I. Why Professional Ethics Now?

"ONE BAD ETHICAL DECISION," warns the ad copy for a new professional newsletter, "could destroy your career." But for the low subscription price of $148.00 the informed professional can "forestall costly lawsuits, avoid unnecessary conflicts with patients, and minimize the time spent with institutional review boards." Taking care to be ethically correct, from the professional’s side at least, can signal simply canny self-protection. Indeed, everywhere the message to professional practitioners and aspirants is to focus on self-interest in the narrow sense. The lay public seems less and less to look to the doctor or lawyer for wise counsel. Today the concern is whether the professional’s malpractice premiums are paid up.

The evident worry among physicians that ethics is necessary to self-protection seems to confirm from another angle what Time magazine announced in late July of 1989: Americans are unhappy with their system of health care. Compared to a decade ago, fewer people say they are satisfied with the health care they receive, and a majority believe that doctors are "unfair in the prices they charge." Americans, it turns out, are considerably less happy with their health care system than are citizens of countries such as Canada and Great Britain. Time concluded that public hostility toward physicians is on the rise and "doctor bashing has become a blood sport." These findings suggest that the rising concern with professional ethics, at least among health care providers, has other sources besides an upsurge in conscience among practitioners. It is part of a larger national worry about the integrity of many central institutions and practices, ranging from business to education, religion, and government.

Today, the professions increasingly appear to be part of this larger problem of institutional integrity. As Americans worry about the soundness and moral responsibility of their institutions, medicine seems to be much on their minds. Compared to other industrial countries, medicine in the United States has long enjoyed an extraordinary degree of autonomy. The result, until very
recently, has been physician-controlled health care. The record is one of impressive achievements in health care for many, and yet also a case of abused autonomy and failed public responsibility. It is noteworthy that, compared to Canada and the Western European countries, the United States has consistently lagged in the areas of public health, preventive medicine, and universal inclusion in health care benefits. As recently as the 1960s, however, as for much of the twentieth century, the professions seemed to many to offer solutions to personal and social problems while to many medicine appeared the model of a mature profession.

The professions once seemed to be embodiments of the American middle-class aspiration to contribute something of value to the world while achieving a respectable status. Yet, the professional ideal gained legitimacy in the United States not just as a middle-class notion but as a kind of cultural universal. Not that everyone was expected to become a professional. Rather, the professions' espoused values of competence, dedication, and service embodied a vision of how technical expertise could be made socially useful, leading individual ambition to serve the larger good.

The economic dynamism of commercial competition has typically gone together with considerable economic inequality, and nowhere more so than in the United States. From time to time this has posed problems for a nation committed to democracy. An increasingly complex, technological division of labor has increased the demand for specialization, with its concomitant diversification of social perspective. For reformers earlier in the century professionalism seemed to provide a way to mitigate these tensions. The merchant might provide whatever was asked for the end of personal gain. By contrast, the professional, guided by an understanding of public responsibility, could be trusted to render what was needed. By combining learning, skill, and public service professionalism itself became an ethical ideal.

Since the high-water mark of professionalism in the 1960s, however, that ideal has come under increasing criticism and attack. The conspicuous failures of public policies formulated by experts in the arenas of world politics, urban reform, social welfare, and education have fueled skepticism about professional claims to superior knowledge. The abuse of privileged positions by greedy professionals without effective control by their peers has weakened the public legitimacy of professional self-regula-

professional ethics, ethos, and integrity

In a less stable, more interrelated yet highly competitive economic environment, old authorities have not always proved up to the challenge of adaptation. As professional authority has come into question, professional privilege has become less obviously a self-evident good. It is in this context that we should locate the concern with the issues the advertisement alluded to: conflict over jurisdiction, standards of practice, public oversight—and professional ethics.

By embracing a concern with ethics, professional groups, such as the American Medical Association and the American Bar Association to name only the most prominent, can hope to pour oil on the disturbing waves of public animosity, while at the same time promoting a renewal of purpose among their own membership. Getting serious about ethics, as opposed to intrusive governmental or other outside intervention, is a means of safeguarding the principle of professional self-regulation while addressing real grievances. But the importance of the questions behind professional ethics is far greater. Professional ethics points toward the vital matter of the changing nature and role of the professions in a democratic society.

II. Professional Ethics As Response

In recent years the most developed area of professional ethics, that of biomedical ethics, has been dominated by a conception of ethics which originated in the academic discipline of ethics as understood in Anglo-American philosophy. This academic philosophical ethics has traditionally concentrated on what is known as ethical theory. For this tradition, ethics is a field of general and abstract theory, concerned to delimit the timeless and universal principles thought to underlie the use of terms such as the right and the good. Only in recent decades have philosophers trained in this approach turned in any significant way toward the concrete problems now being addressed by biomedical ethics and professional ethics more generally.

Professional ethics, within this perspective, is considered an applied field ultimately dependent upon the findings of ethical theory. In ethical theory the dominant questions concern the logic, scope, and justification of the universal principles of the right and the good. Within applied ethics, by contrast, these issues hold important but not the dominating positions. Instead, the role of
The ethicist is to help practitioners apply ethical principles and rules to situations, especially those in which the application of common norms such as “Do no harm” is complicated or unclear. The applied ethicist is often cast as a kind of coach. Ideally, the ethicist should try to provide professionals with a grasp of the whole theory of ethical norms, including their justification, in order to facilitate the work of application. “Apply” is used in this tradition in a particular sense of “deduce.” That is, applied ethical thinking means above all the ability to properly describe actions and situations so that they can be fitted into the general principles and rules elucidated by the general theory. An ethical quandary can be considered resolved if and only if a decision regarding it can be shown to instantiate general norms prescribed by theory.

It is just on this point of application, however, that a different conception of the nature and scope of ethical thinking stakes its claim. This is the approach which concentrates upon ethos rather than general ethical theory. In contrast to the deductive conception of applied ethics in which regulatory principles and rules subsume particular cases as instances of a general norm, this alternative focuses upon the settings and character of professionals and professional life. Its divergence from deductive applied ethics shows up in its insistence that, as the word’s etymology suggests and Aristotle once argued, ethics is concerned with custom and character—both variants of ethos in Greek—and their consequences for the quality of human life.

This view articulates a different conception of the role of “theory” in ethics. Here theory is not so much a body of general principles as a search for a connected view of things which develops in close relation to concrete cases and experience. The function of this kind of theory is not to provide the basis from which to deduce solutions to ethical problems or to prioritize rules in the event of a conflict among duties, but to assist reflection and to contribute to the development of judgment. Applying principles and rules requires judgment and, as Immanuel Kant had noted early in the development of modern rule-ethics, the act of judgment whereby “the practitioner decides whether or not something is an instance of the rule” cannot always be guided by a rule “for that could go on indefinitely.” For this alternative conception, then, ethos is central because it is customs and practices which ultimately form the imagination and shape judgment. Therefore, proponents of this approach argue, it is ethos which guides professional action more than any discrete principles or rules. The ethos approach has affinities for a casuistic approach to ethics, a tradition of reasoning much like certain types of law in which principles and decisive cases mutually influence and determine one another.

A concern with ethos expands the focus of attention from the choices of individual practitioners toward the institutional contexts within which those practitioners must act. In this way, concern with ethos can lead, if pursued consistently, to a shift in the ethicist’s posture as well. While there is nothing to prevent a deductive applied ethicist from questioning the social basis of a conflict among ethical rules, a reflective focus upon ethos is more likely to develop in the direction of an understanding and criticism of the institutions of professional life, including professional organizations, education, and the settings within which professionals practice. This is because ethicists who take seriously the rooting of judgment in character and context cannot logically see themselves simply as experts in normative thinking, leaving the “merely” descriptive analysis of social conditions to historians and social scientists. From within the ethos perspective, normative concerns ineluctably ought to bring ethicists to seek a clearer understanding of the complex social reality which shapes professional judgment and its norms.

Through its concern with professional ethos, then, the second type of ethical thinking can return us to the social and historical context of which the rise of professional ethics is part. But ethical investigation, as it seeks to locate itself within the larger developments to which it is in part a response, finds itself having to become self-reflective. Beyond the stance of critic, the ethicist comes to take up the question of his or her responsibility as a participant with other professionals, their institutions, and their clients in the larger social and political life of the society.

This third, more inclusive approach raises the issue of the integrity of the professions as institutions. The awareness that personal identity is constituted through participation in a variety of communities, each with their moral demands for commitment and fidelity is the contribution of the ethos tradition in ethics. This insight requires completion in the realization that individuals

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can develop and be fulfilled as persons only through the institutions that link them to others. Institutions cannot, however, be understood as simple instruments or tools for individual purposes, though this notion is common in American culture, scholarly as well as popular. Like persons, institutions are entities whose identity is bound up with norms of the good and right. There are good families and not so good ones; good businesses, schools, professions and others which fall in some important way to be complete and faithful embodiments of their declared purposes.

The question of institutional integrity poses the question of whether an institution, such as a medical center or even medicine as such, is functioning in such a way as to support and promote the values central to its character. This question is both an ethical one and a political one, in the classical sense of politics as public deliberation about the organization and conduct of social life. And the question of institutional integrity suggests yet another stance for the ethicist: that of responsible fellow-participant or citizen. From this perspective, I will try to show, it becomes possible to view the concern with ethos as a step toward a more inclusive understanding of the ethical dimensions of professional life. This broader perspective reaches its full development in a conception of institutional integrity which will be illustrated in the case of medicine in the final sections of this paper.

III. From Applied Ethical Theory to Ethos

To make good on this claim, biomedical ethics can continue to stand in for professional ethics more generally, remembering that it is simply a particular, if important, example of larger issues. The rising sense among the public that things are wrong in health care generally and among physicians in particular is intelligible in light of the major changes which have been at work for some time in medicine. An explosive growth in technology has been paralleled by rapid organizational change. After decades of maintaining its institutional independence, American medicine is being more tightly integrated into the larger economy and politics. One consequence of this integration is that the modes of organization typical of the corporate economy and government have spread through the health “industry,” limiting professional control and threatening the long-cherished professional autonomy of physicians through devices such as insurance and reimbursement procedures.

In a situation where peculiarities bred of long-standing immunities to competition and scrutiny are teetering, one would expect a search for ways to justify traditional practice and privileges in less parochial, more universal terms. That is, one would expect a search for agreement about standards and an effort to “establish priorities” in the form of rules for practice and decision making so as to provide guidance for troubled practitioners and a confused public. This is, of course, very much what has happened. But does the approach typical of deductive applied ethics enable us to deal with the contemporary misgivings about medicine in a satisfactory way? Or, must that approach be supplemented by a critical concern with the institutionalized ethos of medicine?

Perhaps these very broad questions can be rendered more manageable by focusing on salient aspects of the changing field of medicine. Doctors, patients and their families, nurses and other health professionals, insurers, administrators, government, employers, and the general public have become increasingly dependent upon one another. This has been the unplanned result of their many separate decisions to seek health care through a complex and growing system which is now driven by technological advance and the allocation of ever larger quantities of economic resources. Even without considering the largely neglected issues of prevention, public health, distribution of services, and universal inclusion, this emerging “medical-industrial complex” has rapidly overwhelmed American society’s traditional understandings of medical practice and the relationships which grow out of it.

To get an idea of the nature and direction of the change, consider the contrast between the patient’s experience of the modern health organization and American medicine of even recent history, say, the early post-World War II decades. Think of the typical physician—in solo practice—and physician’s office in those years. A patient visiting a general practitioner or an internist in family practice in those days was, even in the era of antibiotic wonder drugs, very likely to receive a good deal of hands-on treatment. The office itself was often draped with an iconography expressive of the professional ideal. Very common were prints depicting figures from the ancient world, such as a scene in which a surgeon risked his life by dressing a wound on a battlefield surrounded by attentive students, each a future healer. Another was
the familiar Norman Rockwell magazine cover which rendered an avuncular local doctor taking care of a young patient. These images evoking both care and trustworthiness often hung in juxtaposition to various diplomas and charts which announced the precise, scientific basis of the practitioner’s art.

In sharp contrast, the contemporary medical center or health maintenance organization office is likely to contain some of the trappings of science, but often in a setting which in style could be any corporate office suite. The iconography of heroic devotion to duty and the sacredness of the healer’s office have been stripped down to the symbolism of efficiency and technical effectiveness. Of course, the present age of hospital review committees, concerns with gender and cultural diversity, and patients’ rights marks a genuine advance over the implied paternalism of the Rockwell image.

But there is also something missing in the environment of much contemporary medical practice. One need not be nostalgic for some imagined better time to notice that there seems to be little suggestion of either the nobility or the humanity of medicine which the old icons conjured up. A professional, a “real doctor,” has meant someone who could be counted on to keep faith because of dedication to important values and purposes. The public is apparently far less sure that this holds true for physicians today. With the evolution of the contemporary medical-industrial complex there have been genuine moral gains in areas such as accountability and patients’ rights. Yet the ethos of medicine seems somehow in trouble.

What kind of ethical response is appropriate? Should we assume the perspective of an ethics coach, a critic, or an attentive citizen? On the one hand, advocates of the deductive applied ethics approach argue that since physicians, patients, and institutions are less and less able to rely on the old taken-for-granted ethos of medicine, a search for general principles becomes essential. Yet critics of deductive applied ethics respond differently. They argue that at the core of the problem is confusion and weakening in the ethos of medicine. In today’s more complicated and shifting environment, say these critics, it will be impossible to sustain or improve professional responsibility without special attention to the interconnection of institutional setting and character in the formation of professional judgment. The situation is in fact quite complex, and both positions have, on first examination, considerable merit. Let us briefly examine both claims.

In a situation in which physicians and their institutional contexts are undergoing the stresses of growing complexity and interdependence, it is not surprising that doctors would be unclear about who they are becoming and what they should do. It is just such situations which create the demand, as Robert Veatch has written, for “some ordering of that chaos we term a tradition, some systematic structuring of medical ethics.”11 The purpose of this “ordering,” according to Veatch, is that “physicians, other health professionals, government health planners, and consumers of medical care... can have some grasp of where they stand and why they may be in conflict with others with whom they interact.”12

From the desirability of this theory—in the sense of a thoughtful overview of the situation—Veatch proceeds to argue the need for ethical theory in the special, technical sense. Such a theory aims to produce a set of universal principles “governing social relationships” in general. Only from the perspective of such a unified theory of ethical norms, which would be applicable to all social relationships, can we hope to deduce appropriate principles for the guidance of medical relationships. Medical ethics, in other words, would become a special case of the more general theory.13

Certainly part of the appeal of this conception of professional ethics derives from its use of a rhetoric borrowed from the natural sciences. A “general theory” is to provide the principles governing all phenomena within a specified domain, thus providing the basis from which to deduce the “special theories” applicable to particular domains, such as medical relationships. Particular cases, ranging from confidentiality to abortion to euthanasia, can—so the theory goes—be resolved once they have been subsumed under the appropriate rules and principles. Like natural science, applied ethics is wont to speak in terms of “universal” theory, thereby drawing a sharp contrast to the “chaos that we term a tradition” or, perhaps, an ethos.

On the other hand, advocates of the ethos-perspective, or as it is sometimes called, virtue ethics, dispute the applied ethicists’ implied claim to have grasped in theory the ethically relevant aspects of the practices and relationships they seek to order. The neglect of such aspects of traditional doctoring such as “moral sentiments, the value of moral traditions, and the role of virtues"
has, according to Larry R. Churchill, led ethicists such as Veatch to pose questions in "a thin and unproductive way." The result, says Churchill, is implicitly to deny the possibility of moral pluralism in the rush to subsume particularity under general rules.

Instead of asking, "Are there special principles of medical ethics?"—a question which immediately poses the further problem of the priority of any such principles to the "universal" principles—Churchill suggests another. The better question is, "Should the moral sensibility of doctors be tuned and tuned to different nuances of situations than those of individuals who do not practice medicine?" The point is to focus on the particular kinds of judgment and capacities which the responsibilities attendant upon the identity of physician demand. The particularity of that focus follows from the observation that the role of physician is of such a nature that it cannot be easily put on or off. Becoming a competent physician is more than simply playing a role if by role is meant a social identity quite separate from the real self. On the contrary, taking the role of physician entails a profound shaping of character. By nature, this argument has it, medicine's particularly weighty responsibilities require such an ethos even for their full comprehension, let alone their correct execution.

Among advocates of the ethos- or virtue- position, Alasdair MacIntyre has developed this relationship between "role" and "character" most powerfully. MacIntyre argues that it is one of the salient characteristics of contemporary bureaucratic culture that this traditional distinction is ignored. We could go on to argue that when persons do not see an institution as an entity to which they are importantly obligated, then they will view it as simply an instrumental device governed by impersonal rules. Today, the law is often seen in this way, even by lawyers, while the family generally is not, though schools and educational institutions are becoming increasingly instrumentalized.

These developments are not merely the result of subjective judgments on the part of individuals. The pressure to make institutions of all types—even in extreme cases the family—conform to the model of cost-effectiveness and maximum yield of individual utility arises from the workings of the modern institutional order itself. However, while most institutions exist in part for instrumental reasons, once institutions become instrumentalized to the point of losing any claim upon the loyalty of his partici-

pants, they cease to serve as communities of character. As a result, in the increasingly bureaucratized settings of modern organizational life (such as today's medical practice), the typical understanding of relationships may describe and perceive relationships exclusively in terms of "roles" in the morally trivial sense, oblivious to the whole dimension of character.

When this occurs, ethos is weakened and society can no longer rely on the spontaneous actions of the members of particular institutions to preserve their integrity. As a fail-safe device, in the absence of an effective ethos of character, a society may seek to control these institutions through ever more precise impersonal rules. It is in this context that the distinction between the individual conceived as a maximizer of purely subjective preferences and the "role" makes descriptive sense. It is an empirical question to what extent this effort is necessary and whether it can be successful. But it is a dubious empirical proposition that the institution of medicine can, even today, be adequately understood in this way.

Medicine has been traditionally understood to be a vocation, and with good reason. Good medicine depends upon the more complete blending of personality with social role and responsibility which the term character designates. A description of medical relationships which begins from the assumption that the roles involved lack characterological dimensions misses the particularly close fit between motives and skills found in vocations which form and call for character. This is the difficulty with trying to base ethical judgments on principles thought to apply to any and all human relationships. But the integrity of an ethos, whether in the family, education, the law or medicine, depends directly upon the social conditions which allow and reward this development. The most important of these social conditions is institutions. Seen this way, medical institutions have integrity to the degree that they are guided by concern for the values and practices which define good medicine. A good institutional organization of medicine is, thus, one which enhances the quality of medicine by supporting the ethos needed for its practice.

These reflections raise a serious problem about the adequacy of universal, deductive ethical theories as the sole basis for judgment in professional ethics. Can any approach to professional ethics which views the distinctive ethos and character of medi-
cine as only casually relevant to ethical issues be a useful guide to understanding what is at stake in biomedical ethics today? To the degree that theories aspiring to deduce principles for social relations in general are generalized uncritically from accounts of bureaucratic or marketing action, they may simply fail to include aspects of the situation which have major bearing upon moral questions.

The critics of applied ethics, then, lodge a strong objection. Specifically, does such an understanding help in clarifying and developing the models of loyalty, service, and heroism to which medicine has laid claim? Or, does it submerge these values in a conception of social role and relationship which can only mislead and distort when applied to medicine? The answer to this question will depend, of course, on how we view medicine and its place in modern life, and specifically upon how we view the integrity of medicine in its current forms. This, however, is itself an ethical and political question. The approach we take toward issues in professional ethics turns out to be implicated in the larger questions of the goods involved in the political order itself.

IV. Liberalism, Medicine, and the Good

Let us now pose the question in a different way. Can the political and moral theory of liberalism, as exemplified in the received view of applied ethics, provide the support and guidance needed by medicine in order to flourish under modern conditions? We need to notice that there is a strong “fit” between the assumptions of liberal political theory as that tradition from John Locke to John Rawls and the conception of ethical theory used in deductive applied ethics. Traditionally, liberal theorists have been at pains to argue that liberalism could secure universal consent from all right-thinking persons. Theirs was a theory of political association which aimed to sustain a legitimate polity in the absence of religious or philosophical beliefs about the meaning of human existence, unburdened by the need for any consensus about the ends of political life beyond the protection of individual freedom and equality.17

Today those assumptions have been opened to doubt. In the face of critics there has been growing acknowledgement on the part of advocates of philosophic liberalism that their argument does presuppose a conception of the ends of political association, or a vision of the good life. As a consequence, leading liberal theorists have retreated from their formerly universalistic mode of presentation. It now seems a matter of general agreement among both liberals and their critics that the vision of the good life assumed by liberal theory is one which prizes security, comfort, and individual opportunity. It simultaneously eschews absolute and binding commitments which might interfere with the achievement of this conception of the good.

Because of this dominating conception that the end of political association is individual self-realization, contemporary liberal theorists have followed John Stuart Mill in placing great emphasis on individual autonomy. One consequence has been the great amount of attention liberal ethicists have placed on the question of when paternalism is or is not justified.18 Whether in politics or in ethics, then, the liberal vision holds important implications for medicine as for all other major social institutions ranging from the family to the state.

For example, liberalism has developed a specific conception of the professional. He or she is a person who receives considerable autonomy in work in exchange for accepting the responsibility to use special knowledge and skills to promote specific values, such as health or legal justice. But these responsibilities make sense as part of a consensus on the overriding value of guarding and expanding the possibilities for self-realization for all. This understanding has been especially marked in the realm of biomedical ethics. In tandem with the movement for patients’ rights, which the theory has helped promote, this liberal concern, and thus bioethics, has had real impact on the practice of medicine.

The liberal vision of the good life thus legitimizes professionals in a specific sense. They are persons licensed to intervene so as to provide specific assistance toward enabling persons to achieve full self-development, however they conceive that aim, within the requirements of fairness. But this conception of the good life is neither as neutral nor as utterly open as it appears. Like all other conceptions of the good life, it relies for its plausibility and ultimately its legitimacy on a certain arrangement of social institutions.19 The institutional conditions for philosophic liberalism are the market system, the bureaucratic state and organization, and the complex interrelationship between science, technology, and production which fuels technical progress.20 It
is this institutional pattern, with its distinctive ethos of individual freedom, which has come to play a large role in shaping the context of modern medicine.

The troubling question raised by proponents of a distinctive medical ethos such as Churchill is whether physicians, and medical relationships as a whole, can develop rightly within organizations which are guided primarily by the imperatives of the market and technology. This question, however, shifts the focus of the discussion from a debate between two rival schools of moral philosophy to a matter of public importance. Recently, Daniel Callahan has made a strong case which frames the issue in just such public terms, as a matter of import for citizens. Callahan questions whether the dominant liberal ethical and political understandings are adequate to guide American society as it confronts increasingly difficult choices concerning medicine and aging. We will follow Callahan’s argument part of the way in order to suggest how such work may lead toward much-needed supplements or even replacements for the inadequacies of the liberal model of professional ethics.

In Setting Limits Daniel Callahan has described how the technological augmentation of the powers of medicine has encouraged an expansionary vision of life and health. This expansionary vision has strong affinities for the liberal vision of the good life. Its practical premise is the same set of institutional arrangements which has undergirded the growth of the consumer society, and like that form of life, the expansionary vision of life and health has met any notion of limit as a threat to autonomy.

In what Callahan calls the “modernization of old age,” the later years of life have become to be looked at as a time for individual self-realization beyond responsibilities to the younger generations or society at large. Long life and health have become normal expectations, not the results of good fortune. “Modernized” old age, writes Callahan, “is no longer a time of old-fashioned disengagement and preparation for death.” Instead, it becomes a “continually active involvement in life and a persistent struggle against decay and demise.”

The consequences of this change have been profound. “Medicine becomes not just a way of curing or controlling disease, but no less a way of trying to cure or control the problems of life.”

Life itself seems to shake off its traditional limits and open up to an ever greater, if not indefinite, expansion of possibilities for individual self-actualization. Accordingly, modern medicine’s promise of escape from suffering and early death has become so important that it has implicitly become accepted, even demanded, as a right which all Americans should be able to enjoy.

Unfortunately, if Callahan is correct, this whole vision is running up against major obstacles, the most intractable of which are of technological medicine’s own making. The first problem is that the high-technology, acute care medicine which has in many cases extended life is often also responsible for plunging the aged into years of prolonged suffering. Medicine’s single-minded concentration upon extending life at any cost often has, especially for those in the seventies and over, the debilitating effect of consigning them to a painful, dependent, and financially exhausting life which is a cruel caricature of the promise of “modern maturity.”

The second problem Callahan identifies is economic, and ultimately, social. Demographically, America is becoming an aging society. Both as a proportion of the population and in absolute numbers, far more people are reaching the Biblical “four-score and ten” and beyond. As the post-World War II baby boom ages, the nation’s population will become progressively top-heavy as a larger and larger proportion of citizens reach old age. At the same time the cost of aggressively extending life at its upper limits has grown enormously. Increasingly, Callahan argues, the United States will face conflict which pits the old against the young. How will the nation justify the commitment of an increasing proportion of national resources to people in the last years of life when it means that fewer resources can go to education or childcare, and that the future must be mortgaged to prolong the lives of the chronically-ill aged?

The third problem is less obvious, but in the long run it is the most unsettling. Callahan claims that our technology-driven medicine, together with the individualistic understanding characteristic of a “modernized” old age, undercuts its own premises. A just allocation of resources among the generations will require some widely accepted and reasonably durable notion of human needs, especially the particular needs of the aging. But the development of new medical technologies makes it clear that what
counts as “need” is really a conception of the good. Needs are artifacts of public deliberation, a “reflection of what we think people require for an acceptable life.”

A “modernized” conception of life sees endlessly open choices as the self-evident good, one which justifies itself by the experience of increasing happiness. Driven by technological progress, a society so guided leaves it up to individuals to work out the practical meaning of “an acceptable life.” This is something, however, which few persons, whatever their age or situation, have sufficient resources for doing by themselves. The liberal assumption that individuals are on their own in the realm of meaning, when acted upon, adds to the difficulty of arriving at a consensus about what Callahan calls “the wellsprings of moral obligation toward the elderly in general and our elderly parents in particular.” This poverty of articulate shared meaning hampers collective decision making and amounts to a serious “communal deficit.”

The lack of widely shared convictions about “moral obligation” afflicts the elderly in a special way. In a social climate suffused with the ethos of open choices uncomplicated by the complexities of solidarity, the point of their lives and their place and value in the world go unaffirmed. Often they are simply ignored. This, too, is exacerbated by the conjunction of technology-driven “modernization” with individualism. The elderly, particularly as their strength fails, must struggle to maintain their self-worth against a context which exalts only “autonomy” and expanding horizons.

As society approximates in practice the open horizons vision of liberal theory, then, the outcomes violate many of our considered moral convictions about mutual connection and responsibility. Modern economics and technology have produced real gains in longevity and opportunity which are worth preserving. However, in order to be humanly meaningful, these gains must be connected to the life-defining goods which Callahan enumerates. Among these he places the opportunity to do meaningful work, share human love, participate in the full range of family life, live in community, and pursue moral ideals. These goods are indeed open choices, but they are also more. They represent possibilities for a person’s participation in social practices from which the individual can draw the capacity to form a lasting character and sense of integrity. Only in this way, Callahan argues, is it possible to find life meaningful in itself.

V. From Professional Ethics and Ethos to Political Deliberation

The conclusion Callahan draws is that if we are to deal in a just and humane way with the changing national needs for medical care, we must undertake a “major effort to reorient medicine away from its captivity by the modernizing, technology-driven, borderless ‘medical need’ model of care for the aged.” Life-extending treatment must be given in light of a “natural life span,” the borders of which will vary across individuals, so that the key policy goal becomes a fuller rather than a longer lifespan where the latter is bought at the price of chronic illness, suffering, and burdens on others. This effort will require a “parallel reorientation of the general public,” who, like physicians will be “reluctant to give up their old ‘captivity’ to the mirage of ever-expanding horizons promised by technological medicine.” For the sake of value, we must freely embrace limitation.

The really difficult conclusion is that such a massive policy change “can be morally acceptable only within a context that accords meaning and significance to the lives of the individual aged and recognizes the positive virtues of the passing of the generations.” The values which Callahan commends, like the qualities of the medical profession which Larry Churchill advocates, can only flourish within a particular set of practices and relationships shaped by those practices, a well-institutionalized ethos. To achieve this reorientation of policy, Callahan concedes, will require a long process of public debate and persuasion.
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That process, in turn, will require institutional arrangements which open up space for public discussion about the ends medicine should serve and its means. For such discussion to take place, neither technological necessity nor economic pressures can be allowed to work automatically. To make such dialogue fruitful, a medical ethic concerned with more than autonomy and open choices, valuable as these are, is clearly a necessity. Physicians must be especially attentive to restoring health and alleviating human suffering, yet also aware that these goods are part of a large fabric of meaning to which their work and institutions contribute. Medical problems, such as the continuation of life when the biological gains can only be small and the quality of life improved even less, are also moral problems and will have to be defined as such.

The complicated situation of aging in American society is a microcosm of the many webs of interdependence which the developing technology and economy have woven, often, over the heads of participants. This complexity, unless it is mastered cognitively and given moral meaning through reshaping our institutions, is likely to produce a host of unintended miseries, such as those ironically generated by increasing longevity. Professionals are often those most strategically placed to begin focusing public attention on these issues. They are also often the groups first charged with dealing with them. The moral integrity of professional groups is accordingly a significant public concern.

The argument of this paper has been that to cope effectively with contemporary interdependence demands an overcoming of the implicit moral division of responsibility through a new capacity to learn and deliberate in common. Thus, the ethos of medicine, like the larger public sensibility of American society, faces a new challenge. Can medicine evolve toward a wider, more complex sense of purpose and responsibility without losing its distinctive concerns and virtues? Can professionals in their individual and collective lives learn to think and act cooperatively with us, as both experts and citizens? These are the defining questions for a professional ethics, an ethos, and a politics appropriate to our times.

NOTES

1Quoted in Health Letter, Public Citizen Health Research Group, 5 (Dec. 1989): 2-3. The Time data which this article cites is confirmed by a recent Harris/Harvard School of Public Health Survey reported in the same article.

2For an account of this institutional history, told with reference to its public policy implications and costs, see: Paul Starr, The Social Transformation of American Medicine (New York: Basic, 1982).
3See: Barbara Ehrenreich, Fear of Falling: The Inner Life of the Middle Class (New York: Pantheon, 1989).
4See, for example, the joint AMA-ABA editorial published simultaneously by the journals of the two great professional associations at the end of 1987: "50 Hours for the Poor," American Bar Association Journal (Dec. 1, 1987): 55.
5The literature on professional ethics within this "applied ethics" approach is considerable and contains a wide variety of points of view as to how ethical principles are to be rationally grounded. Their common theme among what can be characterized as deductive theories, however, is that principles can be so grounded independently of the practices and contexts for which they serve as norms. Because of this independent and foundational position of ethical theory, ethical reasoning can be analyzed for its logical validity quite independently of the question of whether the principles or norms involved are judged ethically valid. Empirical facts about situations are highly relevant to ethical decision making, however, as these help identify those aspects of situations which are ethically relevant, i.e. those which can be subsumed under general principles and rules. For some representative samples of this approach, see: Michael D. Bayles, Professional Ethics (New York: Wadsworth Publishing, 1981); Alan H. Goldman, The Moral Foundations of Professional Ethics (Towata, NJ: Rowan and Littlefield, 1980); Robert M. Veatch, A Theory of Medical Ethics (New York: Basic, 1981). The major progenitor of contemporary applied ethics is John Rawls, A Theory of Justice (Cambridge, MA: Harvard UP, 1971).
6The reference is to Aristotle's opening discussion in Book One of Nicomachean Ethics.
10See: Starr, American Medicine, 420-49.
11Veatch, Theory, 5.
12Ibid., 5
BIOETHICS AND DEMOCRACY*

By Bruce Jennings

BIOETHICS, like other areas of applied and professional ethics, has many different voices, and no single, unitary ideology. But it does have a social ontology and a politics: a conception of the nature of the human good and society, and a conception of how freedom, justice, community, equality, and other public values should fit together. In the main, the ontology and politics informing bioethics comes from the tradition of western philosophical liberalism. This is important, both for bioethics and for liberalism, because many of the quandaries and controversies posed by biomedical science, technology, and health care are social and moral anomalies challenging the liberal paradigm. The quest for a normative consensus and workable public policy in the medical domain also provides one medium through which philosophical liberalism is reshaped and transformed. Bioethics is thus at once a school for liberalism and a stage where liberal morality, ontology, and political theory face some of the sternest, most perplexing tests of their philosophical adequacy and continuing viability. These are very important issues. It is surprising how rarely they are discussed.

How can we get a purchase on such questions? In what follows I approach the problem in two steps. The first step is to consider how we understand what bioethics (and professional ethics) is all about. What kind of discourse is it? What are its latent goals and functions? From whence comes its intellectual and normative authority? I distinguish two alternative models of professional ethics—the judicial and the civic—that answer these questions in different ways. The next step, following a line of inquiry opened up by the civic model, is to consider the function of professional ethics in what I call discourses of interpretation and legitimation, and to look at the substantive theoretical subtexts which provide an orientation for the contribution professional ethics makes to these discourses. In bioethics these theoretical underpinnings can best be revealed by contrasting liberal and demo-

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*Early versions of this paper were presented at the University of Minnesota and the University of Pittsburgh, and I am grateful to numerous people who discussed it with me on those occasions. I would also like to thank Stephen Esquith and Daniel Callahan for helpful comments on a previous draft.