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In this article Dr. Camenisch presents a plea for mutual understanding between ethicists and medical professionals. He is Associate Professor of Religious Studies at DePaul University and is a post-doctoral Fellow at the Texas Institute of Religion.

There would be some justice or at least symmetry in the companion piece to Dr. Lisson's article being authored by a physician. And in one sense Charles B. Moore has already done this.[1] But there are also advantages to critical reflections and gentle reprimands originating from within the fraternity being addressed. We ethicists, often with the very best of intentions, sometimes create our own obstacles by our mode of entry into medical areas and by some of our unexamined working assumptions. We also often permit existing obstacles to stand by, failing to clarify the nature of the ethical task. Being aware of these troublesome elements and exorcizing them where possible should facilitate progress in medical ethics, especially at those points where such progress hinges on an adequate understanding of the nature of ethics or on good will between the medical professionals and institutions (not just physicians) and the professional ethicists.

Territoriality

The ethicist is often perceived by the medical professional as an invader, a usurper who seeks to bring under his own aegis territory — problems, decisions, prerogatives — which has until now belonged indisputably to the medical profession. Thus resentment and resistance are often visited on the ethicist who seems bent on upsetting the status quo or at least on further disturbing troubled waters by raising additional doubts in the minds of people already uncertain about the quality of current medical care, the truly human benefits of certain technologically advanced medical procedures, the justice of having to spend so much money in the attempt to preserve their life and health.

The first and most obvious way to defuse some of this resentment and resistance at being "invaded" is for the ethicist to state as clearly as possible that the ethical issues being raised are not identical with questions of the personal ethics — honor, integrity, etc. — of the medical professional. But this is not a simple issue, and those ethicists who simply toss off this distinction as a pan-

acea for all such unhappiness the medical professional feels have simply missed the complexity of this issue.

There is not space here to explore the various levels on which the questions being raised in medical ethics might relate to the moral/ethical integrity and sensitivity of the medical professional. But most ethicists, being teachers, can perhaps grasp something of what medical personnel under ethical scrutiny feel if they imagine themselves in an analogous situation. How would we respond to being accused of engaging in practices, of employing instructional methods, of participating in a system which, in spite of our own personal integrity, injure, even brutalize and dehumanize our students? (Many of us, of course, were accused of precisely this by black groups several years ago when they attacked the "institutionalized racism" of much of formal education.) In such a situation it is some comfort, but not really enough, to be told that one's personal morality is not under attack. Such assurances declare us innocent of the more obvious, the grosser violations. But they still imply that we have been party to other wrongs which we were not perceptive enough to detect. And that is no compliment.

Here the ethicist can only try to make sure that medical professionals do not read into his analysis, his questions and suggestions, personal accusations which need not be there and which most often serve only to obscure the real issues when they do become the focus of attention.

A more significant response to the medical profession's inclination to defend its "territory," however, is to suggest that so long as ethicists are raising the right issues, the territory which would appear to be in dispute between the medical and the ethical professionals in fact belongs to neither of them. The territory —ethical questions about various areas of medical practice such as whether some medical procedures should be used at all, whether some medical research should go forward, and if so, under what circumstances ,etc. — belongs either to the patient/subject involved or to the public at large. In the first case, for example, the question of whether to elect radical and grossly disfiguring surgery to combat cancer or to die probably sooner but "intact" is the patient's question, not the doctor's or the ethicist's. And the question of whether proxy consent should be invoked to permit non-therapeutic research on children is a question of social policy requiring a decision from society at large, however difficult that is to obtain or to interpret. (This last statement does not mean that morality is a question of majority vote, but only that neither doctor nor ethicist can relieve society of the responsibility to shape its own policy, its own moral character in such matters.) Thus these matters do not constitute territory to be awarded as a prize for excel-

lence in disputation to either medical or philosophical doctor. Both may and should make their own contribution to the discussion to aid the patient or the public in arriving at an informed and critical conclusion. But the questions, the territory itself, are not theirs to dispose of between them.

At most the professions deal with such matters as with a trust. The medical profession does not own the human goods it is designed to provide. These goods — health, long life, and the scientific-technological advances which are meant to contribute to them—are not possessions which the profession is free to dispense or withhold at its own discretion.[2] These goods are public trusts which are most extensively dealt with by the medical profession simply because it has been entrusted by society with what are currently seen as the best means for securing and maintaining them.

When medical professionals and institutions realize that these goods are public trusts, then the entrance of qualified and sensitive ethicists into the ethical discussions which those goods generate should be met not with resistance and resentment, but with *relief*. To those aware of their own fallibility (humanity?) it should be an awesome thing to hold life and death, health/wholeness and their opposites in one's hands. And *if* ethicists can achieve the impartiality, the personal disinterestedness they aspire to, then their analysis, their probings, their suggested resolutions should be no more, and no less, than a responsible attempt to help the medical profession bear this heavy load. For example, the ethicist discussing informed consent with research physicians should not be defending some vested interest of his own which must be mapped out and protected against medical personnel. He should rather be offering the analyses, the insights of ethics to the researchers as possible aids in their struggle to discover precisely what society has entrusted them with in this area and how it can be most responsibly dealt with.

Clearly the ethicist can not stand in the physician's place and decide when to operate, when to resuscitate, or how to weigh the cost/benefits of a particular therapy. But serious ethical reflection does aim at reducing the need at such points for medical personnel to draw only on their own past experience and their own hurried reflections. If the ethicist can lighten that burden, it is not because of his own moral/ethical superiority but because of the traditions of substantive values and commitments, of critical analysis, and on rare occasion the societal consensus he can make available to help inform the decisions of the medical professional. On this construction of the situation in medical ethics the ethicist is seen not as an invader of medical territory but potentially as one embodiment of society's willingness to help the

medical professional bear the ethical, decisional burdens attaching to the goods he has been entrusted with. The mystery here is why anyone bearing such burdens would shun any responsible attempt to share and thereby to lighten that load.

The Nature of Ethics

Part of the physician's feeling of being invaded by "aliens" derives no doubt from his correct perception that ethicists are raising questions quite different in kind from those the scientifically trained physician ordinarily deals with. There are several ways of characterizing this difference but here it need only be said that the doctor's questions are usually scientific on some significant level — that is, they deal with empirical data, are usually thought to have objective answers that can be arrived at by agreed upon procedures, answers which can be verified, which are the same for all competent investigators, etc. The ethicist's questions, on the other hand, are "softer" in several respects. They seem to be answerable only on the basis of personal or group preference and taste, commitments and values, all of which are beyond proof. And since many practitioners still see their field on a strictly scientific model, they sometimes resent even having this sort of issue introduced into it. In some circles such resentment is at its height against theological or religious ethicists who are seen not only as raising inappropriate questions but as offering insights and answers which are also inappropriate. Such religious insights are thought inappropriate because they are perceived as deriving from the values and commitments of a limited group — a particular religious community — and as resting on some esoteric base such as revelation or church authority rather than on "reason."

There are several important misconceptions in this response to the ethicist. First, ethicists do not bring the ethical issues into medicine — they are already there. Wherever situations require a decision between competing human goods, there are ethical choices being made. We might refuse to recognize them as such and pretend that they can be answered on some "purely scientific" basis. But that is a dangerous illusion because it permits us to keep submerged and unexamined the ethical grounds we are operating on. The ethicist simply makes the ethical issues already present in medicine explicit as *ethical* issues and challenges the profession to confront them directly and critically rather than pretending that they are not there.

Secondly, the ethicist should make clear that while it is true that ethical questions are quite "unscientific," this is no grounds for eschewing ethics and trying to practice some sort of "value-free" medicine. ("Value-free" medicine would at best be medicine in which the values were permitted to remain implicit.) Rather, this realization that ethical

analyses and claims rest not on some sort of factual or logical proof, but ultimately on human choice, commitment, on values affirmed and goods pursued, should be noted and highlighted not as the death of ethics but as a crucial insight into the nature of ethics — and in fact into much of human life. The fact which must be faced by medical professionals and all scientifically trained experts who might be tempted to take refuge behind their expertise is that they have been and will be making this kind of choice on this kind of ground, and that such choices — at least where they impinge on the well-being of others — must now be made the subject of public discussion.

Finally, if the above assertions about the nature of ethics and the grounds of ethical decision making are correct, then theological ethicists must boldly respond to those who accuse us of speaking from a limited base of commitments and convictions while other ethicists presumably speak from some broader, even universal base. We must insist that all normative ethics finally rest on conviction, that every ethic is a "believers' ethic." That is, that ultimately it speaks only for and to those who share its convictional base. Religious ethics is unique here only in that it publicly proclaims its base. Other ethicists, in making no such public declarations, create the illusion of having nothing to declare. But that *is* an illusion and should be exposed as such.

Thus the question is not whether ethical decisions will be made in medicine, but whether they will be faced *as ethical* and confronted openly and critically. And if the latter question is answered affirmatively, the next question is not whether we will respond to them on the basis of some specific group's convictions and values, but rather *which* groups and/or individuals will be permitted to offer their commitments and values as possible starting points for ethical deliberation. Open acknowledgment and careful elaboration of these points about the nature of all ethical reflection will aid progress in medical ethics by making clear the sort of task we are engaged in.

Constituency

All too often ethicists seem to cast themselves in the role of defender of the public interest against the harm done by self-seeking and/or morally insensitive and/or ethically inept medical professionals. While this assigning of roles is often only tacit, the medical partners in the discussion are alert to it and are rightfully resentful of the various ways in which it shapes the discussion. Such an assigning of roles is unfair and inaccurate on several counts. First, the ethicist rarely succeeds in being a personally disinterested, entirely "objective" champion of the public good. We too have our vested interests. Ours are perhaps less obvious and are surely less rewarding financially than those

the medical professionals are often accused of; but they are equally capable of distorting our analysis and our arguments. Who among us would not like to be acclaimed as a giant-killer, or at least as a full professor on the basis of having tweaked the giant's beard? And what more likely candidate is there for the role of Goliath today than the medical network?

Secondly, this assigning of roles is unfair since the medical professional is seldom as devoid of the worthier motivations — compassion, a sense of public service, etc. — as the critic often suggests he or she is. This is so obvious that it needs no elaboration here.

But perhaps the most significant misrepresentation in this view of the ethicist's role is the assumption that he speaks for the public. On the basis of the presumed purity of our motives and the intensity of our dedication to defending the public good, we often declaim and exhort as though we were the officially appointed spokesmen for the voiceless masses — as though they themselves had sent us into the fray as their last, best hope. But clearly we have no such constituency. We have received no such mandate, no such vote of confidence. We do not speak for the masses except in the limited sense of urging courses of action which *we see as* serving their best interests. Thus it is presumptuous of us to conduct ourselves in ways which seem to say to the medical field, "We have come to speak for those you serve but whom you do not hear — *they* have sent us — we speak with *their* voice!" When either ethical or medical professionals assume this role, they engage in an unbecoming paternalism which is a discredit to themselves and a disservice to the public.

Strategically it is unwise of ethicists even to raise this question of the constituency we speak for since the medical professional can easily put us to shame on this count. The public at least knows who the medical professionals are and what they do. And in the continuing insistent demand for their services the public continues to give them something very like a vote of confidence. It may be a grudging vote qualified by concern over the cost and quality of care, and even by the ill-defined wish that some alternative were available. But so long as the overwhelming majority of the people turn to medical professionals in their search for health, long life and deliverance from suffering, the medical network has an impressive constituency for which it can in some limited capacity speak. Thus ethicists must not draw battlelines which put themselves and the public on one side and the medical professionals and institutions on the other.

The temptation which lies in wait here for the ethicist is a subtle but dangerous one. I recently attempted to survey the physician examining and licensing

boards in the country's fifty-one jurisdictions concerning the ethical dimensions and implications of physician licensing. At my last count only sixteen of them had responded. I was originally indignant at the arrogance of these boards to which the public has entrusted such great responsibility and granted such great privilege in denying to the public insight into how they perceive and carry out their public trust. The fallacy here, of course, is that in requesting such information I was in no real sense acting as a representative of the public. Denying the requested information and interpretations to me could not simply be equated with denying it to the public. And in pretending that it could I was assuming an office to which I had no legitimate claim. I am still inclined to be indignant over the matter. And on the basis of some of the boards' past records I suspect that some arrogance was at work along with other more legitimate and practical reasons for not responding to the questionnaire. But any such indignation I feel cannot be predicated on an affront to the public which did not in fact occur. If there is arrogance in the boards' denial of the information, nothing is to be gained by matching it with my own arrogance. The boards have no right to withhold such information from the public when it has been duly requested. But I have not been commissioned by the public so to request it.

Expectations

I have already suggested that the ethicist can be too much resisted and resented. But it is also possible on the basis of exaggerated expectations for him to be too much welcomed. Some morally concerned physicians apparently feel they have been deserted by the public to bear their burdens alone. In conversations with such persons I have sometimes had the disquieting feeling that they expected more than I could in good conscience deliver, that they hoped for answers which would once and for all set their minds at ease. Of course some ethical traditions do provide just such clear and unambiguous answers. One of the most familiar examples here is the official Roman Catholic teaching on matters such as direct abortion and mercy killing. Ethicists working out of such traditions should offer such anwers with conviction and without apology. And those of us who do not stand in such traditions should know them well enough to insure them a fair and informed hearing from sympathizer and critic alike. But the fact is that for reasons too numerous and too complex to explore here most ethicists do not feel that they can provide "answers" in this sense. They rather approach the questions of medical ethics as fellow-seekers with the medical professional, offering tools which they hope will help in their common pursuit of resolutions to insoluble human dilemmas. But they do not come with catalogues

of ready answers. For those of us operating from this perspective we must first see that we do not ourselves cultivate any such unrealistic expectations. Secondly we must take note of them where they do exist and firmly disclaim them. Being publicly referred to as an "expert in ethics" is so unnerving precisely because it bespeaks such an "answer man" understanding of what we are about.

Competing Goods

In the heat of moral debate it is salutary to keep in mind that in virtually all ethical dilemmas there are competing goods all of which we cannot simultaneously maximize. (That, in one important sense, is what makes it an ethical dilemma.) Consequently we must choose which among these competing goods or values will be given priority. In addition — and here is the crux of the matter — we must remember that this choice is one about which persons of good will may in conscience disagree. For example, the research physician who chooses the future benefits which may result from non-therapeutic research on a child over the absolute inviolability of his/her privacy, bodily integrity, etc., is not thereby revealed to be a ghoul choosing the darkest of evils over a self-evidently overwhelming good. The physician has chosen one good from among the various goods available. Not all of us will agree with that choice. But we should at least be able to see how that choice makes sense in the world the doctor sees. Any opposition to it must therefore reflect the respect we should always feel in the presence of a conscientiously choosing moral agent. Of course, we might in this case feel that this choice favors the most immediate, the most empirical and possibly the most superficial of the competing goods. But it is nevertheless a good chosen and not an evil embraced, and the choice and the chooser should not be morally disqualified or excoriated because it is a choice we happen not to agree with.

It is particularly distressing when ethicists let a single and often rather limited moral issue disproportionately shape their response to medical professionals and ignore the fact that many such professionals appropriately perceive their entire professional identity and involvement as a moral undertaking. To ignore this latter much larger moral reality because the medical professional is not alert to the latest "hot" issue in medical ethics is a serious injustice. For example, it *is* distressing on one level to see medical professionals so very disturbed over malpractice insurance costs (especially when it is not accompanied by equal concern over sky-rocketing patients' medical costs), and in some instances to see their practice of medicine so significantly guided by their desire to avoid malpractice suits. This is disturbing primarily because such facts suggest that the medical professional has traded

in the traditional professional dedication to serving the public for the less edifying self-serving quest for economic gain. But we must also recognize that such concern might reflect the professionals' awareness that the malpractice issue is threatening seriously to disrupt the only system we currently have by which they can deliver to the public essential services they feel morally committed to making available. The malpractice situation is therefore seen as a threat to their ability to make good their entire professional-moral commitment. Admittedly this interpretation of the profession's response to the malpractice situation is too idealistic to fit with the public's current assessment of the medical network as a whole. But this fact alone gives us no real grounds for dismissing it, and therefore no grounds for ignoring it and similar more inclusive moral commitments in any fair response to the medical profession.

Origins of the Present Situation

It is not always flattering to be in the spotlight. The maintenance of good will with medical personnel and institutions requires that we keep clearly in mind the various influences which have put medicine in the ethical spotlight. In most cases it is reasonable to assume that a focus on the ethics of a group or field follows a general agreement that those ethics have fallen to a conspicuously low level. The widespread but apparently short-lived concern with the ethics of politicians and attorneys immediately following Watergate would conform to this pattern. But such an assumption would not be fair in the case of medical ethics. The amount of attention being given medical ethics currently is disproportionate on several counts. It does not reflect an alarming disintegration of ethics and morals in medicine either in some absolute sense or in comparison to other professional/occupational groups. Nor is it proportional to the amount of harm the public suffers at the hands of medical personnel and institutions which the ethicist wants to reduce through his involvement there. Surely other sectors of society such as the economic, the legal and the political inflict as much harm on the public as does the medical.

Medical ethics has attained the prominence it has not primarily for any such negative reasons which would reflect discredit on the medical profession, but rather because of the coincidence of a variety of positive influences. Most obvious among these are the impressive scientific-technological advances made in medicine in the last two decades which presented vast new possibilities for doing both good and harm. These possibilities frequently arose in ethically uncharted waters and therefore pressed the medical professionals themselves, as well as the public and the ethicists, to subject them to careful moral examination.

A second major influence was the willingness of various sources,

mostly private, to fund investigation into medical ethical issues. This willingness arose in part from the developments just mentioned, but also in part from a continuing concern about medical issues of longer standing. And finally, medical ethics has prospered because of the willingness of many within the medical professions and institutions to enter into discussions, to host conferences, and in other ways to foster and participate in such inquiry. Thus it behooves all of us to remember that while being in the spotlight is not always a flattering or pleasant experience, the simple fact that medical ethics is currently there is in itself no negative comment on the moral/ethical state of the medical field.

We should also be aware of the almost universal tendency to blow out of proportion those instances of moral failing — greed, deception, self-seeking — we sometimes find among medical professionals and institutions. This is an understandable reaction to such shortcomings in a professional group when the aspirations and claims of that group and the public's expectations of it are so high. Such wide disparity between the ideal sought and the actual performance observed does perhaps warrant some indignation. But such a response should not blind us to the fact that such failings seldom fall below what is publicly admitted to by, and even expected of, most other gainfully employed persons in the economy. An ambitious power-seeking, money-and-status-pursuing vice-president of General Motors is no cause for public scandal. A doctor operating on similar criteria is more disconcerting, but is ground neither for condemning the profession as a whole nor for reading the individual involved out of the human race.

Remembering Who We Are

One last suggestion aims as much at benefitting the ethicist himself as at cultivating good will between him and the medical professional. It might, however, contribute to this latter goal as well by making clear what kinds of credentials can rightly be required of the medical ethicist. As I understand ethics and thereafter medical ethics, an ethicist working in medical issues — whatever title he carries — must be an ethicist before he can be a medical ethicist. And the former remains his prior, his more basic identity even after he has become a "medical" ethicist. Whether we "do" our ethics out of theological, philosophical, behavioral scientific or some other starting points, our identity as ethicists is a necessary prerequisite to doing medical ethics.

This conviction has several grounds and several implications. The implications are of more interest here. First, it means that however deeply we get involved in medical ethics we cannot afford to let our roots in critical ethics, wherever they are sunk, wither and die. If that happens we have nothing to offer in the medical or any other area but intuitive

ad hoc suggestions. Secondly, it means that we need not be medical experts in order to do medical ethics. We need not "read all the literature." The medical people with whom we converse must keep up with their field. And we need to be "up" enough to be able to join in their conversation without bringing it to a dead halt by continual requests for elementary information. But unless we have paraded ourselves as medical experts we have no need to be such in order to do medical ethics. The feeling that we must be informed on every breaking medical story rests on the assumptions that every medical advance raises new ethical problems, and that only we can solve those problems. Both assumptions are false. Most medical advances offer new occasions for bringing to bear long established values, commitments or principles, but seldom do they raise totally new issues. Heart transplants, while radically new technically, were humanly and morally still about the value of life, respect for life, respect for the dying, etc., values which have helped shape moral reflection for millenia. The second assumption is also false. We need not, in fact we cannot without preempting the moral agency of the medical personnel and the patient/subjects involved, make the applications of the principles or values in every case. Such applications lie in the realm of prudence, a virtue which every agent must exercise for himself. We cannot assume that when we as professional ethicists are not on the "cutting edge" of medical advances, there is no one there to deal with the ethical implications.

The above items, kept firmly in mind and said aloud when others overlook them, can contribute to progress in medical ethics. Where the above seems too harsh on ethicists it should be taken as a personal confession of this ethicist and not as a rebuke aimed at medical ethicists in general. Where it seems too gentle on the medical professionals and institutions it should be taken not as a rejection of needed critical and sometimes divisive moral analysis of the difficult problems in medical practice, but as a plea for mutual understanding between ethicists and medical professionals as well-intentioned fellow seekers of the good. It is hoped that such an understanding will make it possible for ethical debate to center on the crucial substantive issues facing us in medicine rather than on the personal failings of which we all have our share.

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1. Moore, Charles B., "This is Medical Ethics?" *The Hastings Center Report* 4 (Nov., 1974), 1-3.

2. See B. B. Page, "Who Owns the Professions?" *The Hastings Center Report* 5 (Oct., 1975), 7-8.