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PHILOSOPHY LESSONS FROM THE CLINICAL SETTING: SEVEN SAYINGS THAT USED TO ANNOY ME

ABSTRACT. Traditional medical approaches to moral issues found in the clinical setting can, if properly understood, enlighten our philosophical understanding of moral issues. Moral problem-solving, as distinct from ethical and metaethical theorizing, requires that one reckon with practical complexities and uncertainities. In this setting the quality of one's answer depends not so much upon its content as upon the quality of reasoning which supports it. As the discipline which especially focuses upon the attributes of good-quality reasoning, philosophy therefore has much to contribute to the clinical enterprise of moral (and medical) problem-solving.

Key Words: Problem-solving, Practical complexity, Uncertainty, Moral ingenuity, Quality of reasoning, Philosophy.

I. INTRODUCTION

I have been teaching medical philosphy in a clinical setting for about five years, primarily working on hospital rounds with resident physicians specializing in internal medicine or in pediatrics.[1] Five years is hardly what one would call 'vast experience', yet it has at least been long enough to prompt a few reflections. It has been 'hands-on' philosophy, for one engages daily in the effort to render the insights and skills of philosophy practically useful to those who must make sometimes very difficult decisions. There are some who would say that this enterprise is something of a contradiction in terms – that philosophy is inherently too theoretical, too abstract, to be of genuinely practical utility. Others (many of them philosophers) find no contradiction, but rather a kind of servility in the task. Applied philosophy, it is thought, is not really philosophy at all, but simply the rather mundane, common sense business of drawing appropriate inferences from the tenets of one philosophic school or another to the particular situation at hand: e.g., 'now, what would Rawls say about this?'.

If anything has become obvious to me in the past five years, it is that 'applied philosophy' is neither of these. One need neither to resign himself to hopeless abstraction or to tedious inference-drawing. One can be very practical while still fully a philosopher. I will admit that this has come as something of a surprise to me. Although my concept of what philosophy IS (the questions it finds interesting, the methods with which it pursues those questions) has remained quite untouched, my notion of what philosophy DOES (the points at which its questions touch our lives, the ways in which

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its methods can shape our thinking) has changed considerably over the years.

Perhaps the best way to elucidate this is to share some specific views which I have changed. Early in my clinical work I took a particular interest in some common physician responses to ethical issues. I shall focus on seven of them here. Mostly I would find these responses to be philosophically rather vacant, morally useless, and personally annoying. While I still have my quibbles with each, I have found merit in them that initially escaped me, and each has prompted further philosophical reflections which I shall also share.

Collectively these 'seven sayings' can teach us some important lessons about the nature of moral problem-solving. Through them we will see in Section II that, unlike 'pure' ethical and metaethical theorizing, moral problem-solving requires us to confront not only the moral issues themselves, but also their untidy interactions with factual uncertainties, political and legal complexities, and practical obstacles.

And yet – and here I hope is the striking message of this essay – moral problem-solving, untidy though it be, still requires thoroughly philosophical thinking. The moral credibility of a proposed answer, as we will see in Section III, depends more on the quality of reasoning which supports that answer than on the content of that answer. As the discipline which focuses enormous attention on the attributes of good-quality reasoning, philosophy can therefore offer significant contributions toward the resolution of practical moral problems in the clinical setting.

II. SEVEN SAYINGS

Saying 1: "Oh, that's easy – just do X". Particularly in discussions of hypothetical cases, one hears this saying as a physician responds to some terrible moral dilemma with a rather simple, practical answer which at the same time manages to change the case description. To wit, the philosopher: "A patient appears in the emergency room in full cardiopulmonary arrest; he is resuscitated but needs an intensive care bed; the intensive care unit is full, occupied by a mother of four, and alcoholic priest, a scientist, and a convicted rapist; whom should you send out of the unit to meet his doom?" The physician: "Call up a few extra nurses and activate the 'swing' bed so that you don't have to send out anyone prematurely"; or "chances are, one of the patients can be sent to the 'step-down unit' without risk – send him"; or "patients with cardiac arrest do not necessarily benefit from intensive care – let's arrange to monitor him on a regular hospital floor".

He avoids choosing between the rapist and the alcoholic priest – he dodges the issues – and the philosopher is annoyed. It is all very well to find some handy practical exit from a terrible choice in a given instance, the philosopher says, but one must eventually confront those difficult issues straightforwardly and establish some moral priorities which can guide his choices on those occasions where there aren't any such 'dodges' handy.

Here lies perhaps one of the biggest lessons from the clinical setting. In some important ways, the physician is more on the right track than the philosopher. Our moral lives are comprised, not of terrible hypotheticals from which there is no escape, but of complex situations whose constituent elements are often amenable to considerable alteration. And our moral aim should be, not to make dramatic choices which honor one value at a terrible sacrifice to some competing value, but to create a resolution which honors all important values maximally. If the impoverished Jones family vows they cannot afford to have another child they do not, upon discovering that Mrs. Jones is once again pregnant, ask themselves "Gosh, which of the children shall we throw out onto the streets?" They reconsider the situation and decide which things previously regarded as indispensible they shall now learn to do without.[2] Faced with a moral challenge, our moral task is to be as thoughtful, even inventive, as possible. We must become moral 'artful dodgers', eliminating issues and avoiding clashes of values whenever possible. The philosopher may be right in thinking that sometimes we must make terrible priority choices between important values. But with a bit of ingenuity, such occasions can be far rarer that we are inclined to think. And such ingenuity is our moral obligation.

Saying 2: "That's just not practical". A corollary of Saying 1, this cry is sometimes uttered by physicians in response to philosophers' proposed answers to moral issues. A philosopher, for instance, might suggest that a competent patient's steadfast refusal to hear medical information about his condition and his treatment options should be brought before a committee. The committee could then consider whether honoring his refusal is the better way to respect his autonomy and protect his welfare than forcing the information upon him.[3]

"That's just not practical", the physician may reply: "Patients often say 'spare the details, doc, just do whatever you think is best'. If we went to a committee every time a patient refused information, we would spend our lives in committees with no time left to practice medicine".[4]

The philosopher might be annoyed with such a reply. If a particular course of action is morally best, he may argue, then we are obligated to do

our utmost to attain it. Admittedly we must be realistic ('ought implies can'), but we must not bow too early to practicalities. After all, moral values are by definition more important than any other values — including practical inconveniences.

Once again, although this philosophic concern has some merit, it must not be pressed too far. Our moral lives are enormously complex. Moral issues are commonly entwined with political clashes, practical obstacles, emotional reactions, legal requirements, and more. A formula for determining which persons will receive life-saving transplant organs, for example, will turn not only on relevant moral disputes (e.g. utilitarian vs. egalitarian values), but on many other factors: the logistics of transporting these fragile and highly perishable commodities; the national pity which wells up for particularly well-publicized individuals and their needs; the political powers of lobbyists and special interest groups; the other concerns to which policymakers are also drawn.

More importantly, it may be untenable to draw such a sharp distinction between 'moral' and 'nonmoral' elements of a problem. The physician who is concerned about the inconvenience of taking every patient's waiver of information to a committee is not necessarily subordinating moral values to less important concerns. He is interested in the very powerful — and I dare say 'moral' — values of serving as many patients as well and efficiently as possible. More generally, if moral values are those of overriding importance, then it is reasonable to suppose that those practical and political considerations which appear to compete most vigorously with moral values are often themselves moral in character.

Admittedly it is possible to accede too hastily to technical problems or to political obstinacies. But we must remember that the goal of moral problem-solving — as distinct from the goal of ethical theorizing — is not to identify some moral ideal, but to seek the best available resolution under the circumstances. We must change those circumstances to be morally more favorable wherever we can, but must work within them where we cannot.

Saying 3: "Legally, we must (not) . . ." Not too many years ago this phrase seemed a common way for many physicians to begin their answer to an ethical problem. Whether by assuming that legal and ethical requirements are equivalent, or by not being particularly interested in the ethical issue and appealing to the seemingly more pressing legal questions instead, or by not understanding what is involved in addressing an ethical issue, such physicians often avoided ethical discussions. It was in effect a 'practicality' which received very special attention.

This was problematic in several ways, I thought. First, legal and moral prescriptions and proscriptions are not equivalent. Moral requirements often go beyond, and sometimes can conflict with one's legal constraints. Further, where a physician's understanding of the law was inadequate or inaccurate, he sometimes would place needless constraints on his own decisionmaking – tying his own hands with legal myths, as it were.

In recent years this trend has changed some, I think. Indeed, I have seen physicians not only come to realize that ethical issues are not answered with legal citations, but in some cases actually to suppose that it is somehow wrong even to consider one's legal constraints or, beyond this, morally unseemly even to be conversant with legal requirements. "Never mind the law", I have heard a faculty physician tell his house staff, "your obligation is strictly to serve your patient's best interests".

While I still think that it is unwise and morally pernicious to be exclusively interested in technical legal requirements or in one's personal legal risks, nevertheless I believe it is equally undesirable to be ignorant of law or to suppose that legal requirements are morally irrelevant. Our society's most basic norms are embodied in law. In the case of medicine these norms include human autonomy, protection of the vulnerable, professional accountability. Further, citizens have at least a prima facie moral obligation to obey the laws of their society. While a philosopher is not trained to provide legal analysis or advice, it is nevertheless of intense philosophical interest to assess the trade-offs which can arise between physicians' legal interests and obligations, and their more general moral obligations to patients and to society.

Saying 4: "There are no right answers". Here, I once thought, is the ultimate escape-hatch for those who aren't interested in moral reasoning. This slogan could often be heard at the beginning of a physician's non-answer to can ethical issue, or as the conclusion of one. After all, if one insists that there is no such thing as a right answer, then he can conveniently infer that really any answer is about as good as any other, and that it is basically a waste of time to agonize over the issues. One may as well simply make a decision and get on with things.

My annoyance was at least partly justified. That it may be very difficult to choose among rival answers to an ethical dilemma, or that one may never be sure he has chosen the 'best' answer, does not entail that all answers are equally acceptable. Some answers, after all, are clearly wrong, and among those that aren't clearly wrong, some answers are substantially better than others. It is morally irresponsible to throw up one's hands in bewilderment every time a choice becomes difficult.

Yet the slogan does have merit. The essence of a genuine moral dilemma is the forced choice between important values in competition. There are strong reasons for and against every plausible option – else we have no dilemma. Whether or not there is in principle some one 'correct', absolutely best decision,[5] the plain fact of our moral lives is that we are rarely if ever warranted to believe that we have reached the one and only morally acceptable resolution to a dilemma. If we do feel such confidence, it is usually because we have revised the situation to make the conflict of values go away, or because upon closer inspection we have discovered that the situation is not as intractable as we thought, or because we have decided that one or more of the competing values is not so important as we first thought.

In sum, while some answers are clearly wrong, and some answers are clearly better than others, there will often remain several options which defy our efforts of reasoning and moral discourse to choose between them. One way or another, we must learn to live with moral uncertainty and, perhaps, outright moral indeterminism.

Saying 5: "It's a Judgment Call". A variant of "no right answer", this slogan can help the physician to evade responsibility for making difficult choices and more particularly to avoid critically reviewing the choices made by others. Actually, it is probably most often heard when one physician believes that another physician has made a poor decision but is unwilling to say so openly. And so he implies that 'it's all relative', that any choice is about as good as any other or at the least, that no one is in any position to criticize someone else's answers.

This slogan raises important issues concerning the nature of moral disagreement and of moral commitment. On the one hand, we have already acknowledged that differences of moral opinion can be legitimate, that more than one resolution to a problem can be morally defensible. While it may be obvious that one should ordinarily promote the survival of a fifteen hundred gram premature infant, for example, good physicians can legitimately disagree whether to resuscitate the seven-hundred gram infant.

On the other hand, to acknowledge such pluralism does not and should not lead us to embrace complete relativism. The very idea of holding moral beliefs, of drawing a moral conclusion, of espousing moral commitments, means not only that one will believe some answers to be superior, but also that one will reciprocally believe competing answers to be (quite probably) wrong and that one will be disposed to act in accordance with the answer he believes to be best, even on occasion to oppose actively those approaches he believes to be seriously wrong.

Our conclusions concern moral tolerance and its limits. On the most basic level, some tolerance of moral pluralism is terribly important. In order to be held morally accountable, each of us must be allowed as much freedom as possible to make our own decisions and to select our own actions for our own reasons. It is perhaps especially important to grant this latitude to the professional, physician or otherwise, whose work requires considerable exercise of judgment. Thus, "it's a judgment call" captures the importance of exercising some deference toward others' views.

But this does not imply that moral criticism and mutual education are impermissible, or that actions should never be constrained on moral grounds. We have already suggested that some answers to a given problem can be clearly wrong. If we hold moral commitments at all, we as a society and as individuals must set limits upon our tolerance. Among remaining tolerable answers, we may still critically evaluate the quality of reasoning which is brought to support each. This, as we will see in the next section, is a central element in moral problem-solving, and it is sure to be enhanced by moral discussion and mutual challenge.

Saying 6: "Who's to Say?" (or alternately, "Who's to decide?"). This question actually has several distinct uses. One might be asking (1) whose opinion on the issue should actually prevail in the situation, or (2) whose view should be bought or adopted by everyone else as being right. Or sometimes (3) the expression represents a helpless shrug – the (now familiar) belief that there isn't any right answer or that one person's view is as good as any other's. Thus, a physician wondering whether to remove life-support from a hopelessly handicapped infant might query "who's to say whether his life will be worthwhile if he survives?"

This question, in any of its variants, has annoyed me at least as much as any other 'saying'. Regarding (1) and (2) I would respond that we do not find answers to moral issues by following the right guru. The rightness or wrongness of a decision depends not on who pronounces it, but on its own merits, its intrinsic moral defensibility. If survival is a benefit for the infant, it is because his life has a certain worth or quality, and not because of who has been delegated to make a decision. Regarding (3), the 'helpless shrug', we have already suggested that moral uncertainty does not consign us to relativism or to skepticism.

While partly warranted, the annoyance is again somewhat hasty. Many moral questions are procedural: Who should be entitled to (help) decide this question? Those who believe that it is important to respect patient autonomy, for instance, would argue that it is important to honor this procedural value and allow the competent patient to decide his own fate

even where his decision is manifestly foolish or inappropriate. And sometimes, even where we would like to identify a substantively 'best' answer, the unlikelihood that we will ever do so may direct us toward procedural resolutions. We may never be able to piece together one clearly superior formula for the distribution of health care resources, for example: How much for acute care, how much for disease prevention, for research, for life-threatening diseases, for disabling diseases, and so forth. Yet we may do reasonably well with a procedural answer: Whose voices will be heard as we shape our policies, who will administer the policies, how they will be changed, how their results may be appealed. In these cases, "who's to say?" is a question of crucial importance.

Saying 7: "Here's what I do . . ." or "What I usually do in this situation is . . ." With these words a physician has seemed to me either to be setting himself up as some sort of moral paragon to be followed blindly by others, or to be expressing once again a relativism in which moral choices are tantamount to personal preference. "I don't particularly care what you do, sir – I rather would like to know what you think is right, and why I should agree that it's right", I would respond inwardly with considerable annoyance.

Yet one must not underestimate the importance of the moral leadership which may be implicit in such statements. In the first place, house staff are far more likely to take ethical issues seriously and to discuss them openly if their faculty attending physicians do so. Such motivation is tremendously important. Philosophers do not teach people to want to be good physicians or cause them to acquire the virtues which will help them to place a premium on patients' welfare or to respect patients' wishes. These qualities are far more likely to be acquired as the student or resident tries to emulate those physicians whom he especially admires.

Second, a sensitive, thoughtful supervising physician can help his house staff to avoid certain kinds of moral problems in the first place. By his example showing how to communicate effectively with patients, for instance, he can help young physicians to learn HOW to respect patients' autonomy – how to elicit patients' feelings, beliefs, and preferences. It does little good for a physician to believe firmly that such respect is morally important if his communication techniques are so clumsy as to cause only confusion or even alienation.

Much the same lesson can be drawn from a common variant of Saying 7: "If this patient were my mother . . ." (or father/spouse/child, etc) or "If it were I . . .". On the negative side, this slogan can invite the physician illegitimately to introject his personal values into decisions which should

rightly be the patient's or his family's. What the physician would want for himself or his own family does not necessarily match what these people would value.

On the other hand, it is also important that physicians remind themselves whenever possible of what it is like to be a patient or to be a family member facing difficult choices. They need to "walk in the other person's shoes", so to speak, to appreciate what it is like to be afraid, confused, in pain. As empathy is thus an important ingredient in physicians' abilities to help their patients to cope with illness, those who are in the business of educating physicians need to help them to cultivate this important skill. As above, such humane qualities may be promoted best through the living examples set by respected clinicians.

III. PRACTICAL PHILOSOPHY

Collectively, these sayings carry some important lessons about moral problem-solving. While we must of course make theoretical judgments about what is important and about where our priorities should lie, we must also recognize that such theorizing often will leave us with several acceptable options from which we cannot decisively choose by further theorizing. Good moral problem-solving requires an ability to reckon with complexity and with uncertainty, an earnest desire literally to MAKE the best of a difficult situation, and at times, considerable creativity as one forges a resolution which one hopes will honor all important values maximally. Moral problem-solving thus includes, but goes well beyond, ethical and metaethical ruminating.

How does the philosopher fit into this? I am convinced that one can function fully within his professional integrity as a philosopher, yet still provide very practical assistance to those who must solve not only moral, but also other dilemmas in medicine. This conclusion stems from the observations that (1) good-quality reasoning is of crucial importance in good clinical problem-solving (whether moral or medical) and that (2) philosophy is above all a discipline which focuses upon the features of good-quality reasoning.

Let us consider the former point first. We have already seen that moral problem-solving does not admit of the clarity, precision and certainty to which we might ideally aspire in our ethical and meta-ethical theorizing. Interestingly, this same sort of gap also exists between medicine as theoretical science and medicine as clinical practice.

When a patient presents with a problem, the physician initially sees only

a motley collection of signs and symptoms, some of which are probably irrelevant and which together are usually consistent with a variety of diagnoses. In this first stage, he must identify all plausible explanations which could account for the situation. And then he must thin his list. Some diagnoses in his "differential" can be ruled out quickly with a few simple questions or routine examinations. If the list still contains several major contenders, further tests may be in order.

Yet all these together still may not be definitive. If a patient has already received some antibiotics, for example, the laboratory may be unable to identify any organisms in his cerebro-spinal fluid, yet it is still possible that his infection is meningitis. A patient with chest-pain may have an equivocal stress test; lower right quadrant abdominal pain is consistent with appendicitis, but a different diagnosis may in fact be correct.

The situation is similar with therapeutics. Once a physician is reasonably sure of the diagnosis (and sometimes even when he is not at all sure), he usually must choose which courses of therapy to offer and beyond this, which to recommend. One option may have a higher likelihood of success, yet carry higher risks of side-effects. Another may bring good prospects for success with small chances of medical complications, yet may be too complex or too expensive.

For either diagnostic or therapeutic decisions, then, although the physician can usually rule out some clearly wrong answers, he often must choose among several remaining competing answers. Perhaps there is in principle some one answer which is 'correct' or 'best',[6] yet in actual practice he must live with considerable uncertainty. At this point the merit of his decision is not dependent on whether it is eventually vindicated by patient outcome, for sometimes the physician never does find out whether he was right, and other times the patient's outcome has little or nothing to do with his interventions. Rather, its merit depends on the quality of the reasoning which supports the decision. If he gathered the data which he ought to have gathered, if he refrained from gathering data which was unnecessary or dangerous, if he reasoned in medically and logically credible ways to his conclusion, then he has practiced good medical decision-making. Even if his decision turns out to be incorrect, the quality of his reasoning remains the same, as does our evaluation of the quality of his decision-making. If, for example, a physician has good reasons to prescribe penicillin for an infection and no evidence to suspect that the patient is allergic to the drug, then his decision to use it is a medically good one even if the patient ultimately suffers an anaphylactic reaction. His choice may have been unfortunate, but it was not unwise.

Together, these points about moral and about medical problem-solving

can point to some important conclusions about the role of philosophy in the clinical setting. Good-quality reasoning requires accuracy (a proper understanding of the situation and its issues), thoroughness (a detailed identification of ALL the important factors, issues and options), and logical precision (a careful delineation not only of the warrant for one's conclusions, but of their limits and weaknesses). All of these will at some point involve philosophical skills for it is philosophy, more than any other discipline, which takes the examination of reasoning as its chief business. Thus, while a physician may be better able than a philosopher to provide a factual description of the situation (a description which, we should note, may presuppose extensive epistemological, conceptual and metaphysical commitments about normality in human function and about disease entities), the philosopher may be able to help determine which further facts are still needed. He can expose the implicit assumptions which are shaping the physician's description of the situation and its issues, and he may in some instances spot issues which have been overlooked or misidentified. A philosopher can also help the physician to rule out clearly unacceptable options and sometimes even to invent new ones. More important, he can assist in the critical examination of these options and of the physician's and others' proposed answers.

These points about the philosopher's role are not really new. What we can contribute here, however, is a set of examples to show clearly just how clinically practical this philosophical reasoning can be.

Case 1: A fourteen year-old boy is admitted to University Hospital for a pathologic fracture of the left femur, resulting from a chronic osteomyelitis (bone infection). University physicians learn that the local physician had suspected the infection but note also that he had not done all the diagnostic tests which are ordinarily done to confirm the presence of the disease, nor was his therapy adequate. Instead of the medically standard four to six weeks of in-hospital antibiotic therapy, the local physician had treated the boy for two days in the local hospital, then discharged him with a prescription for outpatient antibiotics. University physicians are now inclined to call this treatment malpractice, and they wonder whether they should take action. The boy's family is indigent, and his village is poor.

In order to judge that this is genuinely a case of inferior care, more facts are needed. Did the patient or his family refuse recommended diagnostic or therapeutic options? Did the physician have the ideally desirable facilities available? Has the local hospital discouraged such lengthy in-patient stays for indigent patients? Do we actually know whether the patient adhered to the prescribed outpatient antibiotic regimen? More interestingly, what is our medical evidence for insisting that osteomyelitis be cared for on a lengthy in-patient basis? As cost-containment pressures force physicians to reconsider cherished routines, some of those routines

are sure to be altered with the judgment that "this wasn't really as necessary as we thought". Until we have more answers to these factual questions, it is difficult for us to decide whether the issue is "what to do about a case of physician malpractice", or "what to do about a recalcitrant family" or even "what to do about the poverty which rendered health care facilities so inadequate".

Just as further delineation of the facts will help to establish the issues, so will our description of the issues influence our iteration of the options. If the issue is a colleague's malpractice, then one will inquire whether the university physician should express his disagreement to the local physician, whether he should inform the family, whether he should contact the local medical society, or whether some other course would be best. If the issue concerns the family's recalcitrance, then his options would include working with the local physician (not against him) to help the family understand the boy's needs better; or working with the family oneself; or perhaps, if the situation warrants, establishing contact with the local child protection agency. If the problem is seen primarily to stem from sheer poverty, then again one's list of options is quite different – from lobbying legislators for better support of health care, to invoking local social services personnel, to finding other ways of helping this family and others in that locale.

Case 2: A sixty-eight years old man with advanced chronic obstructive pulmonary disease has recently been discharged from the hospital after a lengthy stay in the intensive care unit. During that time his breathing had been supported with an artificial ventilator. Although most people find prolonged ICU care and ventilator-dependence to be a terrible quality of life, this man had rather enjoyed himself. He didn't have to go to all the work of breathing for himself, and his every need was waited on by attractive young nurses. When finally weaned from the ventilator and discharged, he seemed sorry to leave. Now, two weeks later, he returns to the emergency room in respiratory distress. It is evident that he has not faithfully adhered to his medication regimen. House staff wonder whether they should be willing to place him back on the ventilator, if his survial should require it. Many argue that they should not, on the grounds that he is fatally ill and that it is inappropriate to prolong such a poor quality of life.

While quality of life is often relevant to contemplating prolonged respirator care for patients whose underlying illness is fatal and irreversible, in this case it was something of a red herring. The patient was fully competent and knew, far better than any of the staff, what it was like to live in the ICU on a ventilator. It suited him just fine, thank you. The real issues, as staff later conceded, concerned resource allocation: is it appropriate to offer such expensive high-technology care as a lifestyle? Or should it be restricted to those situations in which some sort of recovery can be hoped for?

Case 3: An intern caring for a dying cancer patient wonders whether to discuss resuscitation options. "No one wants to plan his own death", the intern thinks, "and it is cruel to ask someone whether he'd like to have his heart started again if it should stop. Since it would be cruel to ask, it is also morally wrong to ask. I'd better just make the decision myself".

Here, a communication problem is transformed into an ethical one. The intern does not know *how* to broach this difficult subject in a non-cruel way, and so he feels morally impelled to avoid it altogether. Now, it is not a philosopher's business to teach the intern just how to engage in such discussions. That task falls within others' realm – psychology or counseling, perhaps. But by exposing the illegitimate inference from "I can't think of any humane way to raise the question" to "therefore there IS no humane way to raise it", a philosopher can at least help to call false assumptions to attention, where they can be re-examined and perhaps remedied.

Case 4: A severely demented elderly patient experiences a myocardial infarction at a nursing home and is resuscitated and sent to the hospital. The resident judges that the infarct was not major and that the patient can probably be returned to her previous baseline condition. But he wonders whether he should nevertheless classify the patient as a DNR – do not resuscitate – given her poor overall quality of life.

The judgment that severe dementia constitutes a poor quality of life relies on several dubious assumptions. The relationships between mind, body and behavior raise major metaphysical questions even regarding normal individuals. And here we must make additional epistemic assumptions as we attempt to use our understanding about normal people (who can describe their experiences and share their beliefs about their quality of life) to draw conclusions about people who are neurologically abnormal and who are unable to communicate their thoughts and feelings intelligibly to us.

Even if we were able to defend such metaphysical and epistemic commitments in order to *describe* such persons' quality of life, we would require further normative assumptions in order to *evaluate* it as 'poor'. Yet these too may be difficult to defend. It is not clear what warrant we have for judging the happiness of people with seriously diminished capacities according to the standards we use for persons in full possession of their faculties. The things which make life worth living for the mentally intact may not match those which make life enjoyable or at least tolerable to the demented.

The important pedagogical point here is that, once we raise such challenges, then we must change our description of the issue the resident faces. We must ask, not what is best for the patient with such a poor quality of life, but rather what we should do, given that her quality of life is substantially uncertain.

Case 5: A fifty-seven years old woman, suffering from chronic asthma, appears for her routine check-up. As usual she is anxious about the physician's findings. Upon occasion in the past, the news that her lungs sounded poor that day prompted anxiety which in turn exacerbated her asthma – resulting in one instance in hospitalization. On this particular day her lungs do not sound good, though medically it is a normal variant for this patient and her particular disease. She asks, "how do they sound today, doc?"

The physician appears to have two options, each offending a different value. If he is completely honest, he has reason to think he will cause her harm by triggering her known propensity to worry unduly and, thereby, an exacerbation of the disease. If, on the other hand, he avoids this prospect of harm by lying or by avoiding her question, then he is dishonoring her moral status as an autonomous adult.

This description of the options represents a false dichotomy, however. It relies on a crucial assumption: that the causal link between bad news and exacerbation of the asthma is forever fixed, and that there is nothing we can do to avoid that unfortunate sequence. Yet surely this assumption, once made explicit, can be challenged. Clearly this woman is having difficulty living with her disease. She may have terrible fears about her future, or she may hold false beliefs about her disease or about her treatment. Perhaps she has seen a friend or relative die of respiratory disease and fears she may suffer the same fate. Or perhaps, unbeknownst to her physician, she cannot afford the daily medications which could provide greater comfort and function. One way or another, the physician must explore her concerns with her. And very likely, once he understands her better, he can find ways of helping her to understand her disease better, to live with it more comfortably, and to gain better control over her own responses to it. Once this is accomplished, the physician is in a far better position to honor both values at once: avoiding harm and respecting autonomy. The examination of the inappropriate causal assumption can thus lead to an important, and morally superior, new option.

Case 6: A cardiologist performs cardiac catheterization for coronary angiography. At the conclusion of the procedure the patient's heart arrests. He is resuscitated but arrests again and is resuscitated once more. This pattern continues for over twenty-four hours, and the patient dies. The cardiologist does not count this patient among the statistics for "death due to complications of coronary angiography", because it occurred more than twenty-four hours after the procedure. The hospital's protocol for counting "cath deaths" only includes people who die within twenty-four hours.[7]

This case highlights important value and epistemic trade-offs which must be made by medicine as science. Scientifically, we must establish some sort of protocol each time we wish to gather data. We must decide how to classify phenomena, and which particular events are to count as

instances of the phenomena we are investigating. Thus, we must set specific criteria for determining whether a patient's cancer is 'Stage 1A', Stage 4B', or something in between. And all investigators must follow the protocol, or their results cannot be gathered together into generalizations and conclusions. Yet these protocols can require some somewhat arbitrary decisions, and can invite us to suppose that we have attained a conceptual clarity or an epistemic certainty which we simply do not have.

In the case of counting 'cath deaths' we must make some assumptions about causality. The more immediately a death follows upon the procedure, the more likely it is that the procedure caused the death. Reciprocally, the farther away in time the two are separated, the more likely it is that other factors intervened to cause or contribute to the death. Yet in individual cases, these generalizations may not be true. A death immediately after catheterization can be the result of other factors, and a death occurring later might still be primarily attributable to the catheterization. Wherever we set our temporal cut-off point, we are sure to have some false-positives and some false-negatives. And we may never know how many of each we have encountered. We must simply set our protocol parameter at that point where we believe we will have the fewest false results.

But there are also values involved in setting such parameters. Given that we are likely to err, on which side shall we err? If we set our protocol to minimize false-positives – if we try, that is, to avoid wrongly blaming the procedure for deaths it did not cause – then our final statistics will be fairly conservative. And when patients ask "just how risky is this procedure, doctor?", the answer may not fully reflect the real risks. If, on the other hand, we attempt to minimize false-negatives – if we try to ensure that we count every death which might plausibly be connected with the procedure – then our numbers will be generous. And our answer to the patient's question about risks may be unduly frightening.

It is important that the physician understand these philosophical points, both in his role as clinical investigator and as healer. Physicians are already well aware that the worth of a scientific study's conclusion depends on the quality of its methodology. With a bit of philosophic assistance, they can also understand that the quality of that methodology itself depends on the epistemic credibility and on the moral defensibility of its underlying assumptions.

Case 7: An infant born at twenty-five weeks' gestation has been a patient in the Neonatal Intensive Care Unit for eleven weeks. He has never breathed without mechanical assistance and now requires very high ventilator settings. He suffers severe broncho-pulmonary dysplasia. He has also experienced a grade-four intracranial hemorrhage resulting in major brain damage. He is unable to suck or swallow and must be fed by nasogastric tube. His

periodic seizures are only partly controlled by medication. His renal function is deteriorating rapidly and his liver enzymes now show the beginnings of probable hepatic failure. His parents have been told that his chances for survival, much less healthy recovery, are very poor, yet they continue to insist that the child will do well. "God will work a miracle", they say. Medical and nursing staff wonder how best to counteract the parents' 'overly optimistic expectations', believing that it would now be best for them to adopt a more 'realistic' view of the situation.

While it may be that the parents do not understand — or perhaps do not appreciate the significance of — their son's medical situation, it is also possible that the difference of opinion between staff and parents is not factual at all, but theological. If indeed the parents understand that, from a medical point of view, the child's prospects are very poor and that there is little else that medical technology can avail, then there is not much basis on which staff can attempt to change their thinking. Nor, arguably, would it be legitimate to attempt to change their theology. It is one thing to contend that medicine has nothing to offer the child, and quite another to imply that "neither does your God". Once again one must understand clearly the nature of the issue one faces before he can identify his options or the factors which should guide its resolution.

IV. CONCLUSION

The import of these seven cases and seven sayings, I hope, is to make clear the genuinely philosophical nature of clinical dilemmas — and the very clinical applicability of philosophy. The importance of philosophers' moral analysis has long been recognized, yet there is much more. It requires logic to expose hidden assumptions and gaps in inference; epistemology to examine the non-scientific principles which provide the structure of scientific research and its clinical applications; metaphysics to expose the Cartesian dualism implicit in crying "get a psychiatry consult!" every time one's patient experiences emotional difficulties in living with his disease. The worth of physicians' decisions, both morally and medically, depends on the quality of the reasoning behind them, and much that goes into this quality is philosophical in character. The philosopher who is clinically versed in the practices and principles of medicine, and who is willing to allow his academic pedagogy to be (re)shaped by the confusions and complexities of the clinical setting, can therefore contribute substantially to the delivery of quality health care.[8]

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NOTES

[1] I do not refer to myself as an 'ethicist' except grudgingly on those occasions where there is insufficient time or where it would be socially inappropriate to 'correct' someone for using it. The term 'ethicist' does not fit my work partly because it is too narrow, and partly because it can implant inaccurate conceptions of clinical philosophy in the minds of those with whom I work. I am a philosopher, and my work involves not only the philosophical study of ethics, but also relies intimately on metaphysics, philosophy of mind, epistemology, philosophy of science, philosophy of law, logic, history of philosophy, and even philosophy of religion and aesthetics. As a philosopher I specialize in particular skills of reasoning as brought to these areas. 'Ethicist', in contrast, conjures up images of people who are particularly good at knowing what's morally right — who know the 'right set of rules' — and who can apply them well. It also on occasion elicits the picture of a 'moral policeman', a role even more unsuitable to a philosopher. Neither a Bearer of Right Answers nor a Virtue Enforcer, a philosopher is in the business of examining issues and reasoning. It is difficult enough to explain these functions to non-philosophers, without saddling oneself with the additional burdens of label-inspired misunderstandings and inappropriate expectations. See also [4].

[2] We are assuming that they have rejected the idea of abortion.

[3] See Beauchamp and Childress, 1979, p. 79 [1].

[4] A similar situation arises where the philosopher (or the lawyer) insists that the physician must seek a judicial guardianship hearing every time a patient's competence is impaired.

[5] Art Caplan has attacked what he calls the 'engineering' model of ethics, which assumes that we can deduce from moral principles one (and only one) correct resolution to each moral dilemma. I am inclined to agree with him. See [2, 3].

[6] When we recognize how heavily diagnoses and disease 'entities' are bound up with theories of disease, and how very much such theories rely on debatable epistemic and ontologic commitments, we may wish to question the idea that a single 'correct' diagnosis is always available even in principle.

[7] A similar situation exists regarding some cancer statistics, where 'cure' is equated with 'five-year disease-free survival', even though some 'cured' patients eventually die of relapsed cancer.

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