 the figure was four out of five (Kerridge et al 2002). As a physician, one is at great risk of hurting suffering family members in asking questions about transplantation. The law does not take the responsibility away. Perhaps the family members who refuse feel something like the holiness of life still exists when they can see their family member lying there, looking warm and appearing to breathe.

Jehovah's Witnesses who have spoken anonymously have admitted that they are afraid of being frozen out if they accept blood transfusions (Elder 2000). This knowledge is hard to discuss within medical ethics principles of autonomy and integrity. In Sweden health care personnel are meant to work according to science and tried and tested methods. According to many health care workers it must be possible within school medicine to transfuse in serious emergency situations. Seen from the individual patients' point of view it is hard to know if the best long term outcome is to be respected and be allowed the possibility of dying if you are a Jehovah's Witness (belonging to an accepted religion) but be kept alive if you are an illiterate refugee from some African country who assumes that there are ghosts in the blood?

Single principles, belonging to a religious belief (here the *holiness of life*) or a medical ethics principle (here *autonomy*) can not solve the multifaceted problems of health care. The ambiguities in patients' wishes and the different acceptance in society of different cultural and religious beliefs cannot be deeply discussed within principle based medical ethics.

2.7 GETTING OUTSIDE THE FIGHT REGARDING THE RIGHT TO DEFINE THE WORLD

Clinical settings are situated in a moral tradition (Hoffmaster 1989). The reflection on how facts are interpreted and why they are interpreted as they are, can reveal hidden

value systems. Ritva Grundstein-Amado has described a way to generate a personal value journal (Grundstein-Amado 1992) in order to make ultimate choices consistent with patients' values and beliefs. She classifies cognitive, affective and directive dimensions in five clusters: basic moral, social, political, spiritual and specific values. However good it is as an idea, I find the result is both static in viewing what a human being is and contains the possibility of threatening patients' integrity leaving aside if one can name the most important values and if one acts according to them Just as in today's society we cannot accept slavery or child prostitution there are also individual values health care cannot support.

The philosopher Robert Baker argues that a creative resolution can occur when conflicting moral considerations are viewed as values rather than as principles (Baker 1989). Values lack the all-or-nothing dimension of principles, permitting the possibility of compromises. As an example he names that e.g. Jehovah's Witnesses cases may be resolved if instead of being "filtered through adversarial, self-fulfillment paradigms" (Baker, p. 55), one can explore the complexities of value systems and the potential for cooperation that they allow (Baker, pp. 36, 52-56).

The Brennan's way of approaching moral discussions is used practically in an assessment of health technology (Reuzel et al. 1999). Instead of applying general principles to moral questions a kind of procedural ethics is established.

2.7.1 In real life, things count far back and social context counts

Arthur Kleinman, professor of medical anthropology and psychiatry, writes about a demented man's middle-aged children's sadness, frustration and grief.

> The responses that lead to decisions about when and where to be institutionalized are moral engagements within this family's relationships. They are part of ongoing conversations and exchanges that began even before these adult children were born, developed in ways inseparable from their own trajectories, bled into their actual situations at a particular time, and will without question go on after their father's death (Kleinman 1999, p. 71).

This time dimension has often been lost in modern medical ethics. The philosopher Mats Hanson writes about his clinical ethical rounds at a university hospital in Sweden. According to the text, the nurses and doctors bring up what they find morally problematic in their experience of everyday treatment and care. An ethicist has collaborated as a moderator. Examples of problems are named: "When is it right to withdraw treatment in this individual case? […] Shall a kidney donation from a close friend of this patient be allowed?" (Hansson 2002, pp. 33-34). Hansson names what is going on during the round's *imaginative ethics*. At first these questions from the clinical ethical rounds sound as if they were cut out from the 'real reality': problems with *the patient*. When comparing with the Kleinman's story it is evident that the time dimension is cut away and that a family matter as in Kleinman's text is instead presented as an ethical matter for health care personnel: is it right not to use an extraordinary measure with every patient? What seems suitable for an ethical round must not be the same as what is seen as suitable for an ordinary ward round. Some things are omitted, some things are focused on, a discourse silently born.

At the same time as physicians are criticised for withdrawing from patients' experience by their diagnostic and natural scientific mind the philosophers look at what health care personnel do and give labels: 'Imaginative ethics' or 'Wittgensteinian ethics'(Svenaeus 2001) or something else?

The nature of the problem solving, if it is 'imaginative ethics' based on a Kantian theory or another branch of philosophy, situates what is going on in the big history of scholastic tradition where the lack of time and resources does not exist. This may well be interesting for philosophers but as I see it this poses the threat of taking the focus away from the problems in the clinical praxis. In a world such as the medical world where new methods are tested before accepted, one must also reflect on what kind of help from outside is needed by health care personnel. Blind spots, excellently described by sociologists (Bosk 1979;Zussman 1992) easily remain blind spots with this kind of 'ethical round' approach.

2.8 SUMMARY

We live in a world where some people think that there are 'turtles all the way down' and others think there is some other foundation under one layer (Geertz 1973) (2.3.2.1). There will never be an agreement regarding if there is a bottom layer but one may well talk about moral matters all the same. There exist alternatives to discussing by norms associated with universal acclaims and exceptionless obligations. Values express preferences, signifying that some are found more desirable than others are. Rules and principles can be see as verbalised common sense, if someone deeply does not accept a rule but follows it, from his own point of view, he is not acting morally but (perhaps) socially correct (which also may be a good thing to do). In real life with commitments and ties, problems may change but often follow life.

CHAPTER THREE

METHODOLOGICAL CONSIDERATIONS AND STUDY DESIGN

3.1. OUTLINE OF THE CHAPTER

In this chapter I will explain about:

- My interview study: whom I talked with and about what
- The concept of *life-world*, which is of importance in the study
- The qualitative research approach used
- Problems with the method used, both experienced and potential
- Connections between theory and method in phenomenological research
- Scientific quality control in qualitative research in general, and in my own study

3.2. INTRODUCTION

In chapter one, I described how medical ethics' schools, dealing with problems in clinical praxis are built around different assumptions regarding e.g. human nature and human goals. In chapter two, I illustrated the problems that arise, when, in a multi-cultured society such as ours today, ethical theories with universal acclaim are used and how the role of principles and rules are unclear when cutting them off from a social foundation (Bloor 1997). I also brought up that in modern medical ethics with its focus on finding solutions, the problem side has been paid less attention to. In chapter two was presented the ideas of John Brennan about moral concepts as open-textured (Brennan 1977). The meaning of the concepts can be seen as being under constant negotiation by the users. In chapter two, I also described that when modern philosophic medical ethics was grounded, the ideas of a few philosophers were cut off from their network discussion groups (see figures from Randall Collins 1998, *The Sociology of Philosophies: A Global Theory of Intellectual Change* pp 134-136) and used as a foundation in modern medical ethics This was not a self-evident development and many different types of ideas were published during the years before modern medical ethics was formed.

I talked with doctors about their professional moral problems. As I was anxious to be in time for the appointments, I often came too early. Sometimes I bought a coffee and a sandwich at the cafeteria in the hospital while waiting and sat there among patients (some of them with intravenous drips) and their relatives. I felt at home. I could not help reading the signs of the patients' diseases. As an experienced doctor, this was a

part of my world. This was also the starting point for the present study. My idea was that when experienced clinicians speak with patients and relatives, they do so with clinical background knowledge about a range of factors. I could imagine that these included clinical symptoms, signs of psychological state and probable out-come of both the suspected illness and social matters. In the same way, I imagined that doctors had accumulated experience about work related moral matters, which they had as a foundation when perceiving and reasoning about moral problems. My aim was to discover the characteristics or the structure of their work related moral problems. Just as one can try to find what makes a chair a chair, I wanted to determine what made moral problems moral problems, according to the doctors. In the same way that knowledge which is considered as medical knowledge (e.g. disease entities and treatment schedules) is influenced by scientific inventions, such as the detection of viruses and views on e.g the psychological causes of symptoms, there may be a time-bound influence on what counts in creating a moral problem.

On the whole, formalised medical ethics today has been taught with the language of an outsider. Much of what has been written about doctors has been founded on analyses of written official material. When written material is studied, the change of birthplace from the home to the hospital can be described as the physicians' strong trade union fight against the midwives in order to get material for teaching to the hospitals. (Öberg 1996) Written material, such as the material that comes from the physicians' trade union, obviously does not demonstrate the experience of individual, practising doctors. When home deliveries were predominant, doctors carried instruments in their doctor's bags, which were used for the decapitation of babies that had fastened in a transverse position during labour (Westman 1965). One could ask whether a doctor, who might have to remove the baby in pieces before the bleeding mother died, regarded this as a medical problem. Perhaps the most important factor was that the doctors found themselves in a situation where their medical discernment (deciding the right moment to use the risky instrument) also had a moral content. Such matters are outside the research scope of official papers. In general, everyday practical experiences have not been focused on to a great extent, and probably not written down. I wanted to contribute to this neglected area of research by studying doctors' work related moral problems with a *life-world* foundation.

3.2.1 Life-world

In chapter two, (2.3.2.2) I mentioned the philosopher Edward Husserl. I will now bring up some of his ideas and the ideas of his followers, and explain the concept of *life-world*. Edmund Husserl (1859-1938) was not the first person to use the concept life-world, however, he also elaborated on this concept in a theory of knowledge (Husserl 1901;Husserl 1999). Alfred Schütz (1899-1959) made a sociological turn of Husserl's philosophy (Schütz 1962, 1963a,b). Ludwig Wittgenstein's writings about sharing forms of life by sharing language, dealt with the same issue but with a different vocabulary (Wittgenstein, 1967, 2001, p. 241; Phillips & Mounce 1969, p. 64).

Aiming to shed light on what the doctors saw as moral problems in their everyday work, I was eager to gain access to their descriptions of experiences from their everyday reality. This, the self-evident, pre-theoretic world, within which we perceive

and act, and where we interpret new events in the light of our own collected experience, our desires, and our needs; is our life-world. By living we acquire a pattern for interpretation from our parents, cultural conventions, social customs, and fellow workers. It is more than mere physical reality; it is also the self-evident 'meaning' of a man wearing a police-uniform or a dialect one recognises without reflecting consciously upon these things. In meetings between different cultures, habits and norms learnt from experience can become visible: in the 1940's, married Estonian women refugees were asked by Swedish people, why they had only one instead of two rings and why they wore them on their left hands. In one way, although not quite understanding each other's signs, there was still an understanding that the rings indicated something about a person's civil status. Some issues may be considered by some individuals as habits or matters of etiquette, while for others they may be related to matters of personal identity.

Our everyday world is filled with shared meaning and when a person puts a letter in a box (yellow in Sweden, red in Denmark), that person can be pretty sure that other people, for instance, the postmen involved, understand why one has done so (Schütz 1962, pp. 25-26). We always have some frame of reference: a disagreement on whether something is red is still an agreement about something (Phillips & Mounce 1969, p. 65;Wittgenstein 2001). Sartre tells the story about the young man who had to choose between joining an army at war or to stay at home to take care of his widowed mother (Sartre 1948, p. 45). This choice is not made in a vacuum but founded on the cultural meaning of 'mother' and 'native country'. An uncle does not behave, as an uncle should, towards his brother's children if he only gives birthday presents to one of the children. This "is the sum total of 'what everybody knows' about the social world, an assemblage of maxims, morals, proverbial nuggets of wisdom, values and beliefs, myths and so forth..." (Berger & Luckmann 1966, p. 65).

In our everyday world, one knows when to visit a doctor and how to speak during the consultation. Parts of this knowledge may differ between cultural groups. Braunack-Mayer tells about how medical students, visiting a group of farmers were astonished to see self-healed injuries, which the students believed, ought to have been surgically treated (Braunack-Mayer 1998, p. 352). During a visit to the doctor, one understands that one might be asked to leave a blood or urine sample and one anticipates that there will be bodily contact. As a patient one talks about one thing to the doctor and another to the nurse and the patient usually discusses matters within a legal frame based on insurance rules and so on: the everyday social world has a meaning for everyone. The judge acts as a judge at his place of work: he is aware of this and the people who have to appear in court are aware of this. Institutions are represented by symbolic objects, occurring in everyday life as something self-evident: late after their working days, men from the Swedish military are still dressed in uniforms, when commenting about ongoing wars on TV. Their way of dressing increases their authority in war matters. In the same way, a white coat has a meaning, inseparable from the doctor's work, both for the person who wears the coat and for the patients. I want to point out that depending on who you are, 'objective' situations may be experienced differently. Seeing an American film (*Minority Report*) together with family members in Malta, we could not choose *not* to understand the words of 'Små grodorna', sang by one of the actors. Also if everybody else of the the cinema audience were sure that they had heard jingles without meaning, we were convinced of that we

had heard sentences with meaning. Experienced workers' practical knowledge may be of the same kind (Flyvbjerg 1991, p. 31).
Berger and Luckmann, who are sociologists in a phenomenological tradition, (Berger & Luckmann 1966) distinguish between primary socialisation, which takes place through an emotionally charged identification with a person's significant others, and secondary socialisation, which takes place without mandatory emotional involvement (Berger & Luckmann, p. 141). This secondary, learnt knowledge helps you to decide if you are to tell your lawyer or your doctor about your ulcer pains (Berger & Luckmann, p. 45). In this 'reality', there are roles that one hardly reflects upon, as long as people follow them and where health care personnel acquire a different type of social knowledge than the judge, as a self-evident knowledge in new situations. According to a Husserlian concept, one can say that when an experience becomes self-evident knowledge, this knowledge is at hand as an appresentation (app= ad, a presentation together with a new event). This explains how previous clinical knowledge is still present in new situations.

Alfred Schütz describes how an individual may move between multiple realities, (within the life-world) gearing into the working world (which for doctors sometimes may be a natural scientific world) and the world of day-dreams etc. (Schütz 1962, pp. 207-234). There may be visible sub-universes of truths, such as school medicine, homeopathy, and Christian Science (Berger & Luckmann 1966, p. 86). These sub-universes could be fairly described as discourses (Foucault 1972). Different ways of understanding the world can be seen as different constructions of reality, (Berger & Luckmann 1966) where the Western philosophic approach is situated within the western mode of thought. Because philosophers often write and talk in a detached manner, there is the possibility to understand their position as existing *beside* the life-world. Such a position, however, does not exist. At this point, it is worth emphasising that nobody (not even Husserl) can transcend his/her life-world (Bengtsson 1999, p. 17). Jan Bengtsson points out the risk of seeing the life-world as a primordial world, now in danger of being destroyed by centralised decisions taken by politicians and authorities (Bengtsson 1998, p. 36).

3.3 ABOUT DIFFERENT RESEARCH APPROACHES

As apparent in chapter one and two, there are many different ways of describing problems and solutions in the health-care field, and that an issue that is perceived as value-laden for one person is received as a neutral fact by another. When wanting to study issues that are not fully understood or when wanting to study a particular phenomenon in a deeper way, a qualitative approach is appropriate. Studying problems that are seen from a person's own perspective means that highly structured questions are unsuitable. Qualitative methods of a phenomenological kind are built up with maximum attention on the researchers' prejudices and assumptions and on describing experience rather than explaining the phenomena studied. One does not study the real social situation but how individuals (or a group) perceive it. With my research question, a phenomenological approach seemed suitable.

Instead of a phenomenological approach, I could have used an ethnographic method: e.g. some kind of participant observation, perhaps supplemented by information from sources such as written material (Morse & Field 1996). In regards to my own research

question, I found it would be valuable to obtain verbalised material about the doctors' experiences.

Anselm Strauss and Juliet Corbin call Grounded theory "a general methodology for developing theory that is grounded in data systematically gathered and analyzed" (Strauss & Corbin 1998, p, 273) and "[…] a *general methodology*, a way of thinking about and conceptualising data" (Strauss & Corbin, p. 275). They point out that theoretical coding, in conjunction with constant comparisons, is an important part when producing a conceptually rich theory (Strauss & Corbin, p. 277). This theory was initially presented by Glaser and Strauss1967, and has been modified. Grounded theory is process oriented and allows for change over time (Morse & Field 1996, p. 23). The emphasis on theory building and the early theoretical coding meant that Grounded theory was unsuitable for my research question.

Quantitative studies are suitable in fields where much is known beforehand. In such cases, it is possible to choose subjects for the research through statistical methods. However, one must bear in mind that the categories shown in tables and statistical calculations are based on the researcher's design of the study (the choice of relevant facts etc.) and not on genuine existing entities (Flyvbjerg 1991). The learning of a group of syllables may be made meaningful or meaningless depending on the approach of the different learners (Giorgi 1985, pp. 23-85).

I will give a practical example on how a quantitative investigation of 'reality' all the same is built up on the researcher's ideas, and if these ideas are going to have a public impact, a publisher is needed. In the newspaper *Dagens Nyheter* December 24, 2002, there was a report on how many Swedish inhabitants wished to travel to the planet Mars. If the individuals who are questioned are chosen in a statistically acceptable way and enough persons answer, one can get a good picture of how many people in Sweden would like to travel to the planet. If this study had been made years after scare mongering propaganda about how dangerous life on Mars is, then the influence of this propaganda would not have been possible to discern with a research design such as this. If one wants to obtain a better picture of peoples opinions about travel rather than this extremely crude representation, one should leave a space on the questionnaire, so that the participants can explain their thoughts in their own words. If one wants to gain information about what travelling means to them, a questionnaire with fixed answers is not suitable and it has to be understood that the meaning of travel in a person's life is not the same as their accounts of travelling episodes. The issue of travelling to Mars may not have been in the minds of the interviewees before reading the questionnaires. To make the question a question of public concern, medial – in this case a newspaper's – high lightening must occur.

The difference between natural science and social science is not always great. The same kind of thinking as in phenomenology may also be used in natural science when carrying out an initial investigation of an issue that is not fully understood (Kvale 1984, p. 57).

Many studies mix different methods. This way of working is frequently called triangulation. Using many methods is no guarantee for better quality, as the same fault may be built into several studies (Maxwell 1996, pp. 93-94). Jan Bengtsson points out that when different methods are used, one must work with methods that derive from the same foundation, providing the possibility of integrating the results (Bengtsson 1999, p. 31). David Silverman also sees problems with bringing together different context-bound studies (Silverman 2001, pp. 233-235).

In a qualitative study, one typically chooses participants strategically, according to the needs of the study (e.g. settings, processes or events, in order to obtain a fair representation or typicality) (Maxwell 1996, p. 69;Morse & Field 1996, p. 65). Sample size is dependent on: the scope of the study, the nature of the topic, the quality of the data, the study design, and the use of shadowed data (discussing the experience of others). In a semi-structured interview with shallow data, one needs a large number of participants, at least 30-60, with Grounded Theory, one needs fewer participants, and in a phenomenological study involving deep interviews, one needs the smallest number of participants (Morse 2000, pp. 3-5). Too many informants can result in an overly rich material for systematic interpretation (Kvale 1984). According to Steinar Kvale, a text material, which is not too extensive, is a prerequisite of a thorough and systematic analysis of the content and structure in a text (Kvale 1984, p. 58).

To check the 'scientific strength' of qualitative research, a different kind of examination is required than the kind that is applicable to quantitative research. However, quite often, a mirror structure of quantitative research control is built up. Using an analysis by Egon Guba and Yvonne Lincoln as a starting point, (Guba & Lincoln 1981, 1989) that is based on terms which are accepted in quantitative research, Margarete Sandelowski discusses the possibility of securing rigor in qualitative research. I will now present this (according to my opinion) complicated schedule, as an example of trying to build up a control system, founded on quantitative research conditions.

- Credibility: faithful descriptions or interpretations recognisable to people who have experience in the studied field (corresponds to internal validity. Truth value in quantitative research tells about how well threats to internal validity have been managed).
- Fittingness: how well findings can 'fit' outside the study situation (corresponds to external validity. Applicability in quantitative research is evaluated by how well threats to external validity are managed).
- Auditability: deals with how well another researcher can follow the 'decision trail' (corresponds to reliability)
- Confirmability: is achieved when auditability, truth value, and applicability, are established (objectivity in quantitative research)

(Sandelowski 1986, pp. 27-37)

In a later publication, Sandelowski points out the risk of killing the spirit of qualitative work. She says: "…we can soften our notion of rigor to include the playfulness, soulfulness, imagination, and technique we associate with more artistic endeavours, or we can further harden it by the uncritical application of rules. The choice is ours: rigor or rigor mortis" (Sandelowski 1993, p. 8). It is worth noting that the selection of parameters securing scientific strength in epistemic sciences is also a process based on values (Putnam 2002, pp. 30-31).

Steinar Kvale (Kvale 1989) discusses validity in social sciences as a continual questioning of the subject matter being investigated. He warns against becoming trapped in a vicious circle with the focus on validity, so that this fosters an emphasis on verification of existing knowledge instead of the generation of new knowledge. Kvale says:

> An ideal solution would be to conduct investigations so convincingly that appeals to external certification, or official validity stamps of approval, appear superfluous. Ideally, the procedures would be transparent and the results evident, the conclusions of a study intrinsically convincing, as true, beautiful and good (Kvale 1989, p. 90).

David Silverman discusses the problem of anecdotalism, a noticed tendency to select data to fit an ideal conception of the phenomenon, and a tendency to select data, which is easy to notice at the expense of less dramatic data (Silverman 2001, pp. 222-223).

He also reproduces criteria adopted by the British Sociological Association Medical Sociology Group 1996, where the first two rules deal with the possibility of evaluating whether the methods of research are appropriate and if the connections between the method and a theory is made clear. In phenomenological research, this could be formulated as focusing on if the connection between philosophy, theory, and method is made clear and understandable. Theories in qualitative research can be used as a model concerning what goes on between people in a society, professional roles, experienced from the inside or the outside, what health care (science) is, what health care ought to be, interpretation/analysis of phenomena in health care etc. The question of whether the theory is appropriate to the studied phenomenon is often hard to evaluate.

In order to provide an example of the complicated relationship between philosophy and empirical science, I refer to a debate about whether research with the Husserlian phenomenology, is philosophic phenomenology, scientific phenomenology or something else (Paley 1997;Giorgi 2000). Michael Crotty (Crotty 1996) claimes that phenomenological nursing research has misinterpreted European philosophy. My personal view here is that a philosophical discussion is held when e.g. Paul Ricoeur (Ricoeur 1981) criticises Husserl's development into idealism in *Cartesian meditations* (Husserl 1999). Researchers, studying Husserl, have different interpretations of Husserl's (huge mass of) writings. When carrying out a life-world research one must use a non-transcendental theory and the speculations regarding Husserl's philosophy is outside this research theory. The phenomenological methods do not appear to be unusable, whether or not one finds that Husserl made a mistake in his later days. The theory-user who believes this to be important, must be prepared to describe in which way the late Husserlian's transcendental phenomenology differs from Kant's 'das Ding an Sich' or undistorted pictures from Plato's cavern. As I see it, many advantages can be gained if what Giorgi calls scientific phenomenology could be called qualitative research in a phenomenological tradition. There is a great difference between a philosophy and an empirical research approach/method.

The researcher makes a (more or less crude and more or less conscious) evaluation before starting a study: e.g. if intending to study bodily memories (such as plaiting one's hair or driving a car) choosing ideas from Maurice Merleau Ponty as a philosophy of science (Merleau-Ponty 1962/1945) could be a good choice. If the field studied were mainly memorised in a non-bodily way, a different theory would probably have been more appropriate, although the Merleau-Ponty theory does not fabricate bodily memories. A theory based on that we express ourselves through metaphors, is founded on other presumptions about 'reality' than the theory behind 'reality' studied with field notes of social interaction and body language. While there is awareness that the researcher's personal presumptions may distort the analyses, less focus is placed on the fact when choosing, for example, Løgstrup (Løgstrup 1997) as a theory for good nursing care (Martinsen 1993), one chooses according to personal values. The choice of

a particular philosopher as a theoretical framework for the interpretation of interviews, brings special attention to some features in an interview: "The choice of Gabriel Marcel's […] philosophy as the primary source for interpretation is that he has a joyful notion of ethics that corresponds to the interpretation of stories" (Söderberg 1999, pp. 16-17). This provides a different 'reality' than if one had used social constructionism or health care science as a theoretical foundation. Choosing philosophers that belong to the Judeo-Christian tradition implies that an important part of their moral reasoning will be used in the theoretical framework. When using Marxist theory or a feministic theory in research it is probable that the results will not be the same. The same must be true, if within a life-world research, one departs from a psychological care science perspective or a social constructionist perspective, as one's theoretical base.

3.3.1 More in detail about the phenomenological approach/method

The philosopher and psychiatrist Karl Jaspers, used a phenomenological research approach in 1911, based on Husserl's phenomenology (in its first appearance as 'descriptive psychology') when studying the inner-life of patients. Jaspers (Jaspers 1994b, pp. 6-7) found it to be a possible and fruitful way of describing the inner experiences of the (in this case) sick phenomena of consciousness. Since then, the empirical phenomenological method has developed and has "served as a tool for extremely divergent enterprises" (Spiegelberg 1982). Frequently, the phenomenological approach is regarded as being separated into different methodological schools. Arlene Zichi Cohen and Anna Omery give a description of the established view on the main schools today (Cohen & Omery 1994).

- A Husserlian/Duquesne school aims to reveal fundamental knowledge of the structure of a studied phenomenon; that is to describe the meaning of an experience from the perspective of those who have had the experience (essential to the experience and not to specific individuals)
- A Heideggerian/Hermeneutic school which focuses on the interpretation of phenomena to bring out hidden meanings, linked to cultural practices
- A Dutch phenomenological school with features of both descriptive and interpretative phenomenology

In praxis, the boundaries are not so clear and there are, for instance, interpretative parts in all groups: inner experiences of the Husserlian school are linked to cultural practices. The results are expressed in different ways. Behind the groupings named, there is of course, no homogeneity regarding views on what to study. Material, used by some researchers in order to bring out the hidden meaning of cultural practices, may by viewed by others as coloured by romanticism (Silverman 2001, pp. 8-9).

3.3.1.1 Giorgi's variant of the phenomenological method

My intention was to study what work related moral problems meant for experienced doctors: I wanted to study how problems presented themselves within an everyday 'reality'. For this, a method, which not only gave a tool for analysing lived experience

but also took into account the interviewees reflections (=a reflecting I), was of value. I wanted to work with a method, which in the analysis stage did not require a pre-determined abstract, explaining, analysis tool: I could not know if such a tool could be used to describe the interviewees' experiences. For my study I found Amedeo Giorgi's phenomenological method suitable, in the way it is pragmatically used (not fully according Giorgi's intentions). This means allowing the interviewees interpretations and thoughts (Caelli 2000) and accepting that the stage of reduction is kept within the interviewee's life-world (Bengtsson 1999, p. 29;Hedelin 2000). Working with the Giorgi method, means working with steps, which forces the researcher to keep strictly to the (interview) text and to reflect on his/her own prejudices.

Giorgi himself has criticised the way the method has been used, but as I see it, if a 'Giorgioid' method, developed from Giorgi's ideas, is accepted as a good method of communication within a scientific community, which can also be understood outside that scientific community, it is acceptable. (Besides, there are fundamentalists among those who use Grounded theory that keep to the original model and pragmatists that work with later versions). Giorgi names four essential steps:

- One reads the entire description (as many times as needed) to get a general sense. The reading is made from a particular perspective. For example, in a psychological study, a psychological perspective would be adopted. Giorgi mentions utterances such as "Let's assume that the subject is shy […] "(Giorgi 1997, p. 242) as an interpretation and emphasises that such interpretations do not belong to his method. What Giorgi is referring to is an interpretation (or explanation) of interviewee's qualities and I fully agree with that such judgements do not belong to his method. However, the researcher makes another kind of interpretation when reading to get a global sense. To get a general sense cannot be separated from grasping meanings. In the words of Paul Ricoeur (here seen as a philosopher and not as an owner of an interpretation theory):"[…] the necessity for all understanding is mediated by an interpretation"(Ricoeur 1981, p. 106).
- In the next step, one identifies 'meaning units' in the description, by focusing on the phenomenon being researched. Meaning units can be identified when a shift of meaning occurs in the text. In my case, I was studying moral problems seen as a social phenomenon and therefore, I had a social perspective when searching for descriptions concerning the phenomenon studied.
- In the third step, one expresses the insight about the phenomenon being explored that is expressed in each of the meaning units. A transformation from a concrete expression to insight involves a process where the researcher uses his/her imagination and reflects upon these concrete expressions but not through abstraction. In my case, this meant not drawing on existing ethical theory categories. Free imagination could also be called testing in fantasy, asking the text: if, for example, words could be changed without losing their meaning. Giorgi gives an example of trying to exchange gift, chess, and game in a narrative (Giorgi 1985, p 18). There are, however, limits to how much one can bracket old 'natural' knowledge about the studied phenomenon without making it meaningless (Bengtsson 1999, pp. 29-30).
- The fourth and final step implies synthesising and integrating the insights in the transformed meaning units into a description of the structure of the phenomenon, which can be expressed on a number of levels (Giorgi 1985, p. 10-19). I want to

remind that this step as well as the other ones is "[…] a hermeneutical endeavor. It is a co-constitution between the interpretive meaning-giving investigator and the phenomenon as disclosed or given in the fundamental description"(Titelman 1979, pp. 188-189).

Below, I demonstrate this method by using a part from one of the interviews from my study:

Step 1: Reading the text and trying to get a general idea. I want to emphasise that it is impossible to find an unprejudiced truth. Before starting to read in order to get the overall idea, one decides a disciplinary perspective (e.g. psychological or sociological) and the kind of meaning units one will search for in the next step (2) depends on that perspective (Giorgi 1997, p. 246). Discussing the Giorgi method, Steinar Kvale explains that one should read the text by wearing a certain pair of glasses (Kvale 1984, p 58).

Step 2: Finding meaning units (from a part of one interview) The meaning unit, commented on in the next step is written in Italics

> […] In my speciality, there is a very big difference in the availability of care, and at the same time, there is the problem of unequal distribution, when working in a smaller hospital. One of the problems is that you are not allowed to refer a patient to a university clinic, because the management at the clinic and the management at the hospital do not want to pay. This made me aware when I realised that the patients were placed at greater risk than necessary.
>
> *Now when I work at a university hospital, the problem is not that you are not allowed to send the patients away, the problem is that the management at the hospital constantly maintains that there is a budget deficit, that the clinic costs money and the care costs money. In this situation, some patients mean a bigger deficit than others do. For instance, elderly patients should be avoided because they need a lot of nursing care even if they do not require medical treatment. One learns that one should avoid giving them a bed because the municipality does not want to admit them if they are going to need expensive help. It takes a lot of energy discussing with people at other clinics about who is responsible for taking care of an elderly patient on the emergency ward. It feels unworthy and this goes against our moral attitude towards care. There you have it, patients in every bed and in the corridors. You have pressure on you from everywhere and everybody. The nurses on the wards state clearly that that they cannot manage to take care of more patients and if things continue in this way, they say that all nurses will resign. Then you try to place some of this pressure on other departments and try to convince them that it is a 'this' problem or a 'that' problem or however you can twist things. One cannot continue to play games like this; one must take care of the patients.*
>
> The politicians do not accept that costs cannot continue to be cut down in this way. They may try to employ bosses who can save money rather than be good leaders. They are praised because of their effectiveness but in the end, health care is worse off (S.R. p. 152)

Step 3: Expressing the insight of the meaning unit:

S (subject) has learnt that patients who need a lot of care (which often means elderly persons) are to be avoided at the clinic. He finds himself alone with his problem and experiences that other personnel may make the problem worse. S tries to place the pressure of taking care of an elderly person on another department by convincing them that they are responsible and he does this by emphasising a specific part of the problem. He knows that he ought to take care of the patient.

This step includes a reflection on the 'core': What can be changed, what is necessary? Could the teller, the 'I', be another professional group than 'a doctor'? Does the age of the patient play an important role in forming this problem?

Step 4: A synthesis of meaning units to an essential structure: a try to derive a synthesis of all the interviews' essential structures or reporting as many structures as needed. The results will be presented in the next chapter.

3.4 OBTAINING EMPIRICAL MATERIAL IN THE STUDY

I sent a letter to eighteen doctors, asking them for the opportunity to interview them about their own experience of every-day moral problems in their professional life. About one week later, I called the doctors and arranged meetings with them. Four of them did not participate; two of these replied that they did not have the time. One doctor stated that she was very interested, however, no meeting was arranged due to constant timetable clashes. One doctor declared that he did not want to participate without giving a reason.

Extracts from my letter:

> I am a doctor […]. I work on throwing light on clinicians' experiences of ethical problems in everyday working life. My belief is that doctors that have worked for a long time must have gained important knowledge.
>
> I am interested in meeting you and hearing about the ethical questions that you have experienced in your everyday working life. I am interested in hearing about *your own experiences* (emphasis in the letter).
>
> […] I will phone you at work in about one week. If you have any questions, I can answer them during the phone call (or some other time if it suits you better). If you would like to participate, and share your experiences from your working life, we can agree on a time and a place that suits you where we can talk. I can either come to your place of work, or your home, whichever is best for you. Our conversation will take between 1-2 hours […].

Since I searched for a broad and varied working life experience, I worked for a broad age range, a spread of specialities, and places of work among the doctors who were invited to participate. Doctors of both sexes (5 females and 9 males) and of foreign backgrounds were represented. This range and variation is important in validating my findings. I achieved this variation by working from a list with names, specialities, age groups, and the working-places of doctors in the public sector in Sweden.

Searching for broad clinical experience, I chose doctors with different clinical specialities from the following areas of medicine: anaesthetics, general practice, gynaecology, internal medicine, neurology, oncology, orthopaedics, paediatrics, psychiatry, rehabilitation, medicine, and surgery. The same speciality was represented at the most twice, among my interviewees. In all chosen specialities, one meets very ill people with patients and relatives that are going through existential crises.

In searching for long clinical experience, I chose doctors with a specialist title who were more than forty years old, in this way hoping not to bother doctors who had started to study at an older age than usual. The doctors' age came to be distributed quite evenly between 43 and 65 years. By choosing different ages, I hoped to meet doctors who had experienced different demands from patients and society.

I also tried to contact doctors with non-Scandinavian backgrounds, assuming that having been brought up with other value systems, they could bring a wider range of viewpoints than Swedish doctors alone. Three doctors had non-Swedish names, one of them came here as a qualified doctor, and the other two were born in Sweden.

I interviewed doctors from seven different places of employment (six hospitals, one care centre). The hospitals were of three different speciality levels: district and county hospitals, and a university clinic. The working places that were chosen were situated at a manageable distance from my home (travel-time and interview-time counted together).

In the letter and the phone call, I informed the doctors that I wanted them to tell me about concrete, every-day, professional ethical problems. At the beginning of the interview, I repeated that I was interested in hearing concrete, everyday stories with ethical questions or problems. (I used ethics/ethical in my letter and early conversation, later in the interview also morality/moral, depending on the interviewee's vocabulary and the subject discussed). I also asked for stories from my interviewees' early days as doctors, what they themselves taught young doctors, if they had received any guidance at the start of their professional careers, and if they felt that their training lacked special tuition in moral matters. I also asked them what kind of characteristics they thought a good doctor should have. I tried to explore their stories and I asked more specific questions about the problems that they told me about. In some interviews, not all of my questions were brought up. The questions were meant to be a starting point for the interviewees' descriptions of experiences and themes within their life-world, and were not a strict formula to adhere to. The interviews were focused on what the doctors saw as moral problems.

Two of the interviews took place at the doctors' homes, the others at their place of work. I brought a tape-recorder (as stated to the doctors in the letter). The interviews lasted on average one hour (ranging between 45 min - 1h 15 min), excluding interruptions. I transcribed the tapes verbatim. I have provided the doctors with fictitious initials in order to guarantee anonymity. When quoting in the next chapter, page number from the transcription, 156 pages, will be referred to. I want to remind that the structure of the experience (of moral problems) and not the individual doctors is in focus: their specialities and other characteristics will not be mentioned together with the quotations.

The study was approved of by the Research Ethics Committee, Karolinska Institute registration number 00-301.

3.5 REFLECTIONS ON THE STUDY AND MY POSITION

Designing my study with a phenomenological approach, I planned to interview about ten doctors. When I had talked with about seven of the doctors I had a sense that I had a rich material to analyse. I added some more interviews to get a richer variation of the studied phenomenon. I had not begun to analyse the material when I decided to stop sending letters to further possible interviewees. Sometimes the word "saturated" is named when discussing whether sufficient persons have participated in a study. Within this concept, is the idea that one knows what material the results ought to be saturated with, this however, is not the case in this study. The word saturated could, however, be used in another sense: for instance, during an interview (and later on in the transcript) I often found that the same kind of issues reappeared – that there was something the interviewee wanted to tell.

The study can best be thought of as a detail study of a small part of a picture. These kinds of studies are now made e.g. in the historical field. Birgitta Odén describes the suicides of four persons as their unique experiences, thereby disclosing interesting details about the rules and norms of the surrounding society (Odén 1998). Shedding light on a small part of everyday life, may provide the reader with a readiness to see new events in a somewhat different light. If many small studies show results of a similar kind, our shared 'reality', about which we in our natural attitude can make statistical inquires, changes. This issue will be brought up briefly again in chapter five. My personal view is: that one can be satisfied if the results seem plausible within the field, among people who have knowledge about the phenomenon studied, that the results add new knowledge, and that nothing of importance is left out in order to achieve a beautiful result.

I sent a letter to all interviewees with quotations from the interviews and a summary of the interview analysis (of an earlier version, not unlike the present). Eleven interviewees answered, some of them some wrote comments beside their quotations like "this is important", and three did not answer. No participant wrote back that my interpretation was a misunderstanding. I did not send more than one letter. This kind of research validation is possible when the results lie within the interviewees' self-image (Silverman 2001, p 236).

Interjudge reliability in research of this kind does not have the same position as in other kinds of research. The researcher may have obtained poor data, coloured by his/ her own preunderstanding, but this might still result in a high percentage of agreement between co-judgers when the conceptions are easy to recognise (Sandberg 1995, p. 159). Because the researcher's interpretation of reality and not an objective reality is the basis, it is important to withhold theories and pre-comprehension in the analysis. The description of a 'fundamental structure' can never be outside the researcher's/interpreter's horizon (Titelman 1979, pp.188-189).

Many articles and PhD theses about qualitative interview studies with health-care personnel may look similar at first sight but in fact differ in, for instance, the selection of interviewees. One can not expect to get the same results when sending letters to a random selection of people as the results one would obtain from asking people at a meeting or asking a manager of a department to refer someone. Using a

phenomenological method you may come to study different phenomena. I tried to avoid the risk of a possible 'elite-bias' (Sandelowski 1986, p. 32) by choosing names according to age and speciality without knowing more about the persons. The question is whether those who have ready-made stories to tell, are telling the same kind of stories as those who do not (Caelli 2000)

When trying to compare results between studies, one must bear in mind that one cannot expect to obtain the same answers when asking people to give accounts of ethically problematic care situations (Udén et al. 1992), asking to tell about their work, (Kaufman 1997) their most recent problem, (Holm 1996, pp. 106, 225) and whether the ethical reasoning and decision making (Holm 1996, p. 127) or the experience of moral problems (Braunack-Mayer 2001) (and my study) was in focus.

There is also a difference between asking analytical questions (the interviewees' conception about what makes a problem an ethical problem and their ideas about how ethical problems should be solved) (Holm 1996, p. 225) and asking descriptive questions, because one may well feel that something is wrong without being able to find the words to explain why. Maybe, in reality, the difference is often not so great, because although I asked for descriptions I often received answers with an explanation. While giving a better understanding of the interviewees' accounts, their explanation was however, not the ultimate aim of my analysis (Silverman 2001, pp. 287-288). This means that in an utterance such as the following, I am searching for the structure of a moral problem within her/his profession and not her explanations (that means reflections on the doctors' standard and not standpoints on how a doctor ought to act). In other parts of the interview, the following participant gave concrete accounts of abused children.

> I think about the children who are maltreated for one reason or another. One may suspect that they are battered or victims of some other abuse or one may have a bad feeling about their social situation. Sometimes I find that as doctors we have a tendency to take too much on our shoulders, if we focus on the patients where one suspect that one parent is an addict or suspect that something else is going on. Here, I think that we sometimes forget that we must report to the social services, even when we only suspect something we ought to report. I sometimes feel that we not only try to heal fractures or whatever the child has, but we also believe that we are social workers and think that we can change the parents during the short in-patient periods. We make our professional judgements that they will be able to manage, they have the resources, but it is not up to us to make such judgements, we do not inform the social services in time that there may be something dangerous going on here and here I am quite adamant (M.O. p. 140).

I sent out letters to a few doctors at a time, and talked to one or two doctors each week. I quickly came to realise that story telling is a considerable part of a doctor's work. It occurs during rounds, consultations etc. (Hunter 1991). Often, we agreed on an appropriate time beforehand, where they could fit me into their schedules. Overall, the scarcity of time, sometimes limited to one hour, was not a problem. The clinical work and language was well known to both interviewer, and interviewee. Obviously, the risk of influencing the narratives with personal understanding from my own clinical experience was a possibility. If I was not sure what the point of the story was, I often chose to tell a short story that I thought had the same meaning. I found it worked very well, the doctors answered "Yes, exactly like that!" or "No, not quite, what I meant

was…". I want to emphasise that it is not only to the researcher's disadvantage in a study of this kind to have a knowledge of the interviewee's world: to understand that people may have the most different feelings for 'Små grodorna', named under Life-world (3.2.1) one must understand the language and have an idea about in what connections the song is used.

From a constructionist perspective, interviews can be seen as social productions. In a summary of James Holstein and Jaber Gubrium's work, it is evident that they repudiate "the orthodoxy that interviews are usefully regarded as opportunities for enterprising scientists to mine minds". They reject the idea that "that crisp answers to clean questions can be recovered with professional dispatch once the ground rules are explained by the interviewer to the respondent" (Miller, Manning, & Maanen 1995) p vii. The phenomenological interview with a life-world approach is built up around that the interviewer obtains knowledge of the interviewees' life-world experiences. These wished naive accounts 'from a stream of consciousness' must however have been influenced by reflections after being asked to take part in the study, discussions about participation with a colleague (which I know occurred) and the character of the issue. This meant that the interviewees probably reflected upon the problems before my visit.

The phenomenological method is supposed to be built on the informants' accounts as they experienced them, and not in an 'objective' manner. However, as pointed out by Schütz (Schütz 1974) the interviewee must reflect upon her/his experience when intending to tell something: the lived experience becomes a reflected experience. When formulated into words, a new construction comes into existence and a third construction appears when the researcher understands the interviewee's account. (A fourth and fifth construction appears when the researcher works on the material and writes about the results) (Bengtsson 1999, p. 36).

During the writing process, I came to realise that one more construction is at hand, the receiver's construction of the message: I will now give an example of this. During a course in qualitative methods, two students - separated by a day - gave an account of their own interviews. One of the students had interviewed young teen-age girls and the other had interviewed doctors. In both interview-groups, there were individuals who used the term 'one' when talking about certain subjects. The researcher who had interviewed the teenagers remarked that the girls used 'one' because they were shy, insecure working-class girls. When the interviews with the doctors were discussed, someone in the auditorium remarked that physicians always speak as members of a group and that they dare not show their own point of view because of the possible backlash this may cause.

To summarise, I had come to realise that there was so much outside the careful analysing schedule that the end result could easily be like a distorted blow-up of a blurred picture. The discrepancy between *Philosophie als strenge Wissenschaft* (to use an Edmund Husserl-title from 1911) and the empirical world was for me evident. I understood that there was a risk of presenting protocols hiding other problems – by Neil Bolton named phenomenological positivism (Bolton 1987, p. 57). Criticism of a related kind has been published in a Swedish newspaper. The author and journalist Gunnar Ohrlander ridicules the language and the content of phenomenological research projects. In a newspaper he writes "One invents an incomprehensible language for the most usual everyday occurrences, in this way self-evident issues become inaccessible for the mentally retarded general public and the way is opened for money from the research foundations"(Ohrlander 1997a), "[…] this discipline (phenomenologic

research about e.g. consolation, my remark) implies a new swallow dive down into the academic mud" (Ohrlander 1997b). Such criticisms ought to be taken seriously, as it of course is a problem if research results are not understandable or (due to the vocabulary) possible to criticise for people who may be interested. I have tried to point to the difference between a philosophy and an empirical research theory and, in the next chapter, I try to present the results in such a way that people, interested in clinical ethics but lacking knowledge and/or interest in the phenomenological approach can read and understand.

Finding that my research question would best be handled by a phenomenological approach, I made such a choice and I kept to the steps in the Giorgi method (in an un-orthodox way): guiding me to notice what the interviewees said to keep to what they said. The method also forced me to reflect upon and try to bracket my own presumptions.

3.6 SUMMARY

In this chapter, I have given an account of the design of my study, as it was planned, aiming to describe the doctors' experience of work related moral problems. I found that, with my research question, a qualitative study with a phenomenological approach was a suitable. During my investigation of research methods I came to realise that there partly were smaller differences between methods, which today are regarded as separate from each other. I also understood that different, not out-spoken assumptions on 'reality' (e.g. if health care workers problem was ' the patient' and only 'the patient') could produce big differences in research results.

CHAPTER FOUR

MORAL PROBLEMS AS PERCEIVED BY EXPERIENCED DOCTORS

4.1 OUTLINE OF THE CHAPTER

- In this chapter I will highlight important points about my research approach
- Present the results of my study
- Looking back on the contents of *value* discussion in chapter two will make it easier to follow the presentation of the structure of doctors' moral problems. A short repetition with references to chapter two and a development of the theoretical discussion will be presented

4.2 INTRODUCTION

In this chapter, I highlight some important features of the phenomenological method, so that readers can better understand the results. Following this, I present the results of my phenomenological analysis of the fourteen doctors' everyday experiences of professional moral problems. The phenomenon to be studied is *moral problems* as perceived by experienced doctor, with my interest lying in 'what constitutes a *moral* problem for doctors.' Although much has been written about problems in the health care sector, empirical contributions have been limited. My aim is to highlight how moral problems appear in everyday clinical praxis. By doing so, I wish to supplement the modern, philosophically founded clinical ethics.

Moral values, silent and articulated, are mediated in social life and in clinical practice. I wanted to enlighten what the doctors, as members of society and participants of the medical community, considered as morally loaded. My intention was to analyse the interviewees' accounts, in order to find out what made problems *moral* problems, rather than describe the type of moral problems they encountered. To show the difference, I refer to two examples from the researchers Geoffrey Baruch and Håkan Landqvist (Baruch 1981;Landqvist 2001). They analyse the stories of parents, telling about a child's somewhat late detected illness and about a poisoning accident, respectively. The parents are described as speaking as moral persons. This means that they talk as responsible parents, accepting the standard of *good parents* through living in a society: that is parents who ought to notice the signs of illness in time and keep poisons out of harm's way. When listening to the parents' un-analysed conversation, the meaning may be e.g. the cause of the poisoning accident. Behind this explanation is

an understanding of parenthood: that parents ought to have a physically safe home for their children. Such issues however, are seldom named explicitly. If interviewing parents about their experiences of parenthood one can present the results as the meaning of being a parent (e.g. to be near/responsible…) or the structure of parenthood (e.g. a life-long commitment), both of these deal with the meaning that the parents experience, but in different ways. Literary descriptions may be analysed together with interviews Themes or content analysis (e.g. dangerous traffic and quarrelling children) may be presented but these presentations are of a different character than presenting the parent's experience.

Once again, I emphasise that I have a focus on *moral problems* in my analysis. For example, a doctor (A.D.) describes the problems involved in understanding patients who may be afraid of illness and therefore, hide their symptoms. When the interviewee exemplifies this with a story of a patient who concealed some symptoms and later became seriously ill, I do not see it as a story about *understanding* per se, but as seeing oneself as *responsible for the harm done by not-understanding*. After reading and re-reading the analyses of the interviews, I suddenly realised that some meaning units, although separated by other conversation, were connected and that a unit containing an account of child abuse belonged to a meaning unit with reflections concerning the limits of the doctors' assignment (see 3.5).

4.3 THE STRUCTURE OF THE PHENOMENON *MORAL PROBLEMS FOR DOCTORS*

A moral problem occurs for an experienced doctor in a situation when, according to the professional standard related to being a doctor, values are violated to such an extent that the doctor acquires moral insight. I will point out that situated experience – 'experience in a context' – can involve more than a situation with just one patient. As a doctor, one could think something like: "Tomorrow I will treat patients in a risky way" (see G.T. 4.3.2.4) or one might think: "The social insurance rules are unfair to unemployed people such as the man I am talking to now."

If making a content analysis of the issues the doctors bring up, one can say that a moral problem occurs for the doctors in this and that situation. This mode of presenting problems has been the predominant approach in the medical ethics sector: "two patients, one of them a mother of three, the other patient (defined with some other one-dimensional characteristic): which one of them should be given the bed/the operation/ the respirator…?" This technique of presenting a problem implies that there is a localised 'reality' with only a few dividable parameters of importance. However, if I had presented the participants experiences in this way, I would have failed to point out that the doctors talk about that it is a moral problem that they, as self-evident members of the institutional settings, assumed to be loyal, can not treat patients according to their medical needs. The doctors did not speak as moral agents with dilemmas (as portrayed in medical ethics theories – see 1.8.1, 2.3.2) they speak as *moral persons with bad consciences*. It is not the choice that creates the moral problem, but the circumstances within the institutional setting (in this case there was no respirator available when a patient needed one) that emerge as morally significant when treating human beings

unfairly. All the experienced moral problems have a *context*: which means the circumstances that seem relevant to the situation. Apart from concrete matters such as a shortage of beds, there are also institutional rules regarding which kinds of patients are allowed into a particular department, potential conflicts (between departments or of a more personal character), legislation, and time resources. The context is not only "here and now" because a judgement in the present situation may result in a problem later on. A doctor may send a patient home from the emergency ward, satisfied with their condition, or he/she may be concerned about someone who was sent home due to the catastrophic shortage of beds. Afterwards the doctor might be told that the patient was brought back to the hospital dead. All the participants see moral problems from their viewpoint as responsible professionals, and in this sense, the *medical*, and the *moral* are not separable. If a person has a driving licence and kills somebody by accident the person would most probably not say: "It was only a car accident, a normal day-to-day occurrence."

All interviewees showed that they had abstract, personal comprehension about what work related morality meant. They did not talk about right, wrong, good, or bad according to a universalistic or eternal standard. Instead, they reflected on how a doctor – in taking on a societal role – ought and ought not to behave within existing health care and what *counts* as moral problems for the doctors *as professionals.* It is evident that they have come to a general understanding of what their professional life involves.

> For me it is hard to remember specific patients, what I can say or what I feel is more on a level of principles (B.S. p. 14).

> There are ethical problems or dilemmas at different levels. Some concern the individual patient where one sometimes may feel ambivalence, but there are also more principled occasions where one can find some kind of conflict between the patients' interests and the purpose of the activity (S.H. p. 106).

Although the participants began talking about their reflections on work related moral matters on a general level, later on in the interviews they gave rich and varied accounts of concrete moral problems in their everyday work. For instance, B.S., one of the doctors quoted above, said that he could not remember individual patients, but only a few minutes later he told a very detailed story. Many of the accounts the doctors gave referred to problems about institutional matters that tended to occur over a period of time. Their stories concern problems they see as doctors trying to be competent performers of their assignment as they perceive it.

A person's moral life is not free-floating, individual rationality, instead it is a form of communal or societal participation. A problem is a problem within social settings (see for instance 2.3.5.1 for a fuller discussion). For doctors, this includes the structure within the medical institution, regarding the access of technical resources and hospital beds, the time available for each patient, the motivation of patients and relatives and so on. That which is perceived as relevant for doctors in each situation involves not only the features of the current situation, such the available resources, but also how they experience these features in relation to the assignment that they have internalised as their own.

A doctor encounters a new situation with the experience of what she/he believes a doctor 'is', what a doctor deals with, and how they deal with it. In other words, the

doctor's *standard.* Among the vast amount of information (in a broad sense) available to the doctor, something stands out as significant and the doctor sees: this is unequal treatment, this is cheating… These judgements are not made only according to a free-floating *doctor's* standard because every doctor has, as a human being, grown up in a society and, as a participant in society, learnt about morality. This knowledge may be expressed by "This is wrong" but if asking why, one can get an answer: "This is wrong because this is deception/lying/murder". Being a participant in a society is to be a participant in a value-loaded world. As an adult one has gained knowledge about human values and has integrated them to a basic knowledge of what a human being is. Moral concepts (Brennan 1977) outline conditions of being human. A person cannot expect to attain societal comprehension if he/she says something like: "I strive to be unfaithful/unreliable/to hurt people".

A blacksmith, a police officer, and a doctor, growing up in the same society learn the value ground of being members of the human group: to be a human being. Later in work they learn praxis' internal standards, which partly differ between the occupations. In a situation, something crops up as morally relevant and a police officer says: "This is wrong because this is humiliating treatment of a fellow human being" (If he does not regard the treatment as humiliating he must be prepared to be criticised on the grounds of ordinary common-sense).

An observer, seeing patients receiving intensive care treatment during the final days of their lives, might reflect upon the fact that these days appeared to have been overshadowed by procedures that made them seem unworthy. In order to bring up an issue such as this (as some of the doctors did) you have to have some idea about what a reasonably good life is (an old philosophical question) (Nehamas 1998) and what a good death is. All doctors bring up issues about the tremendous importance of modern health care in people's lives. Reflections on belonging to an enterprise, changing peoples' lives in an unforeseeable long-term way are brought up. This is seen to occur e.g. when revealing a diagnosis like suspected multiple sclerosis or a psychiatric diagnosis.

> There has been a change in society so that healthcare replaces the simple understanding of how to deal with small ailments and to some extent healthcare replaces the Church and spirituality (S.P. p. 70).

> One problem that has been discussed often is whether one ought to use psychiatric diagnoses. Some psychologists say that each patient ought to be treated as an individual and that one does not need diagnoses. Some colleagues argue that a diagnosis of e.g. schizophrenia results in the patient becoming more ill. Personally, I believe that the patient ought to know what illness he/she has, on what basis the diagnosis has been made and information about treatment. I think that this will help us to be more straightforward in our communication with patients. Nevertheless, it is a moral dilemma (S.H. p. 114).

As a health care worker one sometimes wonders about new things brought into the medical world and issues that were clear-cut in the old days, such as, who was perceived as alive and who was perceived as dead, may now be a question of special investigation. The fact that the same test has to be carried out twice, in order to be sure,

can be understood as a new way of working clinically. Yet, for the doctor, the issue has a more long-term dimension:

> You see we have this man on a respirator, his chest moves, he is warm, and his heart beats. I cannot see that he is dead and I have wondered very much what the family thinks about it. I remember one man who wanted to be present when his father's respirator was about to be turned off because brain death had been diagnosed. When the respirator was turned off and his chest stopped moving and his heart stopped beating, the nurse said: "Yes, it's over now" and the man started to cry. All three of us felt that he died when the respirator was turned off, it was a very strange death, and I do not know how we will ever get over it (L.U. p. 137).

Summarising the section, in my analysis of the interviews, *the structure of moral problems for the doctors seen in a social perspective consists of: values, a standard, and a context*. Just as the structure of a chair can be seen as consisting of seat, back and legs, there is a variation of each part. I will present my findings under three main headings, dealing with: *perceived moral values*, the *doctor's standard*, and the *context*. It is implied that they do not exist free from each other.

4.3.1 Values governing the perception of moral problems

In order to facilitate understanding of this section, I will refer to some ideas from chapter two (2.3.3) on the topic of moral principles. Moral principles can be seen as the source of moral problems rather than solutions to problems. D.Z. Philips and H.O. Mounce, who were mentioned in 2.3.3 exemplify by naming that if someone experiences a moral dilemma when he has to choose between lying and helping a friend, this is because she/he holds certain principles (Phillips & Mounce 1969, pp. 86-87). They describe how technical principles and moral principles are different, and explain that a plumber with technical principles can carry out a good job, but that moral principles do not work in the same way. The same can be said about values, which can be seen as prerequisites for a person's principles. From a social life-world perspective, one perceives things from the value ground belonging to the life-world. If a person has internalised bourgeois dressing rules and believes that they are an important part of social life, this same person will notice if someone else wears brown shoes after six p.m. Others who do not know about the Black-shoes-after- six-rule or those who find it ridiculous or meaningless do not notice or if they do, they do not perceive the colour of the shoes as value loaded. If the person who adheres to the Black-shoes-rule sees a man dressed in sandals he will probably think: "He is untidily dressed" rather than "It is wrong to wear brown shoes after six." In the same way, although the interviewees did not talk about right/wrong or good/bad the issues that they referred to and the (thick evaluative) terms they use are indications of their value ground. However, persons are not always aware of what kinds of values they hold, neither do they need to be aware of the specific values that influence their perception of moral problems in a given situation. In addition to this, the everyday world is filled with examples of people who maintain that they hold certain principles yet their behaviour does not always appear to match their principles. I asked for the doctors' experiences with the aim of finding out

what they had experienced and my questions were not aimed at obtaining accounts according to what they found appropriate. The doctors' accounts are from a world with different kinds of values and of values' clashes (Berlin, 2.4.1.1) a fact that they themselves often recognise.

I will discuss how questions about *values* are fundamental in everyday work, and how they are inseparable from the doctors perceived *standard* and a *context.* If the doctors did not have internal standards, which mean that they have to manage all work, then they would not take the political responsibility that they do. If the context had been different, for instance, if hospital beds had been available, the doctor would not have experienced a moral problem in a situation because she/he would not have had to treat anyone unfairly. In their everyday lives, continuing as usual, the doctors experience a situation related – a situated – moral problem, not an offence against values.

The concept *values* are often used dichotomously. For example, when the doctors talked about problems in the medical field in a general way they could refer to dichotomies, such as, the protection of one individual as opposed to societal interests. When talking about real, concrete issues the picture became more complicated. One of the interviewees (M.O.) told about a family with a child that was dying. Parents are meant to care for and protect their children, but these parents, not being able to cope with the child's impending death, turned to wishful thinking as a solution to the situation and they focused on caring for their child by demanding medically meaningless treatment. This situation was one of the tragedies of life and it was not possible to solve by reflecting upon interests or values.

The doctors accounts are accounts founded on values, although mostly implicit, making some problems to *moral* problems. Their accounts of moral problems – moral tales – can be seen based on a mixture of

- Democratic values (experiencing problems of unfairness and also seeing a development in health care without democratic decisions)
- Values which are inseparable from being a member of society, expressed with thick concepts such as 'responsibility' and ' the risk of hurting' (These issues are discussed in chapter two, 2.3.1, 2.3.5, 2.4.1.1): to be a human being is to be reliable, honest …
- Knowledge of a multiplicity of value grounds (in a multicultural society, implying that the doctor's problem is not always a question of understanding, but one of drawing boundaries according to the perceived doctor's standard.

An approach to medical ethics in the form of rights contra duties, somehow presumes that everything is based upon an ordered, unchanging value-world. However, many issues within the doctors' working fields change their 'value content' and move from the realm of facts to the realm of values or vice versa.

Fifty years ago, a doctor would have been disqualified from practising medicine and accused of murder if he had carried out procedures on what today is seen as a brain-dead person. Today these types of actions are approved of. However, half a century ago the human value of a respirator-breathing yet brain-dead person was 'a living person'. It still may be so for many, explaining some of the difficulties with getting organs from brain-dead persons: after years of practice a surgeon may no longer dissect out of brain-dead bodies, without being able to formulate in words why he has become unable to do so (Lock 2001, p 46).

When many Swedish women in the sixties and seventies asked for abortions it was a sign that women had changed their view regarding the meaning of aborting a foetus that had not developed consciousness. The abortion itself was the same act, but for the women the meaning had changed from the legally founded one of abortion being murder, to (perhaps) simply being one of the difficult and sad decisions in life, but not something to be looked at from a moral point of view (Brennan 1977, 166-167). In order to perform the abortions, the doctors also had to change their *standard* as to what a doctor should do and if it was compatible with his own values in fundamental human matters. A new social reality was constructed, initiated from women but with the co-operation of doctors from the high-paternalistic era. As another example I can name that some doctors stopped reporting epilepsy when this disease was still a hindrance for marriage (As a medical student, doctors told me about this). In the clinical meetings it became apparent for the doctors that persons with epilepsy had a different value than regulated by law. This is in accordance with the thoughts of the philosopher Frithjof Bergmann (2.3.4) who described how one comes to an understanding that the law must be changed by looking at a single person on death-row (Bergmann 1983).

One can look back with horror on the days when the human value of a coloured slave was different to that of a free white man. However, even now a person's value can be judged on whether they are citizens of a country, or if they are foreigners from another country. Sometimes this is obvious, i.e., that a refugee without a residence permit will have difficulty in obtaining expensive medication. My interviews took place in parts of Sweden where very few refugees live. If the context had been different, a moral problem could have occurred (but not necessarily, that would depend on the doctor's value ground and experienced doctors' standard)

Many of the doctors' problems appear because values within social life are violated. While growing up one learns, what it is to be a human being (2.3.5.1). Overall, this knowledge is mediated by 'thick' concepts (2.3.1), richer in meaning than the thin concepts right, wrong, good, and bad. 'Hurt' is one of the terms that may be described as being thick in meaning (2.3.1) and where it is meaningless to say that to hurt someone is wrong or bad; avoiding hurting one's fellow human beings belongs to one's humanness (Berlin 1978, p. 166) (2.4.1.1). The same is to be said about responsibility, which the analysis revealed as a basis in understanding the medical assignment. This assignment entails the inevitable risk of causing harm to patients, which in turn causes a loss of self-respect, pain and guilt. Treating patients, their families, personnel, or patients on the waiting list, in a way that the doctors themselves are ashamed of, may create feelings of alienation, depression, guilt, (which may be quite misplaced considering the circumstances) and result in sleeplessness, anger, or activation, A doctor is frustrated not by the actual act of lying but of being dishonest; of deceiving:

> The first thing the family members said was: "No, you may not tell her how bad things are, she will not be able to cope." It was terribly frustrating for me, not being able to speak honestly with her (N.M. p. 34).

Saying that concepts belong to human life is not the same as saying that they are constant in meaning. On the contrary, the meaning of justice and honesty, in terms of behavioural application, vary (Gergen 1994, p. 102). Their meaning can (in the words of Kenneth Gergen regarding abstract principles) be said to be under continuous repair. To name an example, during my childhood in a small village (with no doctor) a man

came home from the hospital which was situated approximately 20 km away. His skin was yellow and the adults explained that the surgeons had opened his abdomen, and closed it again. His wife was told that he had cancer and as I remember, everybody seemed to find it natural that everybody except the man himself was aware of the diagnosis. The act of *not telling the patient everything* was, at that time, not perceived as *deception*. For the inhabitants of the village, the doctors in the town were stereotypes that were talked about with the examples of anecdotes. They were regarded as skilled if they had operated on a person and the scars after the operation were small. The patients belonged to their families not to the hospitals. At this time, it was the custom not to tell everything to the seriously ill patient. This had been established among the members of society and the custom would not have been able to continue if it had only been a sign of the doctors' paternalistic attitude.

I will present sections with focus on values, yet the implication is that values, standard and context are interrelated, making the doctors work related moral 'reality' together. I will point out that phenomenon such as not hurting, being dishonest etc., learnt whilst growing up, can be seen more as a foundation within our social life-world than principles to be applied.

4.3.1.1 Working with the inevitable risk of hurting instead of helping

Working with the aim of being a good doctor one is always at risk of seriously hurting someone or even hastening their death. One never knows if one makes a 'medical' mistake, not understanding what the patient tries to say or if the person who asks for help is afraid and does not tell everything. With efficient treatments with side effects it is known that the risks and uncertainty have grown (Fox 1999;DelVecchio Good et al. 1999, p. 191). Doctors in the surgical sector tell about very ill patients, who would not have been operated on some years ago, now dying on the operating table (B.K., L.U.) Here conflicts between doctors appear, one comes to different conclusions if one judges the matter as a *good-life* question or as one of the fundaments of the assignment that a patient may not bleed to death. This risk of hurting individuals who trust you exists, for example when a doctor treats a person who wishes to have some temporary help that comes in for a routine operation and then dies (A.T.). In other occupations, people also makes mistakes i.e. a pilot or an engine-driver might make a mistake that could hurt or kill people but it is in a more impersonal, collective sense, often connected with technical faults or some other catastrophe outside their control. I do not mean that pilots do not grieve (if they survive an accident) but for the doctors a bad outcome is very concrete and personal for doctors: your patient has died and the members of the family are grieving.

This concrete and ever-present risk of a catastrophe was not only connected with the doctor's actions. If doctors waited too long or if they hesitated about clinical signs and something went wrong, it was difficult for them to forgive themselves. "It is obvious that I failed to make the correct diagnosis" (K.T p. 5). "Looking back I realise that I ought to have understood" (B.S. p. 20). They saw it as a personal failure and felt guilty. In my study, there was nothing to suggest that this part of the work was something one could learn to accept or readily deal with. Usually the doctors carried this burden alone, grieving and blaming themselves. Although they saw a shortage of time as a great problem, when the outcome became adverse, the doctors blamed themselves and did

only marginally consider the problems of external circumstances. An atmosphere, experienced as friendly and helpful did not prevent periods of brooding: “Did I do everything I could, did I make a mistake?” (A.T. p. 52).

4.3.1.2 Moral problems emerging from being a responsible professional

Today there is no talk of ‘class’ as in the late sixties although inequalities still exist, they are seen, mentioned and constructed, in other ways. One interviewee expressed responsibility for the low status people who do not have the appearance or good talking manners appropriate in health care of today but sometimes more in need of care than others who have managed to jump the queue because they can express themselves better (A.D.). Another doctor, with a highly specialised medical assignment saw that within the current system those, who knew how to complain managed to get what they wanted, putting patients in urgent need of treatment further back in the queue (S.P.).

> One thing I have thought of is that people are treated differently depending on their personality, people who are easy to talk with get more from life in general and from health care too. They get help more easily than people who are seen as difficult. (A.D. p. 119).

Institutional resources, other patients and societal regulations e.g. regarding the doctors’ duties to send in reports to authorities are irreducible parts of the accounts. It is evident that the doctors’ responsibility is not only limited to ‘the patient’; it also involves other patients and societal resources. Furthermore, the well being of the family is also a self-evident part of the doctors’ task. In order to protect family members or ‘society’ the doctor may feel obliged to act against the patient’s interests. The word “responsibility” is often mentioned when talking about politicians: that one as a doctor has to take on this responsibility.

> We can do more than we can afford, the politicians do not dare to make decisions between patient groups, they only decide a sum of money and so it is up to us to the rest (K.T. p. 2).

Frequently, a doctor’s sense of responsibility embraces the whole working situation: a doctor goes home and eat and goes back to do the paper work later in the evening, the work takes up all his time and interferes with his sleep. Sometimes the responsibility to do one’s job appears to be absurd for the doctor who tells about more and more paperwork at the emergency ward and many other new obligations. He explains that when he needs a form he has to go out into the stores and order A3X9B8, 10 on the small computer. He comments in this situation: “I am accustomed to it but it takes time away from the work with patients”(B.S. p. 25).

> We try in every way possible to get it to look as though it is working; not only the doctors but also all health care personnel (U.V. p. 64).

> We have to carry out our work with less time and with fewer resources. In the end it is a job, that is badly done, that is the biggest problem (S.R. p. 156).

The first Swedish physicians' rule has a somewhat old-fashioned formulation: "The physician shall [….] follow the rules of honour" (Schöldström 2002). The doctors were striving to be responsible and follow these rules of honour but the work had changed so much that they did not always understand if they were following them any more.

4.3.1.3 Moral problems concerning co-creatorship of a unwanted future

The development of medicine with medicalisation, medicine replacing traditional religion, is brought up as an issue of moral concern. Important yet conceptually muddled questions as the 'medicalisation' of society is otherwise seldom defined as a medical ethics issue (Gustafson 1990).

Technical inventions introduce new issues into the medical enterprise; in the beginning, often without any formal decision, as extraordinary measures. After a while, 'normality' changes. Today the doctors have to write down why they do *not* find heart resuscitation indicated. A doctor (B.S.) tells a story about nurses asking about a signature on a message that read 'Do Not Resuscitate'. After talking with the family members, who understand the issue in different ways he has the feeling that one can possibly reach "some kind of consensus in a quagmire". Another doctor (S.R) names how at his clinic one is forced to decide if a patient with a stroke is to be given a medication which could possibly make him better, but which *could* also make him worse. The mere fact of being a member of the hospital team means that doctors are more or less obliged to take a bigger risk in hurting patients.

4.3.1.4 Violating democratic values

A few decades ago a Swedish district medical officer in a yearly-report from his district, wrote that young girls had begun to use nail varnish. This yearly-report has been ridiculed lately and it is evident today that the report was expressing some kind of viewpoint. The medical officer had gone beyond his obligations as a civil servant and made a kind of moralistic statement. That kind of evaluation of how people ought or ought not to behave in their lifestyles was virtually absent (unless named in a concrete story e.g. that it was a problem that a patient with complications of diabetes was a smoker). All the same, when discussing problems such as unequal possibility i.e. obtaining access to highly specialised treatment, one has a political idea about what kind of society we ought to share. Values that give weights to solidarity with known and unknown others, to the community, and an obligation to show consideration for the disadvantaged, are revealed. Here, the doctor will find him/herself very lonely, if experiencing that the head of the department has gained their position on other grounds.

> The politicians may try to get bosses who can save money rather than be good leaders. They are praised because of their effectiveness but in the long run, health care is worse off (S.R. p. 152).

> We had a boss who promised the politicians that "we will take care of this" and "we will take care of that" but the person who was going to do the job was never asked, there was this wonderful talk about flexibility and no talk about time needed. (G.T. p. 94).

Giving consultation time to and arranging a hospital bed for one patient, means that the doctor has fewer possibilities to arrange for the next patient in need of time and/or a hospital bed. In this way morality and moral problems are connected with performing the working tasks in a moral or immoral way and moral problems are or are *not* moral problems depending on what one counts as belonging to one's responsibility. If no political responsibility is visible i.e. when trying to arrange a sufficient number of hospital beds, this easily becomes a moral problem for the doctors. Naturally, these doctors do not work in a non-political environment but when working it is not easy to see that within this lack of resources political decisions are made.

This moral mission, or internalised responsibility was also experienced for individuals in need of treatment on waiting-lists, as well as for individuals who were in need of getting access to highly specialised care: *a responsibility to see that societal fairness is achieved.* The interviewees were conscious of the tension between the individual patient's needs and other presumed patient needs. A doctor named "the patient in focus" as a good goal for the team (the only doctor who had been on a course in medical ethics), but he also mentioned that one must weigh the actual patient's needs against other patients' needs. Some doctors have tried to get politicians to take over this responsibility:

> The politicians promise how quickly patients must be taken care of and what we shall do and at the same time they want us to do reduce costs. We reorganise the whole time and meanwhile, people in this country are reaching a higher average age. We get more patients and today each individual patient can obtain better care, it is more than operating and sewing. It is not only the patient we have to inform but also all the relatives and most patients have more than one relative. There is the demand that people should be taken care of by the most experienced doctor and be discharged by the most competent doctor and this is not possible to arrange (S.P. p. 68).

> Nowadays the patients call us because they are dissatisfied with our accessibility. We answer "We do what we can but if you are not satisfied you must go to your politicians and try to influence them". After this, you can be sure that you get a letter from the administration: "This patient have contacted us, can you take care of him?" Yes, that's the way it is, it gives you more work (S.P. p. 74).

> There is a conflict between the interest of the patient and society's interests, for instance, can I prescribe a more expensive but at the same time probably more effective medication for the individual patient? It is very hard to explain to the patient why you chose a cheaper tablet with more side effects. This problem is a reality with the new antidepressants (S.H. p. 106).

> Working in a small hospital, means that pressure is on you *not* to refer a patient to a hospital with highly specialised care, individuals do not get access to the same standard of care because of economic reasons (S.R. p. 151).

4.3.1.5 Treating fellow human beings poorly

On the whole, the participants felt powerless about the poor state of things at their workplace. As mentioned previously, many of the doctors suffered from sleeplessness and depression. This sometimes resulted in sick leave of varying periods; five of the fourteen interviewees had been on work related sick leave recently.

One can, as an outsider, wonder whether today's generation of doctors might someday be accused of accepting these conditions. It may help to think about earlier decades. Late in the summer of 1997 articles were published in the Swedish daily newspaper *Dagens Nyheter* about the sterilisation of women in the twentieth century. Physicians were seen as playing a central role in creating and effectuating the Sterilisation Law. A representative for the physicians' trade union wrote that the individual physicians did not have to reflect on whether the operation was ethical or not as the question had been settled by the National Board of Health and Welfare and psychiatrists. He was challenged by a journalist: "Can the physicians of today free themselves of responsibility so easily?" (Lindquist 1997).

For decades, in Sweden, the knowledge of the sterilisations had belonged to the realm of facts. Every man and woman who intended to marry had to sign a paper that they did not have epilepsy, that they were not mentally deficient, and that they were not already married. The change to the realm of public morality that was made, cannot be made by just anybody, at whatever time. Strong groups direct their interest towards some issues and away from others. Most of the doctors interviewed did not have any sense of being participators in these matters. Some years from now, one will perhaps read about issues brought up by the interviewees, for instance "The physicians acquitted themselves so easily from the responsibilities regarding the indecent treatment of elderly individuals" The Board of Health and Welfare is the governing body of the doctors. Telling the National Board of Health that they have made an immoral decision is almost the same as telling the police that you dislike the traffic rules.

To sum up, the doctors daily work has many value dimensions: e.g. changing perspective from the doctor's demand on herself to be reliable towards a patient in the consultation room to be a reliable also towards other persons in need of medical help adds the values involved. How a work related problem is perceived depends on how the doctor understands her assignment with its standard. Moral problems connected with perceived doctors' standard will be dealt with in the next section.

4.3.2 The doctors' Standard

The doctors' understanding of what 'a doctor' is provides the framework for what they define as problems, and likewise, influences on what they see as work related *moral* problems. Their experienced moral problems can not be placed into one of the categories often used in ethical theories, dealing with the moral criterion (= what shall I do?) and the moral ideal (=what kind of person shall I be?) respectively (Thomas 1993, p 64). Their experience includes many different kinds of situations and demands. The doctor should not have to solve every single moral problem that he/she perceives

(neither by working with his/her character nor by finding the right thing to do). It is not evident that the doctor ought to respond to all problems. In many cases circumstances creating problems ought to be changed instead.

4.3.2.1 Influence from contemporary society

As a doctor, you have also had experiences of doctors during childhood when growing up and being a member of society includes hearing stories about doctors. An additional part of this learning about what a doctor is (including good and bad doctors), takes place outside the health care institutions, through films, books, journals and newspapers, and conversation with neighbours and friends. In different ways, all the participants showed that they were aware that demands had changed. These experienced demands from outside health care often seemed too burdensome or in other ways problematic.

> Demands from patients have increased tremendously since the seventies. I think that we have taken too big a load onto our shoulders; I think that we must concentrate more on the medical side of things as we did previously. We cannot act as social workers and doctors all at the same time. The patients must get help from other professionals too. One patient said to me: "I do not need a social worker, because I have you". It is too much for me, one has to draw the line somewhere and realise where one's responsibility ends, otherwise one cannot do a good doctor's job (N.M. p. 40).

> These moral problems that appear today in everyday care, would quite often be dealt with in a better way by the family or a priest instead of the doctor (S.P. p. 71).

4.3.2.2 Personal value ground

What a *doctor* is, is an ongoing process to be reflected on. There is a personal interpretation according to one's own deeper personal beliefs (which can be, but is not necessarily, based upon political view and religious faith) (2.3.5).

> I am prepared to do a great deal of´what the patients want, but one thing is for sure I will not kill them, I will not do that, but otherwise I can abstain from treatment. I can turn off the respirator if I know that the patient will die, but to do something active, inject potassium or the like, no this is not an option for me. At this point I will draw the line. As a professional, there are certain boundaries that I just cannot cross (L.U. p. 131).

One's own personal values influences what doctor one sees as an ideal:

> We have had a kind of apprentice system and there's nothing wrong with that. I have had teachers who have been quite wise and I think that the role models I chose have been very useful for me but the value foundations have been mine all the time. Society influences the individual and so the shift from patriarchal behaviour towards a more equal behaviour is dependent upon changes in society. I say that I think I

> have had good role models, but I am aware that I have chosen them from my own value-grounds (B.K. p. 82).

Ritvka Grundstein-Almado has discussed medical students' education on values with the use of 'value journals' (Grundstein-Amado 1995). Awareness of one's values may of course make one self more conscious in the daily work but individual values are not the only factors influencing the experience of moral problems in doctors' working-life.

4.3.2.3 Internal, internalised standards (from the doctors' life-world)

The doctors gain knowledge through the teachings of older colleagues and they gain both silent and verbalised knowledge by following the more experienced doctors' everyday work and through their own practical work experience.

Naturally, doctors of today work in modern health care, which deals with very different issues than it did a hundred years ago, now 'managing' people with chronic illnesses, making the medicalisation of individuals' lives greater than any time before in history (Young 1987, pp.108-109). One can still imagine, however, that a nineteenth century doctor who came home from a day's journey on bad roads and was met with the message that he is expected to go somewhere else, on yet another home visit may well have thought "How much is expected of a doctor, what are the limits of one's duty?"

A doctor near retirement age goes to the emergency ward in the middle of the night: he has to ignore his own fatigue when helping younger doctors with a long queue of patients waiting to be seen. He says: "Only those persons who have been at an emergency department should have the right to speak of medical ethics" (B.S. p. 24). For this doctor the problems at the emergency ward are concrete problems. His tiredness and participation in a health care system he perceives as poor, lead to thoughts that he tolerates more than he ought to, in order to count as a good doctor today. Reflections on what one finds should *not* belong to a doctor's assignment appear. These reflections involve both the doctor's workload and what the work might involve:

> You get up earlier and earlier, you go to the hospital and work all day, you go home and eat and you carry on like this day in day out, it is dangerous in the long run (K.T. p. 4).

It is a failure for the doctor to not suit a patient. In the doctors' moral world, failure of any sort is hard to accept. The stories about being rejected by patients seem not to be stories about disappointment at losing personal esteem. Instead, they are accounts of professional failure, implying that another colleague could have performed the work better. Sometimes a doctor gets to know afterwards that a patient wants to change doctors. Regardless of the reason, one has made a fault as a doctor: one has not passed according to the own internal standard.

> There is something shameful about a patient wanting to change doctors, another problem is that now and then I notice that I do not communicate well with this patient, how to arrange things in a professional way for this patient and for me. I can get provoked by some patients and get into my own thoughts that both of us would

> be better parting but as doctors, we are not allowed to talk about something, which is wrong for us (R.H. p. 86).

The interviewees were conscious of the fact that *the doctor* was a societal role, someone told about experiences of trying to make friends with some patients, but he had found that it didn't work out. Someone else joked self-ironically that he occasionally found that he had to 'turn the charisma on' about the situations when he found himself exaggerating the superficial behaviour too much. The interviewees seemed aware that patients needed more than medical advice: that many people needed 'a doctor' but that the role had become unclear:

> There is such a great resistance against the old doctor's role, so much so that as soon as you are distinct within the health care group, you are seen as dominant. That's why most doctors choose to always fit in. When you do this, you lose your knowledge: about what role you have, whichever way you look at it you are a *doctor* to the patient, everything has become so blurry […]. The doctor's role has become too vague, when I was a young doctor I found it pleasant but I have learnt that going to the doctor is in itself, part of a therapeutic process which does not work if the patient meets a friend (R.H. p. 91).

It is noted otherwise that young doctors are taught by older colleagues to tolerate more than other personnel (Bosk 1979, pp. 55-56) and in the medical world, it can be difficult to admit that your workload is too great a burden. The doctors' experienced internal standard has become the glasses governing what one perceives as a doctor 's assignment in new situations, e.g. that one has to manage extreme work burdens. One doctor tells:

> There you have it, patients in every bed and in the corridors. You have pressure on you from everywhere and everybody. The nurses on the wards state clearly that they cannot manage to take care of more patients and if things continue in this way, they say that all nurses will resign. Then you try to place some of this pressure on other departments and try to convince them that it is a 'this' problem or a 'that' problem or however you can twist things. One cannot continue to play games like this; one must take care of the patients (S.R. p. 152).

In written work the physicians' profession has been depicted as a strong, tightly knit profession, where people hold each others hands (or maybe the nurses' hands) (Johannisson 2000). The quotation from R.H that was mentioned two paragraphs earlier is about conformity but not closeness or support. An awareness of the different clinics being seen as communicating vessels existed. One doctor, who was specialised in one area that had a lack of doctors, was aware that other doctors had to take over parts of what she saw as her work. Another doctor found that doctors that were specialised in the same field as himself had to take care of other patients belonging to other areas at nighttime and this made his occupation less attractive for young doctors.

> For us it is obvious that emergency cases have increased during recent years. Patients from nursing homes come and need a bed for a few days, the patients do not need our surgical skills and our surgical patients with cancer have to wait, and

so we can not fulfil our assignment. The work has changed from surgery to ordinary medical care (S.P. p. 71).

4.3.2.4 The doctors' lack of help from rules

At first sight, work which aims at reaching a socially accepted agreement regarding the question of priority between different patient groups (Statens offentliga utredningar: SOU 1995:5) seems to be very practical work that benefits the doctors. However, the priority issue looked in a different way inside the doctors' institutional settings. Their work consisted of assessing patients with multiple problems and comparing who is in most need of a consultation time or hospitalisation. This assessment occurs during every round and every ward conference. Living in a medical community one learns about these assessments and internalises this as 'insider's' clinical knowledge. This knowledge, of course, can be criticised from the outside, sometimes on good grounds. From the inside, for the doctors working in a department with a lack of resources, the problem is that there are no available beds for the patients that the doctor sees as having a greater need. A doctor stating that something bad had happened to a young person may be saying indirectly that it was worse than if it had happened to an old person and that he feels that he has destroyed the life for someone who had more to expect than an old person. It may also be that he thinks of the patient with 'youth' as a characteristic when reminding a patient story. Such remarks were rare and the overwhelming message that emerged from the interviews was that the problem was that patients were selected in a haphazard way depending on the specific (e.g. institutional) conditions present in any given situation.

Every profession has codes (informal and formal) that regulate behaviour in the workplace (Greenwood 1957). The present study is not designed to shed light upon the influence of the physicians' written professional codes, nor to gain knowledge about how much the codes are known to the interviewees. The influence of written codes in modulating behaviour in practical work is unclear. The codes change as society changes and they are partly to be seen not as governing but governed by praxis. Some codes may have been known by the interviewees to be officially seen as important, however, in reality, viewed merely as empty rhetoric. Other codes, such as not accepting large gifts or engaging in sexual relationships with patients, maybe seen by most experienced clinicians as being obvious, i.e. that it is not possible to have a therapeutic relationship after receiving an expensive painting from a patient. How to interpret a rule in a situation is different from merely following a rule. It is clear that all doctors concur in a standard of being useful and not causing harm but this could just as well have been learnt from society before they began studying medicine, through practical experience and through trying to emulate good role models.

The doctors were aware of the fact that patients were treated in an unfairly way (regarding the treatment of their illness or something else) was recognised without consulting the Swedish physicians' rulebook. In the physicians' set of rules the *problems* are seen as self-evident, mostly by dealing with the patient in the consultation room. One example is the newly, modernised (by bringing in 'empathy') rule number four: 'The physician shall treat the patient with empathy, conscientiousness and respect'. Knowing either the old rules or the new rules (of which the named empathy

rule is one) would not have solved the interviewees' problems by heart (Schöldström 2002). One doctors says:

> Tomorrow I am the only doctor available for 48 patients and their relatives. Some of these patients are dying, some of them have serious infections, everybody wants things to go on as usual but there are no margins (G.T. p. 94).

If looking closer at a story such as G.T.'s, spending the next day alone with 48 patients, most of them very ill, some dying, the question can easily be "Who is the real patient here?" Talking once again with an old lady, who has been repeatedly brought back to the hospital, does not want help at home but is unable to manage by herself and only lies on her bed at home, makes the doctor realise that *the law* is cruel to this patient. He gives another example from his work: while talking with a patient he gets a call from the local home help service that a patient can go home. A nurse tells him that the ambulance is there and here he is: talking with a patient at the ambulatory. It is not the rule *that* he must show respect but *how* to show it and *to whom* that is his primary concern.

I have no reason to doubt that writings exist from a group or school of physicians called the Hippocratic school, and parts of its teachings can be found in a more simplified form in 'the Four Principles'. With my approach, Hippocrates might as well have been invented as a myth invented and kept alive in a time of insecurity and difficulty. Apparently, the connection to pre-Christian Greece has not hindered doctors from doing the cruellest of things to their fellow beings and to be bought by pharmaceutical and other companies. Only one doctor of my interviewees named the old Greeks and Hippocrates. He did so when quoting what a lecturer (who was not a physician) that took part in a course on medical ethics had said. In my study, I have no reason to take sides regarding history of physicians' (I think it can be written in many ways).

A Swedish study showed that physicians in an intensive care unit may overcome conflicts in situations of ethical difficulty by "incorporating and affirming the message of the other" (Söderberg 1999, p. 16). This is achieved by "understanding the situation *from within*, which opens the physicians to the 'trusting in' beyond reality." The doctors I interviewed were asked to talk about everyday experiences. They did not seem to see work related moral problems as problems with *one* right answer, regardless of religious beliefs. Aiming to be doctors in a modern society there were however situations where the doctors' personal opinion resulted in their refusal of certain demands. One doctor (l.U.) named that there was a difference between treating family members and treating patients, as one never knows if one have understood the situation right.

To sum up, working as a doctor means existing and acting within a value-loaded world and this entails a multiplicity of values. How a situation is apprehended is dependent on the perceived standard of being a doctor, which I will discuss in the next part

4.3.3 Circumstances, which appear to be morally significant: Context

The doctors are situated in concrete working situations with demands arising from these conditions. Moral problems in everyday professional working situations are not only focused on issues relating to the *patient.* They can also be related to the working situation as a whole or circumstances connected with the institutional settings. Sometimes a doctor may find out afterwards that something has happened. Although the doctor may have treated a patient in what he believed was being professionally correct way, disastrous complications of the treatment can arise after treatment. The doctor can also be unaware of that problems have arisen until he/she gets a letter from the National Board of Health and Welfare stating that a patient had made a complaint.

It is not possible to solve every single problem by teaching people skills in *ethical care.* Moral problems also occur when working in circumstances the doctors do not see acceptable or sympathise with. This may be the case e.g. when one has lost control over the working day and has to make important decisions without time to reflect on things. A moral problem may occur when working in a small hospital where it seems to be more or less forbidden to refer to a university clinic. The experienced problems are contextualised problems. Naturally, different problems appear in different working situations. Working as a GP one usually meets adult patients who come to the consultation alone. On duty at the emergency ward or at the ICU (Intensive Care Unit) the patient may be unconscious and the family (in medical ethics named as 'proxy') may be in great despair and have different wishes regarding the level of treatment.

Under the heading: *Internal, internalised standards* (4.3.2.3), the following quotation is found:

> There you have it, patients in every bed and in the corridors. You have pressure on you from everywhere and everybody. The nurses on the wards state clearly that they cannot manage to take care of more patients and if things continue in this way, they say that all nurses will resign. Then you try to place some of this pressure on other departments and try to convince them that it is a 'this' problem or a 'that' problem or however you can twist things. One cannot continue to play games like this; one must take care of the patients (S.R. p. 152).

With one's standard that one ought to manage one's job and a value ground that one ought to be reliable and a context with lack of beds a moral problem occurs. I will discuss how something in a situation can turn out to be a moral problem for clinically working doctors. Without values and without a standard of what a doctor is one would not have problems. The problems however are experienced as situated concrete problems and not value problems. I will outline the medical assignment with its risks and uncertainty. I will then discuss how interactions with family members – self-evident as members of the patients' lives – can create problems that are experienced as moral problems. Thereafter I will discuss the problems around discrepancies between legality and morality and problems around failing professional co-operation.

4.3.3.1 Problems around the medical assignment

The doctors spoke as moral persons, from a position where they had constructed moral demands on themselves in interaction with social expectations; this occurred while growing up, during their time as students and later as doctors. All the doctors experienced their medical duties as moral duties. These duties were inevitably connected with the risk of causing damage to individuals who had asked for help. When the participants told stories about medical matters that had gone wrong, the stories were very detailed even if the situation happened many years ago. This indicated that these incidents had had a profound impact on their lives. All doctors referred to stories where they found that their medical judgements had been wrong. Some of the doctors talked about long periods of sleeplessness and some of them had been on sick leave after such incidents. This is not the same scenario as in in mainstream medical ethics where a case ends with the choice (who gets the bed/X-ray/respirator?). Often the storyteller named details indicating that he/she knew that the treatment was influenced by a shortage of institutional resources (e.g. hospital beds). Regardless of this they blamed themselves: just in this one case they ought to have disregarded the lack of beds. The interviewees talked about everyday situations that could somehow appear different afterwards. Through one's prescriptions someone is hurt or has died, sometimes because one did not understand the seriousness and did not act. As a surgeon on duty one often sends patients with stomach pains home from the emergency ward, as an internist one often sends home patients with chest pains, sometimes due to a disastrous lack of beds; other times because one does not find the symptoms so alarming. A doctor (A.T.) explains here that what interferes most with her sleep is when the day after an operation she comes back to work to hear a colleague say: "we had to re-operate on your patient because he was bleeding". This starts a period of internal questioning:

> Did I do everything right? Ought I have done something in a different way? (A.T. p. 51)

In the self-questioning that occurs after an incident is the belief that one as a doctor ought to understand everything, at all times. Somehow, you are responsible even if the patient was so scared that he did not tell you everything. With this sense of responsibility, every complication can be seen as one's own fault.

> What one remembers and what wakes you up early in the morning, is when you look back and realise that you have given a patient the wrong advice (B.K. p. 83).

> There is a problem of language: we speak in different ways depending on background and gender and the like. We do not always understand what patients mean. Sometimes the patients say it in a different way because they dare not say things as they are and sometimes the doctor does not dare to understand. That may seem like a small problem but I think of a man who had a very serious disease and at the time I did not understand what he said. I blame myself and I think that a different doctor could have handled things better. I think that I myself could have done things better too but I could not at that time (A.D. p. 118).

Even without a special patient in mind, this self-blame can appear. One doctor reflected on the treatment of patients with heart arrhythmia – the once recommended treatment – that had many side effects and in time it became clear that treatment had made some individuals more ill.

> One escalated the dose to a level that is not accepted today. Patients died, some of them probably because of the toxicity. There were many of medicines of that kind where one did not understand the dangers of in the way we do today, one have to take the blame for treating people in such a way that they were worse off as a result of the treatment (K.T. p. 5).

The lack of time for making judgements, based on best possible information, makes the doctors conscious of the fact that they work in a risky way. A doctor, who is aware of that the next day there will be such a shortage of time he at the same time is aware of that his talking with personnel on the ward has to be inquires and not as dialogues. Even if not directly hindering people from talking, the risk is that they could steal too much time. One has to use the co-workers in an instrumental way and patients and their families in a non-personalistic way. The risk of a medical mistake is ever present and he knows that if circumstances were different, he could do the work in a more professional way.

A doctor (A.T.) describes how she has only 15 minutes to talk with the patient, dictate the journal (and other papers) and often talk to family members. She has to sit late in the evening so that she can call patients and their relatives and dictate further journals and letters of referral. This lack of time for important matters makes her sleepless.

A doctor says that for him, not having enough time for patients with dementia creates a moral problem. The nurse mediates information and the assistant nurse provides information and the personnel at the nursing home also offer information. Quite often, their stories differ slightly and he does not have the time to obtain first-hand knowledge. He has to make decisions based on contradictory information. He notices that, when talking directly with the person who needs help the important issue is not whether to arrange an X-ray or not, it is about the patients' social situations or how they experience their illness, family relations and the like. This important possibility to get first-hand information does not exist for him as his work is now. The quantity of work in combination with the impossibility of doing one thing at a time is a big problem:

> In the old days you had more time to reflect, now the lack of beds and consultation times force you to make decisions (B.S. p. 16).

> On the emergency ward eight or ten patients may be waiting for the doctor, it is enormously stressful, people see you as the person responsible for the situation, you have to organise beds and cannot consider the medical (B.S. p 22).

All of the participants gave accounts relating to experienced lack of time. There was not enough time to talk with patients and their family members, not enough time to let the personnel talk freely, not enough time to complete one's work during working-hours. Going back later on for the paper work meant that one did not have enough time

for one's own family. This lack of time was by a doctor near retirement described in physical terms: in a rush at work and running up and down the stairs. One of the doctors had taken back her appointment book, in attempt to regain some control and she now booked in patients herself.

In one of Sweden's largest morning newspaper, one can read reports on the lack of time available in health care. This is printed on a page where ministers and party leaders struggle for space and writers are expected to provide an analysis of the problem they bring up. However, regarding the lack of time plain subjective experiences from the healthcare sector are today published: "The doctor is late […]. The whole consultation is over after five minutes" (Axelsson 1998). "After five minutes talk he was prescribed some pills" (Moberg et al. 2000). One of the participants told that some years ago he had 22 patients between 1 p.m. and 4 p.m. At that time this would probably neither have been a public affair nor talked about in the family. Cultural apprehension of what 'a doctor' is and should do has an impact on what doctors see as doctors' problems. The medial high lightening of an issue makes it public. Both articles in *Dagens Nyheter* were about tragic life events: the miscarriage of a longed-for baby and of a suicide. The discussion about how public resources will be available has hardly begun (Tudor Hart 2002). The subject will be brought up again in chapter five, here can be concluded that the doctors find them non-owners of time, responsible regardless.

When discussing the work related moral problems encountered during the first years as a doctor the interviewees mostly talked about the struggle with "pure" medical knowledge. They talked about fear that they would not have sufficient medical knowledge and their happiness when they found that they were capable of coping alone on duty.

> It was a mixture of horror and bliss, somewhere this enormous fright at the emergency department, "Oh, God, what should I do now?" but at the same time, "Wow, I can manage it, I managed this cardiac arrest and that fracture…"(N.M. p. 37).

> When I worked as a [states speciality] I was simply afraid and I can still understand this, but I also had a hunger to learn (U.V. p. 63).

Naturally, they saw situations from new angles as experienced doctors: they found themselves having more responsibility, they had more difficult problems to try to solve, and they were often more alone than in younger days. When they discussed what they tried to teach young doctors today and which characteristics a good young doctor ought to have very practical issues came up. Statements such as following emerged: "does not promise too much," "is engaged," "can give bad news when necessary," "treats everybody with the same respect," "has keen ears," "does not investigate symptoms in absurdum," "is not prestigious". None of the issues discussed were directly mirrored in the moral problems the doctors explained were their own experience of today: Instead it was of a much "softer" character than what they themselves experienced as their problems from their young days. The young doctors, when occupied by how they should correctly handle the medical problems, may have been afraid of hurting patients

and they must not have been turned into insensible natural scientists during their years as students.
One of the interviewees (S.R.), told about a clinical ethics seminar for medical students which he was invited to as a representative for clinically working doctors. The seminar began with the words of a teacher with a non-medical background and he referred to 'the Four Principles'. At that particular seminar, the principles were not referred to again after the opening reference (in the next chapter, alternative ways of discussing moral issue with medical students will be brought up).

4.3.3.2 The family, fellow human beings in crisis and parts of problems

As a doctor one may be aware that there is a great conflict between a husband and wife, treating both, one does not know what to do (A.D.). Awareness of the fact that the family member who seems to be the closest during hospital stay may not be the one who is most important for the patient at home has led a participant to engage a social worker at the ward to carry out 'family research' (B.S.). This means that the patient is seen not only as a unique person but also as a part of a social unit outside the hospital. It also brings attention to the fact that other people in a patient's circle are also human beings, who must be treated decently. In many cases there is no problem, the family is treated together with the patient:

> At this ward, where all the patients are very ill, everybody understands that one must take care of the family, they are all in crises, life changes for all of them (G.T. p. 96).

As a doctor one is taught to work in the best interests of one's patients. When one understands that the patient or somebody else in the family may pose a danger to other family members there is never the possibility of getting a logical, definite answer (S.H., M.O.). One has to decide if one should report the matter to the social welfare office. That can mean taking measures against one's own patient and being uncertain of whether or not the patient's family members will improve. One has to make a decision and this can be difficult, if the previous time one did so one received threatening phone calls and was forced to change one's telephone number.

Doctors have an ongoing, internal search regarding how far the doctor may accept other norms that he/she does not find right. Many times one can hear that in a pluralistic society medical ethics must show respect for foreign beliefs and convictions. All the same, not all belief systems are worthy of respect (Callahan 1999). Being trapped into considering taking action against your patient or someone in her family or social circle, of having to choose between different outcomes where innocent persons may be harmed is something different from prioritising (e.g. between different patients with different ages or illnesses).

> In our job we deal with probable certitudes (B.S. p. 19).

> It is impossible to know in what way you ought to act when you suspect that a child is maltreated. I remember a case where the patient was suffering from a psychiatric disease; he beat his wife and also the children. I understood this when, on one

> occasion, I got the chance to talk with one of the children. The child wanted me to do something but the wife pleaded with me not to do anything. With much anguish I reported to social services. The patient got furious about it and the wife too (S.H. p. 108).

The same is true when one finds oneself in the midst of a family conflict. It is not possible to treat a patient outside a family that functions in a neurotic way. In order to tighten their own family band, their anger might be focused on the physician instead (Marzuk 1985). This happens to the doctor who treats a patient with a serious illness where the family wants her to be spared. The doctor is forced to do what she sees as a professionally bad job.

> The first thing the family members said was: "No, you may not tell her how bad things are, she will not be able to cope." It was terribly frustrating for me, not being able to speak honestly with her. There was an enormous pressure from her family, they drew me into their way of thinking, and I was manipulated by them. The family surrounded her the whole time, they did everything to make her life easy because they believed that she should be spared anything that was considered bad, it was a very strange situation, it took me one year or perhaps a year and a half before I could see the situation clearly (N.M. p. 36).

4.3.3.3 Following the law does not banish moral problems

There is awareness that legal frames are to be followed but, in reality, it is not always in the best interest of patients, and that which law prescribes does not always lead to the best possible outcome in the clinical world. In healthcare there is the widely accepted idea that patients ought to make their own decisions, to "be autonomous". Individuals, who have lost the ability to judge how to take care of themselves safely, go back and forth between hospital and home. As a doctor one have to work in accordance with the law and societal/institutional customs. A doctor describes how he finds himself obliged to write prescriptions that patients may take in a dangerous way.

> Patients are sent home and they have medication at home but they cannot handle the medication. They have been in-patients at many departments and everything gets chaotic. Today a woman we sent home one week ago came back to our ward, she does not want any help at home, she finds it too expensive, but at home she does not eat or drink. She just lies on her bed. She is prescribed medication, which is dangerous if taken incorrectly. She does not open her door when the district nurse comes. This woman costs the taxpayers lots of money, she is articulate but without insight and will probably go home and come back again (G.T. p. 100).

Doctors brought up that in complicated matters there is always an interpretation that may go wrong. One doctor (L.U.) says, with Brennan's approach: Some cases will be wrong because they will be murdering (Brennan 1977):

> If we had a law, permitting euthanasia, like the one in Holland, I do not think that will make anything better, it may easily be abused (L.U. p. 132).

4.3.3.4 Problems around professional co-operation

Working with colleagues from other specialities can be seen as very rewarding.

> There are cultural differences between clinics, anaesthetists can look at things differently than the internists or the surgeons, i.e. regarding how active one ought to be. It is very educational to have your own view questioned a bit and sometimes changed and one can question other points of view too (S.R. p. 156).

Things do not always work smoothly and there may be difficulties, especially in acute situations with unknown patients.

> An ethical dilemma that is visible in today's healthcare is that one must come to an agreement within the team about the medical goal. Several times, when an acute operation has been discussed we have seen that doctors from different fields can have different standpoints on what action should be taken. There may be professionals who want to give treatment whatever the human cost. Others call this terror-care. There is a communication problem, which we must change and in this case, a lack a lack of resources is not the biggest problem; it is a question of what is best for this patient (B.K. p. 77).

The increased medical security with teamwork is brought up. The participants name the co-work with physiotherapists, speech therapists, and assistant nurses are named. The clinical knowledge is in focus, and a female doctor stated that she got help from experienced nurses when she was young. She believes that her strategy of being humble and trying to be smooth and easy-going as a key factor to the successful co-operation. Only female doctors mention a thought-through strategy, which they use when co-operating with nurses and other personnel and keeping a low profile is described by three of the women. The replacement of old assistant nurses with their clinical knowledge by young nurses, is regretted (K.T., B.S.). In the end, the doctor experiences the responsibility as a personal responsibility.

4.3.3.5 Comments on context

I could also have presented parts of the interviews as:

- To be a good doctor is impossible, since one inevitably causes harm sometimes through one's medical decisions (this includes decisions that were made too late)
- To be a good doctor is difficult when one is unable to work with discernment
- To be a good doctor is impossible if one does not sympathise with the societal aim and/or the medical goal

By saying this, I want to point out that some of the problems (experienced as work related moral problems) may not completely disappear, but they might be eased if more resources were available. However, many of the problems seen here are an inevitable part of the doctors' working-life.

In the letter to the doctors I used both 'questions' and 'problems'. Some of them referred to 'ethical questions' when speaking more generally, but the stories they

narrated were about ‘problems’. I myself did not use the word ‘dilemma’ as this word has been used about extreme situations with a choice between two alternatives and when one has chosen, the dilemma disappears. An example is the ‘Prisoner’s Dilemma’, which is popular in basic philosophy books: you live in a dictatorship and you are arrested and have to choose between different options**…** (Rachels 1993, p. 143). When the interviewees used ‘dilemma’ it was about situations that seemed unsolvable; for instance the interest of the individual contra the interest of family or society.

The doctors I talked with had worked for many years and treating patients was their work, all of them. had found a personal way of accomplishing this. The following two quotations are from the same doctor:

> As time has passed one has met all kinds of moral problems so at my age you do not come up against a moral problem that you have not seen before (S.R. p. 151).

> This 50-year- old man with children and expected grandchildren is suffering from a serious chronic disease, it will be a catastrophe for him and the family (S.R. p. 153).

The experience of having met all kinds of work related moral problems is not the same as losing one’s empathy.

4.4 HOW DO THE DOCTORS DEAL WITH THEIR PROBLEMS?

One strategy is by taking each issue as it comes up including having a bad night’s sleep occasionally.

> Structural problems keep you awake and make you twonder if are going to be able to continue working as a doctor (A.T. p. 48).

Another strategy is to try to set boundaries and do exactly what one must do and then aim at retiring at the age of 60. One of the interviewees has tried to talk about the viability of achieving goals and about medical development. He has found it extremely difficult to get colleagues involved in discussions and quite often they have become angry instead. He feels that healthcare has developed to the point of grotesqueness:

> It is awful that so many doctors have given up, if a doctor says: “It is not my task to decide if this patient ought to be operated upon, I will only anaesthetise, I do it in a professional way and after that I go home.” and the surgeon says: “It is not my business to decide if the patient will benefit from being operated on. I just decide if it is technically possible and then I go home.” If you get many doctors of this kind who just focus on the least possible job, it is comparable to: “I only pour the poison in the hole, I do not know what happens down there” and somebody else says: “I just shut the door.” I can reflect that if we had abstained from doing something with this man and he had died in his bed instead of in the operating table, would that have been a big crime? Why is it more wrong not to act, we are so terribly afraid of missing something. Is it more right to slowly torment ourselves to death in order to

> save two lives and that the ones who do not die pay for the other's suffering, what is it that says that it should be like this […] By some strange reason one has not to defend oneself if one wants to use all resources but as soon as one finds it right to abstain from active medical treatment there follows a struggle because there always is someone who wants to go on (L.U. p. 135).

There were also a few who had succeeded in becoming active:

> I do not have any patented solution that it will be better, in part it is a democratic question, we live in a democracy and democratic decisions must be made […]. It would be easier for us workers in health care if people had a more realistic expectation of what we can do; so we can get away from struggling with dissatisfied patients who do not proceed in the queues: "They promised this and that". I cannot see it as our problem that the resources are too scarce and that's why it is valuable both for them who take the decisions and for people in need of treatment. As I see it, it has been a bit better here lately because being active as I have been on TV, radio and newspapers, the general public gets informed and they are not stupid, they understand only if they get to know. If politicians say that one ought to prioritise, they ought not to go in afterwards and say that one should not prioritise (S.P. p. 74).

4.5 SUMMARY

In this chapter I have described the *structure of moral problems* for experienced doctors. A moral problem occurs in a situation – context – when, according to a professional standard, values are violated. Many problems are of a kind that working with the doctors' moral character will not solve the problems: many problems belong to the tragedies of life without solutions and many problems have a societal dimension. A moral life is a form of communal or societal participation. A problem is a problem within social settings. What counts as relevant for doctors in each situation is not only in the features of the current situation, such as which resources are available, but also how they experience these features in relation to the assignment they have internalised as theirs.

In the next chapter I will summarise the results and discuss them in the light of medical ethics of philosophic origin. I will also outline complementary ways of discussing moral problems in health care.

CHAPTER FIVE

CONTEXTUALISED PROBLEMS, TRANSFORMED TO *MORAL* PROBLEMS BY INTERNALISED VALUES AND DOCTORS' STANDARDS

> And this, perhaps, is the ultimate irony of bioethics' history: the persistent yet perhaps illusory quality of our desire to routinize the humane, to formulate and safeguard timeless values in a world of ceaseless change, social inequality, and utopian laboratory expectations (Rosenberg 1999, p. 44).

5.1 OUTLINE OF THE CHAPTER

In this chapter I will

- Further discuss the result of my interviews
- Look at the results in the light of modern medical ethics as presented in chapter one
- Refer to further research in clinical ethics
- Refer to practical application, questions of how to proceed
- Present a conclusion

5.2. A VALUE-LOADED ASSIGNMENT

> *When I had finished the interviews I read my research proposal through. I had written that I wanted to shed light on how moral problems look after many years of clinical work.*

If looking at the concrete *problems* the doctors tell about it is evident that the factual circumstances described make them to *doctors'* problems, not *police officers'* or *teachers'* problems. It is also evident that the details of the problems are applicable to *today*, not problems belonging to the fifties or some other century. All the same, the experienced problems, although situated in the health care sector, are not isolatable to this particular domain. The value ground making the problems moral problems is the

foundation also of their ordinary lives: not hurting, not deceiving, not treating fellow beings in a humiliating way. However, working in a special field such as health care or social work modifies the content of the concepts learnt in earlier life, making the worker richer in empirical knowledge but at the same time – as everybody else – still experiencing from a position; according to a standard. The moral problem of realising that you are performing a poor job, where people do not get medical help according to their needs, is a moral problem because of personal values (incorporated when growing up as a member of a family and as a member of society) and an experienced doctors' standard.

The problems experienced by the doctors are justified from inside. The philosopher Gilbert Harman, who was referred to in chapter two (2.3.2.1), says that one must have a theory to be able to see that something terrible is happening, for example, when one sees children set a cat on fire: what one observes is theory-dependent. In this Harmanian way one could say that the doctors have a 'theory' or an idea about what a reasonable good life is and reasonable good health care is and what a reasonable good doctor is. One can say that they have an 'in-built working moral theory' when perceiving; noticing a number of features and deeming them to be morally relevant. At the same time, other issues are regarded as not belonging to the problem in a situation. Generalising is founded on the experience that one has grasped the comprehensive essence (Wittgenstein 1967, p. 79), which is something different than applying an ethical theory on facts.

In the doctors' accounts from the world of clinical uncertainty, medical and moral problems are without clear demarcation. Clinical moral problems are inseparably connected with the way the doctors use medical knowledge, with institutional resources, and with the socio-economic state of things. From the doctors' point of view, clinical problems can be seen as a moral or immoral way of performing their work, considering what is reasonable and legal in a democracy. Their problems are contextualised problems, where something within the institutional setting with given allocation of time and technical resources, and pressure from patients etc., crystallises as morally significant. This happens in a world with meaning where the doctors have preconceived ideas about what a reasonable good life is and what humiliation and unfairness is.

The doctors have loyalties to other people, not only the patient in question. Working as a clinical doctor means working aware of the tensions between individual patients' needs and the needs of others who are on waiting-lists, patients calling for help, and so on. Patients at the emergency unit in need of a bed are judged on the knowledge that there are no available beds and that the ward personnel refuse to admit more patients. Instead of seeing physicians as moral agents, trying to solve problems with one patient at a time one can see them as moral persons, working in institutional settings with given resources. The mere fact that they are doctors means that in their line of work, they are forced to perform actions that involve certain risks for patients. If one has to spend a long time talking with one patient's family and arrange a hospital bed for that particular patient, this means that the doctor has less time for the next patients who also require time and/or a hospital bed. The context is often a mixture of different issues: the patient's family relations, or a delay that took place early on in the day that led to delays for everybody else later on, or legal rules and institutional customs etc. The novelist Milan Kundera describes how the main character (a doctor) in *The unbearable lightness of being* met his wife-to-be through six improbable fortuities the same day

(Kundera 1984, p. 46). One of them was that his colleague needed help because he was suffering from lumbago, another involved the time of a train departure; all occurrences for the doctor experienced as interrelated and necessary in order to bring about the meeting between the him and his future wife.

In this moral world, many problems are not problems beforehand but they become problems after the events have occurred, for example when the doctors blame themselves for medical complications. This also means that the problems that are perceived as moral *problems* are regarded as such because they do not have any self-evident solution. In striving to be what they see as fair regarding equal treatment and the like the doctors take the responsibility for political issues on themselves.

5.2.1 The purpose of the study is to high light a few doctors' experience

This study is based on social constructionist theory, and the aim is *not* to generate a theory of how doctors ought to behave in clinical work. The intention is to highlight a part of 'reality'(Flyvbjerg 1991), and provide an opportunity for reflection, on whether this new knowledge suites the current, publicly accepted view of medical ethics (where parts are presented with a scientific claim (Beauchamp & Childress 1994, pp. 44-47).

However, I would like to point out that the same way of reasoning exists among others in society, not only among the doctors that were interviewed. The interviewees' thoughts are shared by other clinicians although not focused on in contemporary public debate as *medical ethics*. I will now provide some examples from (at the writing moment three proceeding issues of) the Swedish physicians' weekly professional paper:

- *The moral problem of being a worker in an organisation as health care of today, medicalising people's lives is brought up in the interviews*. In *Läkartidningen*, a GP writes about the medicalisation of poverty: claiming that the insurance system works in a way that a doctor, in order to help a poor patient, must provide her/him with an illness and diagnosis (Nykvist 2003)
- *The moral problem of being a worker in a system that only looks like it is functioning, is brought up by interviewees*. In *Läkartidningen*, a doctor writes about the bureaucratisation of measures around patients "[…] what seems important is that control is exercised and that illusory activity is going on […] It is painful to face one's own contribution to the sick system (Bengtsson 2003)
- *The moral problem of having hurt patients (although one had done the best one could at the time)*. In an article in *Läkartidningen*, a story is told about a Danish radiographer, who blamed himself for using a contrast medium with a long-term carcinogen effect (Dahlman 2003)

The accounts in the journal can be described by *a value foundation*, *doctors' standard* and a *context*. If starting from a general point: that a doctor ought to treat a patient with respect and show consideration for the patient's integrity and autonomy, one cannot reach the problems the doctors experience nor shows a way to discuss legal and other factors that are a part of the problem.

5.3 CLINICAL MORALITY IN THE LIGHT OF MEDICAL ETHICS

In this study, my intention was also to describe some theory-bound approaches to medical ethics. This has been done in chapter one and two. My aim was to observe whether the experience of the interviewed doctors was articulated in modern theory-founded ethics of philosophic origin and whether the doctors' experience of problems could indicate that medical ethics teaching and discussion ought to be supplemented.

The fourteen doctors, who had not received any formal education in medical ethics, struggled with the old philosophic question about how to live their lives (Bourdieu 2000, p. 18;Nehamas 1998) as responsible professionals. The question is which relation their experiences have to modern medical ethics of philosophic origin. Three general points regarding ethical theories have been discussed in earlier chapters:

- The lack of support of medical ethics theories' validity regarding universal claims is dealt with in chapter two.
- The lack of consensus between theories is also brought up in chapter one and two. If the theories are to be seen as more than different readings of what is taking place in health care and to have a prescriptive claim, the theories must be accepted in society and found suitable to use in health care. Two knitting techniques may create the same end result but this is often not the case when analysing a situation according to the two theories named in the preface (deontology and utilitarianism), which are currently taught to health care personnel. There are differences between using entities such as these in research as a means to communicating to a society of *researchers* or teaching *health care workers* these theories. If one uses theories when teaching medical ethics, one must be prepared to explain why a specific theory e.g. old fashioned Kantianism and *not* neo-Kantianism, critical rationalism or any other among the many different groups, seems to fit health care.
- A remaining structure from the scholastic ages: the philosophically grounded medical ethics has a connection back to the Middle Ages' sharp, logical philosophic debates with stipulated procedures. These philosophical debates were held within limited fields in "social weightlessness" (Bourdieu 2000, p. 13). In this way, medical ethicists with connections to analytic philosophy have more than once struggled against religion (sometimes called "religious prejudices" (Genberg 1997, p. 11;Singer 1993;Smith 1994). This fight, which at first sight seems to be an academic fight against the theologians, has also been directed towards the deeper beliefs of many non-professionals. In periods of suffering a faith can provide meaning and help relieving anxiety (Churchill 1999, pp. 260-261;Callahan 1999). If counting on utility of some kind, the world would be in a better state of things if many individuals died a peaceful death, finding that their lives and suffering had a meaning.

Here, I will point to some problems with a theory-bound approach to moral problems in clinical practice, starting from what was revealed in the interviews. For the doctors, not

every single issue of moral concern, makes sense within the established medical ethics' reasoning of today (Hacking 1999). Besides not being able to get access to all the different kinds of problems, revealed in the interviews (=*loss of knowledg*e), one can also see that the medical ethics' knowledge, often repeated publicly, interferes with the activity itself (=*production of new knowledge)*.

The psychiatrist and philosopher Yaman Örs points out that there may be problems with this new way of practising ethics:

> At all events, *philosophy is certainly to be seen as an academic discipline, a 'professional' activity* with its own ways of thinking, approaches, techniques, and so on, and with its specific mental, intellectual and social milieu. As such and like other disciplines and activities, *it has to have an ethics* 'of its own' whereby the value questions or moral issues arising in the course of its 'practice' that is philosophizing, are to be discussed (Örs 1996, pp. 451-452).

It is easy to understand that empirical experience is *situated*, seen with a kind of 'colour-blindness' but also theoretical, learnt activity is situated within a frame where some concepts are crude or badly suiting to describe an insider's perspective. Ludwig Wittgenstein raises the question what one would see, if one did not already have the concept of e.g. 'modesty' or 'swaggering' (Wittgenstein 1967, p. 68).

5.3.1 Loss of knowledge

There is awareness that some issues have been neglected, through the act of incorporating the medical ethics "growth industry" (Gustafson 1990, p. 126) into the clinical enterprise. Albert Jonsen and Stephen Toulmin note:

> […] physicians, lawyers and social service workers face myriad professional problems the moment any client walks through the door. They may end up by referring some of those clients to other, more appropriate professionals, but they can not choose to ignore them or their problems (Jonsen & Toulmin 1988, p. 31).

This awareness, however, has no prominent public/medial space today.

5.3.1.1 Not discovering social problems

In philosophically grounded medical ethics a person's social reality is often left outside (Bourdieu 2000), and if not, it is used as abstract, idealised situations with few parameters. There is no lack of time, mistreated children or people with bad consciences when a member of their family becomes ill. This absence of social factors may be a remaining structure from the scholastic ages. Pierre Bourdieu (Bourdieu 2000) maintains that with scholastic thinking it is not easy to study events that can not be formalised, such as social ethics.

5.3.1.2 Not counting on clinical uncertainty

Clinical uncertainty remains clinical uncertainty and this is basic knowledge in clinical praxis. Ronald Carson talks about the goal in clinical work being *probable certitude* (Carson 1990). This always-existing uncertainty is easily shadowed in a theoretical approach.

5.3.1.3 Lack of focus on everyday medical problems

In contemporary debates, a selection of subjects deemed suitable for discussion has already been made. Therefore, although there are many problems that one can focus on, extensive focus has been placed on a person's right to obtain assistance to commit suicide or get other help to die. In Oregon where assisted suicide is now legal, 6-9 /10000 obtain help such as this (Ganzini et al. 2002, p. 586). This has been seen as a more important issue to strive for, than freedom from the sexual exploitation of children or help for the family members of patients suffering from dementia. Topics, understandable and identifiable from one's own point of view, such as dying, are painted out in a personal way with reference to individuals' pain and suffering. Abortion has not been presented in the same personal way. Instead, the main structure of the abortion topic when debated in modern medical ethics has been an intellectual game where the pregnant women's pain, when she understands that she can not take care of a child or the pain of the child, born unwanted is not included.

5.3.2 Production of knowledge

In "Social life as a bootstrapped induction" Barry Barnes describes social life "as a gigantic inductive bootstrapped induction"; meaning that social activities and utterances implanted in society are self-referring (and ineliminable). He mentions how a rumour about the collapse of a bank makes people act (Barnes 1983, pp.536-537). In this way, what is incorporated in society as ' true' changes what one sees and what one does. A field of knowledge such as medical ethics with public accessibility, became not only the possessor of its particular knowledge, it also produced new knowledge or a new reality. The same concepts, phrases and topics of medical ethics' books, journals and newspapers have produced a new reality for us all. Produced within the academic world, this way of thinking is absorbed into ordinary public life. In chapter one (1.4) I named how a difficult and serious question has become a TV-issue where you can vote 'for or against'. This also happens in our school: school teachers, who have been educated in philosophy while at university, bring up topics from the modern medical ethics arena in their teaching. During short philosophy courses in school, teenagers debate abortion according to the model of 'for or against', 'rights contra duties'. Issues of complicated human decisions are washed out from the meanings of human lives; issues expressed by thick concepts such as: abandoned, poor, commitments, ambiguity.

In the same way, the social/political perspective has been removed from other issues in medical ethics. The principle of Autonomy has formed the entire area of modern medical ethics, as the way it is used means that doctors are expected to be politically responsible without political resources. When certain issues are emphasised (such as

the principle of autonomy) or when problems are presented as if they are only situated in the consultation room between *the patient* and *the doctor* and these kind of descriptions get public (recurrent medial) space, a new shared social reality is shaped. As mentioned previously, some prominent spokesmen for modern medical ethics regard ethical theories as equivalent to scientific theories (2.3.2.1). With this viewpoint, one can say that modern *medical ethics normal science* is established. With a social constructionist view this shared reality is one of many possible.

5.3.2.1 The Patient as a whole person with the right to autonomy

Since the mid seventies, awareness has increased about *the patient's* psychological needs and it has been emphasised that as health care personnel, one must meet and communicate with the patient *as a whole person*. Today, it seems like the nurse-patient relationship has always been a *whole person* relationship since the beginning of nurse' history. However, it is noted that standard textbooks for nurse students show on that this is a new paradigm (Armstrong 1983).

Today, doctors are also expected to consider *the whole person.* It is worth reflecting on what such a concept may imply. David Armstrong, investigating the concept, describes how a discourse on the patient as a defaulter made a search for defaulter-signs meaningful. A discourse on communication invented communication problems. A discourse on *the patient as whole person* made a patient, invented within the discourse with facets all the same created in the care givers mind, *compliance, communication* etc. (Armstrong 1982). In this framework, it is the health care worker's perspective, which decides what constitutes the defaulter, what is perceived as good and bad communication and what is perceived as *the whole.* A patient must have a will to communicate, in a way which health care workers find appropriate (Kuipers 1989) p 102. (For the everyday language philosopher as John Austin (Austin 1962), the perspective was placed upon what the person wished to communicate.) The message that is perceived by the caregiver can never be outside his/her imagination.

This approach might easily sell out biological medical knowledge: one ought to see the patient as a whole person but who is the person if she/he has a right-sided brain damage or a left-sided brain damage or a frontal-lobe tumour or a severe psychosis? With this whole person approach it becomes clouded that legal and other societal (for instance insurance) circumstances has an influence on what kinds of issues are brought up in the consultation room and how they are brought up (abortion is discussed from this perspective in chapter two (2.4.1). Health insurance rules may be causing problems for a group of patients, which forces them to go to the doctor.

The *whole person* idea implies that important issues are also reachable and that the patient is able to articulate them. The fact that the patient may be a wife-beater, tax-evader, a hit-and-run-driver frightened of publicity, or a person governed by paranoid beliefs seems not to belong to this *whole person.* As a doctor one must be aware that one's patient could be the one who disrupts and destroys the life for the whole family with his fits of rage. One never knows whether a mother, coming to the emergency ward with her child, is the one who has hurt it. If health care workers believe that there is only human goodness in those they come into contact with, the risk will be that health care personnel too will desert those who are already abandoned by the people, who are supposed to care for them. Discussing clinical realities such as a goal for the

chronically ill, which both the patient and the family members accept, involves talking with *many persons*, not *one whole person and proxies*.

In discussions about 'the patient' a great deal is discussed with an imagined *patients' rights* perspective: patient autonomy against physicians' paternalism. Enormous differences between different social layers have existed in society until recently (and still exist today but in a different way). In Sweden, corporal punishment by teachers was forbidden in 1958. Society at that time was authoritarian in a different way from today. The school system has become much more democratic. There are still many problems in the school, possible to discuss without naming the earlier paternalistic teachers. The teachers' personal qualities and characteristics are not the only issues focused on in the discussions; economic constraints and societal changes are referred to as well. In health care, however, the moral problems are still often described in terms of how the problematic paternalistic physicians should be dealt with. As an example of current work, designed to get the doctors 'in order' I refer to a chapter in an anthology named: "Ethical dilemmas for nurses: Physicians orders versus patients rights" (Kuhse & Singer 1999). In this way, it seems to be the physicians and not societal constraints that make the lives of the patients problematic. This fight against the doctors' paternalism has not been a prominent feature in reality (Bosk 1999, p 63). In a study, patients that were asked about this, maintained that being provided with treatment with respect, dignity and confidence, and trust in providers was more important than being involved in making decisions (Joffe et al. 2003).

It is hard to find modern medical ethics writings where problems regarding the paternalistic physicians are not referred to. This has been repeated so many times as a collective stereotype that the doctors' ordinary human characteristics sometimes seem to just vanish. The groups that believed that the paternalistic doctors were the cause - the single cause - of problems won such a prominent place in the public sphere, that it came to be the public truth; internalised by doctors themselves and by the newspaper-reading public. In public consciousness physicians became villains, responsible for a great deal of damage. In this *reality* the problem, *the paternalistic doctors*, provided people with a problem that was connected with a solution: fighting against the doctors' paternalism. Many issues, which did not fit into this way of describing the problems in health care sector, became problems that were not connected to medical ethics. The concept of autonomy has got such a prominent place in medical ethics that it has become internalised and therefore already present when a caregiver perceives something in a medical situation. However, one must however bear in mind that the interpretation of what counts, as belonging to the moral problem in the situation is the caregiver's interpretation. On a course on death and dying, health care personnel saw a film about a man, who asked for and was granted his wish for euthanasia. The participants, who prioritised the principle of autonomy, tended to favour the possibility of euthanasia as a means of helping a patient *before* other possibilities had been thoroughly discussed. They saw it as a choice between a man being granted permission to use his autonomous will, and a man dying a lonely, miserable death.

The way, in which the concept of autonomy has been used, means that it is often regarded as equivalent to free choice. The question is whether one, as a patient, can demand everything when it comes to financial, technical and personnel resources. People are not only patients, they are also members of society and when they choose to vote, they have the opportunity to indicate what kind of health care one wants. If there is no increase in staff and hospital resources, those who cannot speak up for themselves

today will continue to be neglected in the future. The most difficult part of the patient autonomy discussion has not yet begun.

Often, the concept 'autonomy' has been used as if we all belong to the Western, individualistic society. Other ethnic groups deal with issues around e.g. 'truth' in other ways than what today is seen as correct in northern Western countries (Capron 1999, p. 312). All moral practices are not understandable for outsiders (Phillips & Mounce 1969, p.105).

Focusing on patients' autonomy, conceals the fact that we all are dependent on others in different ways and that a person's illness or age-related symptoms increases the work burden of family members' and changes their lives.

The meaning of signs and concepts must be understood by people in approximately the same way, otherwise they will not signify the same conditions and we would not be able to use them (Wittgenstein 1967, pp. 68-69). Putting one's hand up in school is supposed to mean that one has an answer, but the school teacher never knows for sure because the pupil may try to guess or intends to cheat. I will outline how concepts had a different meaning in public debate, only a few decades ago:

5.3.2.2 Back to the sixties

Today the concept of patient autonomy is used as if freedom is possible without any social context, a kind of freedom in a vacuum. In 1975 Ivan Illich, criticised the growth of high-technology medicine, which made people dependent on a health care system and he argued that dependence on medical service in the industrialised countries resulted in people losing control over their lives (Illich 1975). Illich maintained that by manipulation, people have become dependent, consuming help from doctors. He talked about people taking back their own care, and not allowing doctors to manipulate them to take away all pain and to let illnesses heal naturally without medicines. While Illich saw manipulation by medical bureaucracies as the cause, Vicente Navarro maintained that the capitalist states reinforced what is already there: the need for consumption, the dependency on something that can be bought; "a pill, a drug, a prescription, a car"(Navarro 1976, p. 112). The discussion between Navarro and Illich regarding whether capitalism or industrialism has brought us to the position we were in during the seventies also encouraged non-professionals that were interested in societal questions, to join the debate. The debates of today highlight that peoples extreme dependency on health care and on doctors is greater than ever (e.g. the complaint about quick consultation times in chapter four (4.3.3.1). Illich's use of autonomy is more like the Kantian idea of freedom of influence (The Kantian *autonomy*, although still coupled to Kant's name, has in many of the debates taking place today, come to mean self-fulfilment instead of being the opposite of *heteronomy)*.

During previous decades medical ethics has mainly focused on patient autonomy, but medical changes today are often due to new inventions or medical industry, and this has changed people's views on the role of health care. The use of antidepressants has increased (Petersen & Willig 2001) in a way hat was not foreseeable in the sixties when Illich dreamed of a future where patients would be autonomous, that is, free from health care. For the clinician the problem may be how much one ought to consider the costs, if a new more expensive drug seems to be more effective. Another example on the medical evolution, ruled by pharmacological products, concerns the activity around

patients with senile dementia. This is completely different than it was three decades ago. With the 'one patient-one caregiver-perspective' that is nowadays predominant, it is be hard to discuss difficult structural problems. All the same, it is not the democratic decisions that affect progress, instead it is the sudden pharmacological and technical inventions which are incorporated into the medical business that decide what progress is made and how much it costs: in money and in risk increase. The owners of this problem is not the pharmacological industry but the individual doctors, who may be sceptical regarding the advantages of new inventions, incorporated in the daily working life.

5.3.2.3 The *Natural Scientific* physician

In the old times physicians' knowledge was based on natural philosophy. The Galenenian theory of four humours was followed by a tension theory in the eighteenth century. During the late eighteenth and nineteenth centuries, it was specified which parts of the body were deteriorating and later on a specification of diseases was made. Around this time, empirical knowledge was growing and treatments for these ailments were beginning to be discovered. Today, there is a widespread image of the doctors of that time that they were distancing themselves from the whole individuals' experience. Patients and physicians from that time are today described as no longer close to each other. Natural science somehow is seen to destroy the mind of the doctor, making him lose his view of the patient as a whole person.

As described in chapter one (1.12.2.1) most people in Sweden 200 years ago were born, lived and died without seeing a doctor. In the beginning of the nineteenth century some of the Northern counties were provided with their first physician; the inhabitants had not had the possibility of seeing either a friend-physician or a stranger-physician before.

From the point of view of some philosophers, the natural scientific knowledge appears to make doctors one-dimensional. One philosopher explains that philosophical theories may make us wiser and that physicians would benefit by learning conceptual or phenomenological analysis, performed in the proper context: "[…] it can teach doctors that there are more things going on in medicine than merely those that can be spelled out in the language of biology" (Svenaeus 2001).

The history about patients and physicians who have become strangers to one another (Toombs 1993), is often built up around ides of the old good days. The lives and ideals of high-status physicians are studied with help of official documents. Often, these physicians are seen as representatives for the physicians of their time (Eklöf 2000;Johannisson 2000). It is also difficult today, to find written material regarding ordinary, clinically working physicians (as my interviewees), making the question of what will be discovered about physicians, who are working today, some decades or a century ahead, rather interesting.

In Sweden in 1950 scarlatina epidemics were common (Sveriges officiella statistik, Kungl.Medicinalstyrelsen 1952). Children were sent to isolation hospitals, and because of scientific developments, the isolation period became shorter. The evolution of medicine within natural science made it possible for physicians to think in a more personal way. Rat extinction campaigns were held: indicating that even a that time, the doctors' assignment had a content that was partly impersonal. All the same, although

based on biological knowledge, their work was not the same as work, “spelled out in the language of biology”(Svenaeus 2001). This may be based on an idea that unknown people would have better lives without rat-borne diseases. If the doctors had only focused on a gradual narrowing of individual patients’ and their own medical horizons in the medical encounter, both patients and doctors may have found it to be a wrong or an immoral way of performing their jobs.

The interviewed doctors, when reflecting upon their younger days, remembered the horror they felt when left on duty alone, insecure as to whether they had medical knowledge to cope. With the tremendous mass of knowledge that is required, this is an understandable situation, which changed as time progressed. I want to emphasise that the result of having insufficient medical knowledge is of course not only medical, neither for the patient nor the doctor her/himself. Why natural science should be a poison for the doctors is not clear, nor is it clear whether most Western patients would accept a doctor from the natural philosophy time. In social constructionist writings, it has been described how people move between multiple co-existing realities (Berger & Luckmann 1966, p. 68;Schütz 1962, pp. 207-234).

One must bear in mind that also without biology in one’s mind one can come to very different views regarding solidarity with the disadvantaged. If the ultraliberal philosopher Robert Nozick would have been a doctor, it is hard for me to believe that the biological knowledge would have been the knowledge that would have made some patients feel uneasy when consulting him (Nozick 1974). It is also possible that Nozick would get an insight in a concrete situation when meeting a desperate pregnant teenager without insurance and without enough money to get an abortion (Kampmann 2002). By looking at this girl he may have understood that the law must be changed. It hardly had changed his mind regarding help to the disadvantaged to think matters through with help of an ethical theory. If one says that Nozick, with his own theory, is an exception, because he needs no other ethical theory, one could just as well say that doctors have a theory about life, built up within their life-world (Harman 1977). In the same way, if Martin Heidegger had been a doctor as well as a philosopher (2.3.2.2) it must have been his contempt of the modern democracy and not a biological knowledge that would make him a potentially dangerous physician.

The interviewed doctors felt a moral responsibility for many issues that were outside medicine, and as the work burden was heavy, some of them dreaming of the chance to limit their assignment more to the medical field. Improved knowledge about the doctors’ working day (and night at the emergency department) must be of value for the non-healthcare worker, teaching medical ethics. The teaching of medical ethics today is built up as teaching clinicians in much the same way that one teaches how to cook. The aim of following a recipe while cooking is to produce a tasty pie, for example. In medical ethics, the result which one aims for is defined in terms of e.g. autonomy or integrity. However, working as an experienced doctor, can from a life-world perspective be seen as playing chess or use a language where the rules how to move the chessmen are known; the problem however may be that it is hard to play as one wishes. If your co-player makes a different move, the situation becomes different, perhaps without apparent problems. Changing the rules creates a different game (Wittgenstein 1967, p. 59). I will shortly discuss research that shows that professional standard and problem context have an impact on perceived medical moral problems.

5.4 OTHER RESEARCH, COMING FROM OUTSIDE, DISCOVERING THE PRAXIS-BOUND MORAL WORLD

Annette Joy Braunack-Mayer, University of Adelaide in Australia, has carried out a research project bearing some similarities to my study. Writing about her results from interviews with 15 general practitioners in Australia, she concludes that the variety of views about what makes a problem a *moral* problem indicates that the moral domain is perhaps wider and richer than mainstream bioethics would generally admit (Braunack-Mayer 1998, 2001). She remarks that there may be different ways to understand the nature of moral deliberation and decision-making, than those currently in focus. Braunack-Mayer notices that the moral problems of some of the GPs in the study, were centred on their own emotional reactions, naming for example, a doctor who tells about a situation where three patients, whom she felt she had taken extremely good care of, left her practice.

Charles Bosk (Bosk 1979), a sociologist, was a participant-observer of the surgical training program at a hospital. He has described how physicians draw boundaries and determine their professional identity through the selection of young co-workers, how super-ordinates practice control of performance, how norms of responsibility to patients and colleagues are articulated and how a professional person copes with the existential problem of the limits of his skill and knowledge. Bosk finds that there is an internal norm of what a good surgeon is to be tested against: "He [the surgeon, my remark] is expected to treat conditions as they arise or to make certain that they will be treated before he moves on to other tasks. Fatigue, pressing family problems, a long queue of patients waiting to be seen, a touch of the flu – all the excuses that individuals routinely use in everyday life, are inadmissible on a surgery service" (Bosk 1979, p. 55). Bosk finds that the general view is that normative errors occur when the doctor, in the eyes of others, have failed to discharge his professional obligations conscientiously (Bosk 1979, p. 51). The doctors I interviewed were *their own* strict judges, and many of them did not receive any support at all.

Robert Zussman, who is also a sociologist, followed the work at intensive care units He describes how physicians move the issue from the realm of values to the realm of technique when resisting wishes from patients and families (Zussman 1992, p 102).

Renee Anspach and Diane Beeson, both sociologists (Anspach & Beeson 2001) have studied health care personnel strategies in an intensive care unit for new-born infants; and they describe how the babies' appearance has an effect on what ward personnel (nurses and doctors) perceive as reasonable action to take.

Reports such as these show that evaluations and deliberations are going on outside the ordinary medical ethics domains, not always coming into the spotlight when using principles. These research results are of course not the final disclosures but they provide excellent examples, giving us the insight and the opportunity to reflect on certain aspects. For instance, the Zussman example could be used as a starting-point in discussions. How should the doctors deal with problems of the kind Zussman describes: when they find that a patient or the family has unreasonable demands? There are limits and boundaries even with our current medical knowledge and resources are also restricted – even in a Western society. When the doctors take over the responsibility and hide an issue in 'technical' disguise this must not be paternalism but a kind of

unarticulated – and infelicitous response to the fact that autonomy does not mean the right to subjective interpretation (at least not in public health care).

I have previously mentioned some examples of case stories, where the patient's fate is seen as inseparably entwined in the fate of the rest of the family (Nørrelund 1998;Kaufman 1997). Sharon Kaufman tells about a doctor, who worries about the fate of two children, who are in the care of their 79 year-old grandmother, suffering from dementia. The children's father is a homeless heroin addict. Their mother, also a heroin addict, is dead. Kaufman remarks that the old woman is not the doctor's real 'patient' but someone whom she has met at a 'Grandparents Who Care' support group. She concludes that in the doctor's tale, the 'facts' that make the doctor feel responsible, are her knowing that the health and well-being of other family members are tied to the functional ability of the grandmother. Another 'fact' for the doctor is knowledge that the social service system is not sufficient. Her responsibility emerges from this understanding.

In conclusion, also other research points to, that doctors' experience of work related moral problems have a broader dimension than focused on today. Through the Robert Zussman example, I have provided an outline as to how one can broaden moral discussions. In the following sections, I will bring up additional ideas about how to complement the medical ethics of today.

5.5 HOW TO MOVE FORWARDS PRACTICALLY

In my research formula I pointed out that experienced doctors' knowledge about moral problems had practical implications both in the ordinary daily work and in teaching.

5.5.1 The role and the boundaries for school medicine and doctors' assignments

The interviewees described the way to their professionalism. This could be through an insight into how an older colleague managed a difficult patient that seemed impossible to deal with. It could also happen when a doctor understood that he/she had been manipulated into prescribing too many tranquillisers or realised that an older colleague was right when giving advice on not being too optimistic when there were no reasons to be so. These were all accounts of growing into an accepted doctor's role. The participants remembered very detailed situations that had occurred decades ago, indicating the importance of this learning process. However, learning how to be a doctor could also be forgotten and colleagues that admitted close friends onto their wards could be seen change to unprofessional behviour. The colleagues were said to have lost their medical judgement, asking for a single- bedroom when this was medically unnecessary etc.

It has been described elsewhere how young doctors struggle with how much engagement they ought to give patients, this can involve having contact with them after

their treatment, during their free time or feeling antipathy towards some patients (Kushner & Thomasma 2001). In the Swedish novel *Doktor Glas* a doctor becomes deeply and personally involved outside his professional role (Söderberg 1967/1905). He struggles with the question on how far he can go in helping his female patient who is suffering in her marriage and the doctor accepts her description as the truth. Although many GPs treat many members of the same family, antipathy towards someone is seldom brought as a great problem. Maybe this is not considered a problem or maybe it is a problem that is not deemed discussible today.

The philosopher James Rachels tells about Wonmug, who manages to get a good degree, marries the woman he loves and is awarded the Nobel Prize; but behind his back people ridicule him, his wife does not love him and he is not worth the Nobel price. It was a joke: he was cheated (Rachels 1986b, pp. 46-47). When thinking about Wonmug who was cheated, one can also look at the doctor who always shows empathy and always finds the right words; does he/she cheat by faking consideration? The performance, the 'as if' role character has been described by many researchers e.g. the carefully arranged, 'natural' talk during a gynaecological examination (Gusfield 1981, p. 177). Jean-Paul Sartre tells the story of a waiter whose movements are a little too precise, a little too rapid (Sartre 1984). If people are satisfied, does that still mean that something is wrong? The physician Clarence Blomquist (Blomquist 1971) believed that teaching ethics to young doctors was an important task. As I see it, it is important for health care personnel to talk to each other, but young doctors may have important things to contribute to discussions regarding the doctors' role (i.e. they are not only the ones that can learn something from these discussions).

There is often a great difference between the patients' ideas on what they believe has caused their of her symptoms (Toombs 1993) and the doctors' interpretation of the symptoms. There are boundaries for a doctor of the modern Western kind concerning how far he/she can go into the patient's world. In this context, one can ask the question whether physicians ought to participate in cosmetic surgery, circumcisions and the like. There is a normative effect in society when doctors participate in activities. An agreement will never be reached on he boundaries of the doctors' assignment but a discussion is always helpful.

Personal troubles that bring patients to doctors are often rooted in social circumstances outside medicine, and medical encounters tend to convey ideological messages supportive of the current social order (Waitzkin 1989). A great deal of the societal part of the work is seen as a matter of course and doctors are informed when insurance rules are changed etc. However, the physicians' role (the writer of certificates, the team-worker…), and the societal and political assumptions behind the need of certificates are seldom brought up to discussion in a systematic fashion. This has been noted by others (Musick 1999, pp. 242-244).

During the most recent decades of the twentieth century, technological progress has changed the concepts of life and death. Without being against a procedure such as heart resuscitation, a doctor can find that this treatment of a dying/dead person is in some way a violation of a person. In a debate regarding organ donation, representatives of the National Board of Health and Welfare stated that the anaesthetists ought to take on more responsibility for taking care of organs (Rehnqvist & Gäbel 2003). All the same, responsibility may be experienced in different ways and individual doctors must be given the opportunity to decide the boundaries for their own responsibilities. There is

no evidence that adults can learn morality through theories or principles if they have no other moral insight.

1687 there was a big ideological argument in Uppsala about the possibility of accepting a new kind of philosophy. It was suggested that the old professors had difficulties in learning the new Cartesian way of thinking (Bring 1754). Now, some centuries later, many people still do not think according to the Cartesian way: growing up in a society where the thoughts are available, was not enough for changing the mind of everybody. One can often learn to change one's conduct by learning rules. However, if this is the same as moral change from inside is unknown. What a person finds as morally relevant – when to use a rule, principle or theory – is still connected to their previous perceptions, which are based on internalised values. If, in a future after democratic discussions, it is decided that we are to adhere to e.g. Kantianism, there is still an initial judgement to be made when deciding whether a problem is a moral problem. One interviewee talked about the *cruelty* of not allowing compulsory institutional care to people who are left alone in poverty and destitution, another that he will not *kill* any one after having discussed clinical uncertainty, and that among doctors as among other professional groups some individuals have a strange personality. These are moral judgements that become visible with the use of moral concepts (= words filled with a moral content), founded on personal experience of psychotic patients in miserable life situations and on having seen one's colleagues be manipulated. The content of their concepts has been modified by their experience and if talking with doctors about practical work related moral problems, the doctors can not begin to reflect outside their experience. If the doctors' own trade union came to a different conclusion and the doctors, named, obeyed their trade union they would merely be following the rules of conduct, but for them, this would not be a moral way of treating patients. A representative for a Swedish physician's interest organisation names that the physician's organisations in their declarations express a duty ethics-based posture with support of arguments of a consequence ethics source (Ottosson 1996) The question is how such international consensus reports relate to an individual doctor's moral judgement. Whether theoretical knowledge provides a changed type of behaviour is not clear.

5.5.2 A broader discussion with more participants

> *In my research formula I wrote that in the previous decades' medical ethics has been formulated with concepts from philosophy. One of my aims with this work was to point to alternative ways of discussing moral problems in clinical practice.*

Discussions on medical ethics however, became public talk with a few voices being heard. This is a significant problem as health care and the doctors' work, is built up on basic societal values and laymen's public voice is necessary when discussing what kind of society and what kind of health care we desire. Physicians can debate in their professional journals (and they do). Newspapers and other public journals, governed by economic factors and political assignments are closed for most people. Michel Foucault, realising this uttered:

> Sure, I could offer my opinion, but this would only make sense if everybody and anybody's opinion were also being consulted. I don't want to make use of a position of authority while I am being interviewed to traffic in opinions (Foucault 1994, p. 142).

I do not believe in that a theory on communication as e.g. that of Jürgen Habermas (Habermas 1971) is of any benefit. This theory implies: (1) every utterance ought to be grammatically correct and understandable, (2) it must be true, (3) if the utterance contains an opinion, it must be the person's true opinion, and (4) the utterance must be correct in a moral meaning, e.g. if one is giving orders, one must have the right to give such orders. These rules have existed and been widely known during the years that medical ethics have been publicly debated by a small number of people, and today, we are further away from a broad societal discussion than ever. If I, as a worker in the medical field, do not understand practical examples brought op by non-medical debaters, who is to decide their truthfulness? Also if there was a public debate of a different kind than the one that exists today, I do not see a Habermas' four points programme to a communication as the most fruitful for medical ethics, because this view does not have any place for muddled intuitive feeling, which in the end may be important. With the Habermian theory we are on the way to a universalistic claim and not only toleration within the borders of a democracy. Ethical theories, used in discussions on medical ethics' during recent decades, contain a political standpoint regarding what kind of society we ought to strive towards. Although, at one time these were thoughts in a contemporary society, they now appear in the medical ethics of today, lost from the original context. Michel Foucault, in a drastic manner, has formulated a dream of the opportunity to communicate without such made, fixed constructions.

> As far as I'm concerned, Marx doesn´t exist. I mean, the sort of entity constructed around a proper name, signifying at once a certain individual, the totality of his writings, and an immense historical process deriving from him (Foucault 1980, p. 76).

Such theories, built up around one man's thoughts exist as a main part of the enterprise or construction of mainstream medical ethics. All the same, although it has become customary to discuss medical ethics issues in this way, nothing shows that this is a necessary (or a sufficient) way in a democracy of today. Those who believe in a Kantian ahistorical self and a universal truth must have right to speak up as well as those who do not believe that such a state of things exist.

As I see it, the trustworthiness of any participant in my study would not be greater if the person could call him/herself Religious, Marxist, Kantian or anything else. Nobody's ideas ought to be disregarded in such a debate by being named *infantile leftism* (Rabinow 1984, p. 381) (as Michael Waltzer did about Foucault's ideas at a Princeton lecture1982 (Flyvbjerg 1991, p. 132). Also the aesthete and therapist, products of modern life, detested by Alaisdair MacIntyre (MacIntyre 1985, p. 30), must have the right to exist and take part in discussions. An awareness of collective presumptions about other groups improves discussions.

The moral may be seen as a dimension of local practices (connected to systems of beliefs and rituals which in symbolic form express goals and cultural values: social

myths (Ahlberg 1937, p. 66). As I see it, there are no good doctors or good people: only good doctors and good people according to a standard. We live in value-laden worlds yet what we find as morally significant differs to some extent. Many questions that are today referred to as medical ethics and discussed only by a small number of people need a broader discussion.

5.5.3 The possibility of bringing up more issues in democratic discussions

If seeing human value as an absolute value that should be respected in health care, this still does not solve the question of how to divide time and resources between different patients. Another question concerns whether only the inhabitants in one's own country as having this human value. Two of my fellow students from the Pompe's Cafe discussions (mentioned in Preface) are just now working in Afghanistan and in the United Arab Republic respectively, their view on what counts as fellow human beings has in praxis been different from that of many other Western doctors of today. Although today it is self-evident that medical ethics means philosophical ethics, one can also imagine another development from the sixties onwards.

Depending on what one defines as being important in a situation one can get different end results. For example, physicians' participation in organ donation can be seen as a neutral, legal everyday clinical fact, or an opportunity for the diseased to give a final gift of love, or as a murder (2.6). If one departs from an idea that there is an ethical theory or ethical principles suiting every situation one can, as an example in this question, not bridge over the different stand-points. Those who count on end state as universal utility or universal happiness and those who see sanctity of life as a ground principle still come to the same conclusions regarding organ transplantation from patients that are brain-dead. When there is a law (as there is in Sweden) health care workers need no dispute regarding principles, instead they need to reflect upon their personal standpoints and need to ask themselves whether they can accept the law according to their own value grounds. The *immoral* may for some health care workers can be that they find people were asked to donate in an offensive way with a paper looking as 'nothing to declare'. The same may be said about that dying individuals, not known to have made a decision about donating organs, now and then are placed on a respirator in order to prepare them to the possibility of giving organs. One can also imagine that some individuals find that transplantation is a too expensive and luxurious: that the money could be used for e.g. the care of aged, chronically ill persons.

When raising a practical question, one raises the question within a context. During the seventies in Sweden doctors could (and did) order extra vigils for dying patients without family. Later, this was later seen as too expensive and was no longer permitted. Problems are problems within institutional settings with economic frameworks, restrictions in medical knowledge etc. If one begins by naming *what* in a specific situation counts in making the problem a *moral problem* (or a *non-moral problem*) one can come closer to what individuals experience makes a *problem* a *moral problem.* By using an approach such as this, the chance of finding possible solutions in a democracy is greater. I agree with Richard Rorty that in a liberal democracy it may be good to have philosophical articulation but one needs no philosophical backup. One must be able to

discuss basic societal democratic values without agreeing on the foundations (Rorty 1991, pp. 175-196).

5.5.4 Back to the sixties once more, and the fifties and the forties…

Michel Foucault, avoiding universalistic theories and describing the historical forms by discursive practices, reflected on whether we can escape from the big philosophical – Hegelian – systems in our thinking. Foucault jokes: "We have to determine the extent to which our anti-Hegelianism is possibly one of his tricks directed against us, at the end of which he stands, motionless, waiting for us (Foucault 1972, p. 235). Also if it has been the most common way to use philosophy in medical ethics today, to see philosophy as longitudinal strips (Wittgenstein 1967, p. 80) of e.g. utilitarianism and Kantianism as keys for problem solving, one can also see philosophy as finite cross strips, the last strips conveys (of course) that we never can come to an end of our thinking. However, in small cross-strips one can try to understand one's own conceptual colour-blindness when comparing with other people's experiences. One must also bear in mind that sciences such as psychology and sociology have developed from philosophy. These new sciences must be outside the possible Hegelian gaze,

When public history is created, some ideas are rooted, some get publicly shadowed, for a while or forever. The year 1966 a reprint was published of Karl Poppers *The open society and its enemies*, with its repudiation of the usefulness of philosophical ideas as long-term predictors of societal evolution (Popper 1966/1945). At the same time as one could read Popper stating that it was not possible to structure societal evolution, ethical theories with universal acclaim became the foundation in the modern medical ethics. In Sweden, during the same year (1966) a book was published on American Pragmatism (Wennerberg 1966) which is more or less non-existent in medical ethics of today. *Social-philosophic essays* by the philosopher Axel Hägerström (Hägerström 1966/1939), belonging to the emotivist school, was reprinted the same year. Hägerström had been immensely important in the Swedish philosophical world only a few years earlier. He was on his way out by the late 1960's (although he was never taken seriously by those involved in medical ethics). The ideas in these three books represent an extremely small part of ideas, thought within the contemporary Western philosophy. It is not the philosophy *per se* that restricts the richness of public ideas but the constellation of groups with power to publicly define the world (Foucault 1980;Wittgenstein 1967, p. 61).

5.6 CONCLUSION

According to a social constructionist approach, moral life is not a free-floating individual rationality but a form of communal or societal participation. Individuals can be seen as perceiving, interpreting and acting within a social life-world where things and events in everyday life have a self-evident meaning. Moral experience is connected to concepts like loyalty, deception and (un-)fairness. In order to find a relevant concept one must have certain ideas beforehand regarding social roles and other aspects on human life.

Values, implanted in social life, and the doctors' *standard,* are the foundations of the fourteen interviewed doctors experience of moral problems in their everyday work. Their understanding of what 'a doctor' is provides the framework for what they define as problems, and in the same way, influences on what they see as work related *moral* problems. Sometimes values are violated to such an extent that the doctors obtain an insight of an existing moral problem. What counts as relevant in each situation – in *the context* – is not only in the features of the current situation, within social and institutional settings, i.e. what resources are available, it also depends on how the doctors experience these features in relation to the assignment they have internalised as being theirs. For the doctors, medicine and morality are inseparably intertwined, grounded on the profound knowledge that their medical assignment inevitably entails hurting fellow human beings.

For the interviewed doctors, morality is allied with the question: *How shall I live my life as a responsible professional?* Reflecting on the boundaries of the profession's standard, is, for the doctors, different than working practice where they themselves often interpret the standard as: *I have to manage everything laid on me*.

The ethical theories used in modern medical ethics, all have their own underlying presumptions regarding human nature, societal goals etc. Using a theory presents problems and solutions according to the theory, interfering with the activity it was aimed at analysing. Many of the doctors' problems involve social and economical aspects and cannot only be discussed within the framework of philosophically founded medical ethics' theories. The problems that are experienced are connected to issues, such as, what kind of society, what kind of human relations, and what kind of health care we desire: the contents of the value concepts. In discussing these issues – negotiating about the contents of our value concepts – non-professionals' experience as well as healthcare workers' praxis-bound experience are necessary elements.

GLOSSARY

Apriori
Before experience.

Aposteriori
Founded on experience.

Communitarism
Used about the ideas of some late twentieth century philosophers who from differing political standpoints all emphasized man as a social being: that the identity and values of men are founded in society (with its culture including religion).

Consequentialism
A moral doctrine, acclaiming that the right act in any given situation is the one that will produce the best outcome, judged from an impersonal standpoint, and which gives equal weight to everybody's interest. One version of consequentialism is utilitarianism.

Discourse
Foucault: Forms of knowledge within a sphere/praxis. Ricoeur: the event of language or talk or its predicative function. Habermas: discussion about validity of arguments in a communication.

Deontology
(Greek *deon*: necessity, duty), a moral philosophy doctrine based on duties as the foundation in morality.

Deduction
Conclusion by rules.

Epistemology
Theory of knowledge.

Empirism
Knowing grounded on experience.

Essentialism
The idea (which can be followed back to Aristotle) that properties are decided by what a thing is (essence versus existence).

Ethics
1) (Individual, group or societal-) rules about actions and evaluations.
2) A philosophical discipline studying moral phenomena, see: *morality*.

Existentialism
Philosophic branch dealing with meanings and conditions of human existence.

Ex nihilo
From nothing.

Hermeneutics
Theory dealing with interpreting, understanding.

Idealism
Reality in some way dependent on, or constituted by, human consciousness, thinking or principles.

Induction
General conclusions drawn by individual observations.

Ipso facto
Something known by the fact itself.

Is-Ought-gap
One can not derive a moral evaluation (an 'ought') from a factual description (an 'is').

Morality
"The term *morality* refers to social conventions about right and wrong human conduct that are so widely shared that they form a stable (although usually incomplete) communal consensus, whereas *ethics* is a general term referring to both morality and ethical theory"(Beauchamp & Childress 1994, p. 5).

Meta-ethics
The theory of ethics, dealing with marking off from non- ethics, knowledge questions and the like.

Norms
Evaluative and/or action-guiding rules.

Objectivism
A view based on the conviction that there is some ground or framework, determining for instance knowledge about conditions (moral objectivity: there is a non-empirical, non-natural good or right).

Natural Phallacy
According to the philosopher G.E. Moore: to place 'good' in the same category as natural properties.

Ontology
Theory about being.

Paternalism
Making decisions for other individuals in a ‘fatherly’ way, meant to be benevolent.

Phenomenology
A philosophical movement, aiming at describing events and actions as they appear.

Rationalism
The idea that true knowledge about the world is to be reached by thinking (rationalism versus empirism).

Realism
There is a reality independent of if it is experienced (in moral philosophy: there are objective value properties and facts).

Relativism
In moral issues: morality is dependent on for instance culture or social circumstances.

Scholastics
The way philosophy and theology was taught in European Universities 1100-1500, discussing classic texts in accordance with established rules.

Semantics
Belonging to the study of the meaning of language terms.

Structuralism
A counter-movement to philosophy of existence and phenomenology emphasising the unconscious structures governing human behaviour.

Theory
A set of concepts to define or explain some phenomenon.

Transcendence
Beyond comprehension directly from senses and/or reason.

Utilitarianism
A philosophical theory aiming that the best set of affairs is the one that contains the greatest net balance of pleasure, happiness or satisfaction.

LIST OF PERSONS

Aristotle (384-322 BC)
Greek philosopher, discusses the human good as a state of the agent: human beings can through education improve in character. Striving after a virtuous life is the good life in course of time and practice.

Bentham, Jeremy (1748-1832)
British lawyer and philosopher, worked for societal changes. The right action in a situation is the one, which gives most pleasure. According to B. one can calculate the amount of happiness in relation to pain if one considers intensity, persons involved etc.

Brentano, Franz (1838-1917)
Austrian philosopher, founder of descriptive psychology with 'intentionality' as an important concept in mental phenomena. Brentano's ideas were developed by Husserl.

Buber, Martin (1878-1965)
German-Israeli philosopher and theologian. According to B. a human being is constituted in the relation with another human being.

Descartes, René (1596-1650)
French mathematician and philosopher, today mostly seen as the inventor of the soul body-dualism.

Foucault, Michel (1926-1984)
French historian and philosopher, in his research showing on concepts or codes delimiting what is possible to think in an epoch. 'The soul is the prison of the body'.

Gadamer, Hans-Georg (1900-2002)
German philosopher, follower of Heidegger, has given philosophy an important contribution with a theory of interpretation of (historic) texts.

Hegel, Georg Wilhelm Friedrich (1770-1831)
German philosopher, can be seen as the last big system builder, idealist. Human reason 'ratio' is dialectic, containing its own opposite (= antithesis), creating a dialectic evolution.

Heidegger, Martin (1889-1976)
German philosopher who developed a revolutionary ontologic hermeneutic about human existence in the world.

Hume, David (1711-1776)
Scottish philosopher and historian, a main person in the classic British empirism. His scepticism has contributed to the philosophical discussion about objective knowledge.

Husserl, Edmund (1859-1938)
German philosopher, founder of (what came to be) the phenomenological movement, working out a philosophy 'phenomenology' as a theory-free science.

Jaspers, Karl (1883-1969)
German psychiatrist and philosopher, a key person in philosophy of existence. Discusses human *limit situations* like suffering, guilt and death, not possible to grasp with cognition.

Kant, Immanuel (1724-1804)
German philosopher, said to have made a Copernican turn in philosophy (Copernicus placed the sun in the centre), things are dependent on our knowledge, which is filtered. The moral good is possible to do if wishes or inclinations do not influence you.

Lévinas, Emmanuel (1906-)
Born in Lithuania, working as a philosopher in France. Writes about ethics in the meeting the suffering Other.

Løgstrup, Knud (1905-1981)
Danish theologian and philosopher. According to L, basic in human life is trust, compassion, the open speech, making social realisation possible. An ethical demand is beforehand built into human meetings.

Merleau-Ponty, Maurice (1908-1961)
French philosopher, in the group called existence philosophers. Perceptions are made in a context, the percepting subject is embodied. Living presupposes engagement.

Mill, John Stuart (1806-1873)
British philosopher, inductivist. Developed Bentham's Utilitarianism to a theory where qualitative (and not quantitative) aspects in human happiness was the main ground. Working for representative democracy and women's rights.

Plato (427-347 BC)
Greek philosopher, aiming that the true reality is the ideas: about the ideas one can get knowledge through thinking.

Sartre, Jean-Paul (1905-1980)
Existential philosopher, assuming a Cartesian mind in his works. 'Human beings choose through their actions'. 'Mankind is condemned to freedom'.

Socrates (470-399 BC)
Greek philosopher sentenced to death on political grounds. Discussing the art of living, aiming that only a wise man can reach happiness (eudaimonia). Dialogues where the philosopher acts as a midwife to bring out hidden wisdom.

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I do not wish to romanticise my childhood as a member of a working class refugee group, however in the context of writing about moral matters, this has given me possibilities to remember that advanced moral talk is taking place outside the academic world and newspapers' pages. Growing up in two cultures made me aware of that there are good reasons to see things in different ways.

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The idea of carrying out a study emerged during my daily, somewhat monotonous work in the stables, an occupation that was ideal for reflecting on the contents of my newly read morning newspapers. The next step involved cutting out every 'linical ethics'-article from our three newspapers, for a period of two years. Reading them gave me a picture of our public, medial discourse of clinical ethics today. From this, grew the wish to talk with doctors, whom I did not know beforehand, about their experiences of everyday work related moral matters.

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