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Philosophical Challenges in Teaching Bioethics: The Importance of Professional Medical Ethics and its History for Bioethics

Laurence B. McCullough
Baylor College of Medicine, Houston, TX, USA

ABSTRACT

The papers in this number of the *Journal* originated in a session sponsored by the American Philosophical Association's Committee on Philosophy and Medicine in 1999. The four papers and two commentaries identify and address philosophical challenges of how we should understand and teach bioethics in the liberal arts and health professions settings. In the course of introducing the six papers, this article explores themes these papers raise, especially the relationship among professional medical ethics, the ''long history'' of medical ethics, and bioethics. The tendency of bioethics to deprofessionalize medical ethics is rejected, in favor of an historically informed professional medical ethics. It is suggested that bioethics should be critically reconsidered from the perspective of medical ethics as professional ethics.

Keywords: bioethics, history of medical ethics, professional medical ethics

I. INTRODUCTION: WHAT WE DO FOR A LIVING

Most of us in the field of bioethics make our living and our lives – in whole, large measure, or part – from teaching. In the course of this very interesting way of life, we encounter a wide range of philosophical challenges. These include getting clear on what bioethics itself is, what medical ethics is, the relationships that should be understood to obtain between the two, acceptable methods and how to present them (at first or in the context of clinical cases and policy questions), topics and how to present them, and the relationship between bioethics and medical ethics, on the one hand, and philosophy, on the other.

Address correspondence to: Laurence B. McCullough, Ph.D., Center for Medical Ethics and Health Policy, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030, USA. E-mail: mccullou@bcm.tmc.edu

There is much informal discussion of these philosophical challenges in our field, but they do not often receive priority in our scholarship. As a corrective, when I was a member of the American Philosophical Association's Committee on Philosophy and Medicine, I volunteered to organize the Committee-sponsored session at the East Division Meetings (this is really the national meeting) of the Association, in Boston, Massachusetts, in December, 1999. I invited six colleagues for whom I have the highest regard as philosophers and teachers of bioethics to present papers. Richard Momeyer and Rosemarie Tong gave papers, on which Stephen Wear commented, and Robert Baker and Maureen Kelley also gave papers, on which Rosamond Rhodes commented. In response to the commentaries, the four authors of the main papers undertook revisions of their papers and the commentators generously undertook to rewrite their responses. As the Guest Editor for this number of the *Journal*, I have the privilege and delight to lay the results before the reader.

II. RELATIVISM, PLURALISM, AND PROFESSIONAL MEDICAL ETHICS

Richard Momeyer opens our consideration of philosophical challenges in teaching bioethics by questioning the view that the discovery of moral truths in bioethics results from applying theories of moral goodness and moral right to concrete circumstances. On this view, one would begin a course in bioethics with a consideration of major ethical theories and then explore critically the implications of those theories for topics and morally problematic cases. As a counterpoint – and explicitly *not* as yet another tired exercise in ''principlism bashing'' – Momeyer suggests a different way of conceptualizing applied ethics generally and bioethics in particular. His argument is to the effect that moral truth emerges from a ''process of inquiry conducted in a certain manner.'' Moral imagination plays an indispensable role in this inquiry, inasmuch as it underscores the important role of narratives in helping to identify ''embedded norms of a particular practice.'' Wide reflective equilibrium is then brought to bear. Moral truths in this pedagogy emerge from the resulting, philosophically rigorous reflection on practices and exhibit an interesting and potentially fruitful instability. Managing that instability in a philosophically responsible fashion prevents the disability of moral relativism.

Rosemarie Tong takes us on a journey through her teaching during her career, from application of ethical theory and principlism, to ways of doing

ethics that emphasize emotional and interpretive skills, to classical American pragmatism, to narrative and then feminist and postmodern approaches to bioethics. Morality in general and bioethics in particular involve both becoming a good person and making right decisions. The postmodernist philosophical challenge, especially, questions whether there are any substantive, shared guides to character and behavior. Tong finds an antidote in the work of Uma Narayan (1977), who argues that it is possible to engage in a critical evaluation of cultures and traditions from both inside and outside them, and in Martha Nussbaum's (1999) work on the ''capabilities'' approach. The result is a method for bioethics that embraces a pluralism of moral traditions and judgments, but counters relativism by reminding students about our discoverable samenesses in a sustained Habermasian democratic conversation (Habermas, 1979).

In his response, Stephen Wear underscores at least three main differences between bioethics teaching in the liberal arts setting and in the setting of medical education, ''at or near the bedside.'' First, medical educators teach and train medical students, residents, and fellows to take care of patients. The results of our teaching are carried into effect in the clinical setting, in which some outcomes – preventable and unnecessary death, disease, disability, pain, distress, and suffering – are not acceptable. Second, the teaching settings are very different from those of the traditional liberal arts classroom, ranging from hospital wards to committees that write and implement ethically substantive organizational policy, e.g., concerning when requests for futile treatment by patients or family members may justifiably be overridden (Brody & Halevy, 1996). Third, stable and settled moral truths are taught and implemented – e.g., competent, adult patients are in authority over themselves and cannot be treated without their permission except in emergencies (life-threatening circumstances in which there is no time for the informed consent process in even a quick form) – and relativism plays a role only in areas of clinical ethical controversy. Ethical issues about authority and its proper use and abuse come to the fore, including the authority of the medical educator who teaches bioethics ''at or near the bedside.''

III. BIOETHICS, HISTORY OF MEDICAL ETHICS, AND PROFESSIONAL MEDICAL ETHICS

Robert Baker criticizes a common approach to bioethics as applied ethics (in the sense also criticized by Momeyer) because it results in an ahistoric and

rationalistic account of bioethics and medical ethics. Analogously to Thomas Kuhn's classic critique of philosophy of science, Baker argues that bioethics would become ''deeper, richer, and more philosophical'' were it routinely to integrate into its self-understanding – and therefore into its textbooks and teaching – the ''long tradition'' of medical ethics (Jonsen, 2000) that precedes bioethics. Critical attention to the history of medical ethics would bring to the fore analysis of moral change as central to the self-understanding and teaching of bioethics, as well as of ethics generally. An historically informed conceptual and pedagogical approach to bioethics would provide an important counterpoint to the historically inaccurate view – implicit in many textbooks of the field – that everything in the field of bioethics is up for grabs, that there has been no successful management of moral change in clinical practice or health care policy. To be sure, whether therapeutic cloning should be permitted for the purposes of obtaining stem cells for treating diseases in the individual cloned is enormously controversial, because this topic is inextricably tied up with intractable (and therefore engaging for ahistoric bioethics) disputes about the moral status of very early prenatal human life forms. The view that bioethics is inherently and endlessly controversial simply ignores the achievements that have been made, e.g., concerning informed consent and end-of-life care. Baker also mounts a powerful critique of the ''engineering'' model of bioethics. Just as engineering transforms and does not simply apply science, so so-called applied ethics transforms ethics and philosophy, as Baker shows in the pivotal historical figures, Francis Bacon, John Gregory, and Thomas Percival. Not only does the history of medical ethics become integral to bioethics, the history of medical ethics becomes integral to the history of philosophy.

Maureen Kelley undertakes a reflection on professional ethics in the context of teaching across the health care professions. Professional ethics has taken an agent-neutral approach to the moral dimensions of practice, emphasizing role-related rather than individual or personal judgments about the propriety of character and behavior of clinicians. Kelley identifies a number of changes within the health care professions and health care organizations – particularly team-based decision making and clinical care – that challenge the adequacy of an agent-neutral approach to ethics for the health care professions. Kelley argues that greater prominence should be given in professional health care ethics to the individual professional's understanding of his or her role in team care and the moral life of a health care organization.

In her response to Baker and Kelley, Rosamond Rhodes distinguishes two senses of medical ethics. The first concerns medical ethics as a subject-area of applied ethics. The second concerns the ''professional moral commitments'' of physicians and the other health care professions, which share essentially the same professional ethics as medicine. Rhodes argues that the second sense of medical ethics should certainly include the history of medical ethics but not include reference to agent-relative judgments, referring rather to the role-related, agent-neutral fiduciary responsibilities of health care professionals to their patients. Rhodes draws on the work of John Rawls to construct a philosophical account of a professional ethics for medicine.

IV. MEDICAL ETHICS, HISTORY, AND BIOETHICS

This set of important, provocative, and engaging papers suggests that where we make our living as teachers has a great deal to do with how we should understand bioethics, medical ethics, and philosophy and therefore undertake our teaching of them. In liberal arts education, the teacher of humanities is usually understood to be responsible for giving students the critical intellectual tools that they then need to use, as they see fit, to form themselves for their lives after college or university, as citizens, parents, working people, and the other social roles from which human beings derive meaning and satisfaction. Understanding bioethics as inherently controversial is an attractive view for the teacher of bioethics in the liberal arts tradition, because it invites and reinforces the role of the professor as neutral to students' work of individual moral formation; teaching the view that there are settled truths that should be accepted by students could be seen as an illicit boundary crossing and therefore an abuse of professorial authority in the liberal arts classroom.

On Momeyer and Tong's accounts, it would be permissible for students to reach such judgments on their own, but (almost) certainly not appropriate for the professor to announce settled truths of the kind Wear identifies. Wear is correct to point out that, in medical education, there are settled truths – the welcome results of the very history of successful management of moral change that Baker underscores – that we teach again and again, so that each student, resident, and fellow learns them and understands that the standard of care requires adherence to them. It is simply not permissible to perform heart catheterization on an adult, competent patient without his or her permission (except in emergencies) and the information that a patient has had this

procedure is not to be released to anyone without authorized access to such information. In this respect, teaching medical ethics is like teaching students the conceptual and clinical skills of interpreting an electrocardiogram, for which there is a settled science and its clinical application. Rhodes is correct that medical educators are responsible, all of them, for the professional formation of medical students, residents, and fellows. Teachers of medical ethics are no exception and the neutrality of the liberal arts classroom should be and is considered a failure of professors' responsibilities. Wear's concerns about abuse of authority come to bear here; teachers of bioethics ''at or near the bedside'' have an obligation to their students and patients to prevent such abuse.

Baker's critique of the ahistoric view of bioethics is decisive, in my judgment, because ahistoric methods of bioethics fail to bring the indispensable critical perspective of historical study and reflection to bear on bioethics. As a result, bioethics is at risk for becoming unhinged from the humanities, just as some methods in contemporary philosophy have become unhinged from the history of philosophy and, as a result, also become desiccated and uninteresting (though not without political power in philosophy).

Bioethics from its beginnings in the late 1960s and early 1970s has often had a breathless quality, treating every new scientific, technologic, and clinical advance in laboratory science, clinical practice, organizational change, and health policy as ''new and unprecedented'' changes that threaten to ''outstrip'' or ''outpace'' our capacities to reflect on and manage them in a morally responsible way. To be sure, emphasis on this sense of the new may help to build enrollment and enhance our job security. However, this view makes sense only if one holds the belief that there has been to date no successful management of moral change – a belief that is, unfortunately for its adherents, false, as Baker shows decisively. Managed care, for example, is but the latest chapter in a history of attempts to manage the practice of medicine that began as early as the eighteenth century in Britain and in response to which physician-ethicists such as John Gregory and Thomas Percival developed sophisticated ethical critiques that remain applicable to clinical and management decisions in contemporary health care organizations (McCullough, 1999). Ashby Sharpe (2000) has recently provided an important account of the development of accountability of physicians for quality, a crucial aspect of well-managed managed care, from the early eighteenth through the first half of the twentieth centuries, and identified the ethical significance of this history for moral critiques of managed care. Most of the current literature on ethics in

managed care is impoverished by its failure to attend to this history and thus fails to address a central ethical concern that emerges from that history: preserving medicine as a fiduciary profession through a centuries-long – not decades-long – history of organizational change (McCullough, 1999).

An historically informed and shaped concept and pedagogy of medical ethics as *professional* medical ethics becomes a powerful counterpoint to the view, common in bioethics, that medical ethics is just another sub-field of bioethics. The problem with this account is not just that it is ahistorical, which as Baker shows is already bad enough, but that it *de-professionalizes* medical ethics. If Rhodes is correct that we can successfully undertake a Rawlsian construction of medical ethics as indeed professional medical ethics, this view of the relationship is philosophically suspect, at best, and decrepit, at worst. Moreover, this view of the relationship between bioethics and medical ethics de-professionalizes medical ethics at a time in which medicine needs its professionalism as an antidote to the ethical challenges raised by long-standing conflicts of interest in clinical practice, in managed care no more or less than in fee-for-service, and in clinical research, as recent tragic events at major American academic medical centers have made plain. The morally responsible management of economic and other forms of conflict of interest is neither ''new'' nor ''unprecedented.'' John Gregory and Thomas Percival, the central historical figures in Baker's paper, took conflicts of interest to be of paramount ethical concern for medicine as a fiduciary profession. Indeed, Gregory can be read as writing the first modern professional ethics in the English language precisely in response to what he took to be a moral crisis that resulted from irresponsible management of conflicts of interest by then-contemporary physicians in clinical practice *and* clinical research (McCullough, 1998). A bioethics that took a neutral stance on physicians' economic and other conflicts of interest, treating them as endlessly open questions, and therefore de-professionalized medical ethics would, Gregory and Percival would correctly point out, mean the death knell of medical ethics as professional ethics. At a time in which there are increasing calls for professional integrity to protect vulnerable patients and research subjects (Kahn & Mastroianni, 2001) in response to the crisis of professionalism in medicine generated by the entirely voluntary decisions of physicians and health care organizations, de-professionalized medical ethics becomes part of the problem, not part of the solution. From the critical perspectives on bioethics afforded by professional medical ethics and the history of medical ethics, it is past time to rethink the nature of bioethics, its relationship to medical

ethics and its long history, and therefore to critically re-assess bioethical pedagogy.

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