I begin with three distinct groups of problems, each so urgent that the medical conscience ought to be – and indeed clearly is – haunted by them – and not only the medical conscience. Consider first such problems as: ought abortion to be legal? Is it ever morally right? Ought those in extremes of pain to have the right to take their own lives? Ought physicians to have the right to take the lives of patients with terminal cancer, who are in extreme pain?

Or consider secondly such other problems as: Should a physician be obliged to tell a patient that he is dying? Should a physician be obliged to give a patient a true diagnosis about his condition? Should a hospital be obliged to publish each year the percentage of operations in which after an organ was removed it was found to be undiseased and undamaged?

Or consider thirdly such rather different problems as: What is the justification for paying such high salaries to American physicians and surgeons as compared with the salaries of their counterparts in certain other countries, when in infantile mortality rates and the life expectancy of a man aged 45 the United States lags substantially behind those countries? Ought the supply of medical care to be surrendered to the demands of a free market economy? Ought the sole criterion for the availability of medical care to be need? How should resources be allocated between different needs?

The first set of problems concerns the relationship of medical practice to the good of preserving human life; the second concerns the relationship of that practice to the goods of trust and truthfulness; the third concerns the relationship of medical practice to the good of justice. Each group of problems is notoriously a matter for contemporary moral debate. I am going to argue that we have no rational method available for reaching a conclusion on these questions and that this springs from the
peculiar character of moral debate in our liberal, secular, pluralist culture, rather than from the special character of these problems or from the general character of moral argument.

II

One way to approach this thesis is to set out examples of opposing arguments on one out of each group of issues:

1(a). I cannot will that my mother should have had an abortion when she was pregnant with me, except perhaps if it had been certain that the embryo was dead or gravely damaged. But if I cannot will this in my own case, how can I consistently deny to others the right to life that I claim for myself? I would break the so-called Golden Rule, unless I denied that a mother had in general a right to an abortion.

1(b). Everybody has certain rights over his or her own body. To establish such rights we need merely to show that it cannot be shown that anyone else has a right to interfere with the implementation of our own desires about our bodies. It follows that at the stage when the embryo is essentially part of the mother's body, the mother has a right to make her own uncoerced decision on whether she will have an abortion or not. Since she has a moral right, she ought also to have a legal right.

2(a). A physician should decide whether to tell a patient who is gravely ill or dying the truth about his or her condition by reckoning on the consequences in that particular case to that particular patient of giving or withholding that specific information. If the patient's health and happiness will be increased by telling the truth, then the truth should be told; but if not, not so.

2(b). To treat an agent with moral respect is to look to his dignity and not his happiness. To deprive a man of the truth about his disease or his death is to deprive him of dignity. More particularly every man can only respect himself if he faces up
to the fact of his own death. Hence to deprive patients of the truth about themselves is to do them a wrong and a wrong that insults their status as human beings.

3(a). Justice demands that every citizen should have so far as is possible an equal chance to develop his talents and his other potentialities. But good health is a prerequisite for such development. Therefore every citizen should have an equal right to access to the means of good health, so far as it is available. Therefore justice requires a free national health service, financed out of taxation, with no private sector of medical practice.

3(b). Everybody has a right to incur only such obligations as he chooses, to be free to make such contracts as he wishes. Every doctor therefore must be free to accept patients or not and to practice on what terms he chooses. If others then do not wish to deal with him, that is their free choice. Freedom requires freedom of contract. Freedom of contract requires medicine to be a matter of private practice.

About these six arguments I want to make two main points. The first is that the goods which each argument aspires to vindicate are incommensurable with the goods invoked by at least some of the other arguments. Each of the arguments moves validly from premises to conclusion; but the premises are so independent of each other that those who accept the premises of rival arguments share no common moral ground. Given each set of premises, it is rational to move to each conclusion, but there is no argument available, no criterion available, no rational procedure to decide between rival and incompatible conclusions.

We appear therefore to have to make a non-rational choice between alternative positions, so far as our own moral judgments upon each issue are concerned, and to have to resort to non-rational persuasion if we are to affect the choices made by others. What puts us in this position? One standard type of answer is that it springs from the nature of morality as such. C. L. Stevenson's position in Ethics and Language requires that moral disagreement be rationally interminable. Sartre's moral philosophy – at least in one version – notoriously makes an arbitrary choice the
fulcrum upon which moral judgment depends. If they and those who think with them on this matter are correct, then the place of arbitrary choice and of interminable disagreement in morals will be the same irrespective of time and place, irrespective of the differences between different social and cultural orders. But is this true? As a preliminary to raising and trying to answer this question, it is important to glance at the historical background to the present situation.

We ought first to note that the historical provenance of the six arguments which I outlined is very various. So far as their philosophical ancestry is concerned, the first has its roots immediately in Kantian thought and more remotely in Christianity, the second in the thought of Jefferson, Robespierre and Rousseau, the third in Benthamite utilitarianism, the fourth in Hegel and Kant, the fifth in T. H. Green and in Rousseau, the sixth in Adam Smith and John Locke. But of course the premises of the six arguments have a genealogy which extends beyond explicitly philosophical texts, indeed far beyond any texts. For some of these premises at least have informed a variety of types of social and moral practice and as such have defined in part cultures which are our moral and intellectual ancestors. But then they were parts of wholes, ordered within some total moral scheme which provided a vision of man's true end, of the relation of his empirical nature to his essential nature. It is a tacit assumption of secular, liberal, pluralist culture, of the culture of modernity, that to a rational man no such vision is now available, because we can have no rationally defensible concept of man's true end or of an essential human nature.

Consequently what we inherit from the varied and different strands of our past is a collection of fragments, of moral premises detached from the contexts in which they were once intelligibly at home, survivals now available for independent moral assertion from a variety of moral points of view. It is this that makes moral argument appear to consist merely of the clash of bare assertion and counter-assertion marked by what is only the appearance of argument, so that non-rational persuasion seems to be the only way to terminate disagreement, and arbitrary choice seems to be the only way for an agent to resolve the issues in his own mind.

That is to say, the Stevensonian or the Sartrian conclusion expresses a genuine sociological insight into the fate of morality in modern culture, rather than a philosophical insight into the nature of morality as such.
But the Stevensonian or the Sartrian – or a Nietzschean – philosophical claim about morality could only be vindicated if no thesis about essential human nature and its true end could be made good.

Does this mean that in the present historical situation we are doomed to arbitrary non-rational solutions to moral problems, including the moral problems of the medical practice? In order to answer this question we must first enquire how the general character of the moral history of our culture has affected the special character of medical ethics. For it might be claimed, and it often has been claimed, that the morality of the medical profession is in a special way autonomous. The medical profession has had to safeguard and to transmit its values in a variety of very different social contexts: late medieval Catholicism, renaissance Italy, eighteenth century France, twentieth century America. The very claim to be a profession and not merely a trade characteristically involves a claim to be the guardian of certain values.

The values to which the medical profession has specifically claimed to be committed through changing social and moral environments are at least threefold: there is the unconditional commitment to preserve life and health, the responsibility for justifying the patient's trust in his physician or surgeon, and the demand for the autonomy both of the individual physician or surgeon in making his judgments and of the profession as a whole in sitting in judgment on its own members. The crucial question is: could these virtues not only survive in their integrity, but provide an adequate moral criterion for medical practice in a culture with a history of moral fragmentation such as ours?

At first sight it might seem at least not impossible that this should be so. For certain virtues incarnate goods, the rational claim of which upon mankind seems to be independent of cultural history and variation. In order to understand why this can be so, I must give a more general account of the virtues.

III

It is a commonplace that societies differ in their accounts of the virtues. There are not only differences as to which human qualities are to be accounted virtues, but there are of course also differences as to the criteria by means of which the virtues are to be justified. Fifth century Athens is in many ways at odds with twelfth century Iceland; Polynesia is radi-
cally different from Pennsylvania. But it is a condition of our ability to point out this truth (so often one of the premises from which a facile relativism is deduced), that we are able to identify in each of these societies one and the same focus upon a set of human qualities, the presence or absence of which in a man determines how he is to be assessed as a man. Were this not so, we would not be able to understand these various cultures as differing from each other over one and the same thing. Our perception of difference presupposes a perception of resemblance.

What then makes a virtue a virtue? We define and we cannot but define our relationships to other people by referring to certain goods. A, B, C and D are friends. D dies in obscure circumstances, A discovers how D died and tells the truth about it to B, while lying to C. C discovers the lie. What A cannot then intelligibly claim is that he stands in the same relationship of friendship to both B and C. By telling the truth to one and lying to the other he has partially defined a difference in the relationship. Of course it is open to A to explain this difference in a number of ways; perhaps he was trying to spare C pain or perhaps he was ashamed to reveal the nature of his enquiries about D to C or perhaps he is simply cheating C. But some difference in the relationship now exists as a result of the lie.

Just as we define our relationships to each other, whether we will it or not, by reference to standards of truthfulness and trust, so we define them too by reference to standards of justice and of courage. If A, a professor, gives B and C the grades that their papers deserve, but grades D because he is attracted by D's blue eyes or is repelled by D's dandruff, then he has defined his relationship to D differently from his relationship to the other members of the class, whether he wishes it or not. Justice requires that we treat others in respect of merit or desert according to uniform and impersonal standards; to depart from the standards of justice in some particular instance defines our relationship with the relevant person as in some way special or distinctive.

The case with courage is a little different. We hold courage to be a virtue because the care and concern for individuals, communities and causes which we feel requires the existence of such a virtue. If A says that he cares for some individual, community or cause, but is unwilling to risk harm or danger on his, her or its own behalf, he puts in question the genuineness of his care and concern. Courage, the capacity to risk harm
or danger to oneself, has its role in human life because of this connection with care and concern. This is not to say that a man cannot genuinely care and also be a coward. It is in part to say that a man who genuinely cares and has not the capacity for risking harm or danger has to define himself, both to himself and to others, as a coward.

I take it then that truthfulness, justice and courage — and perhaps some others — are human goods in the light of which we have to characterize ourselves and others, whatever our private moral standpoint or our society's particular codes may be. For this recognition that we cannot escape the definition of our relationships in terms of such goods is perfectly compatible with the acknowledgment that different societies have different codes of truthfulness, justice and courage. Lutheran pietists brought up their children to believe that one ought to tell the truth to everybody at all times, whatever the circumstances or consequences, and Kant was one of their children. Traditional Bantu parents brought up their children not to tell the truth to unknown strangers, since they believed that this could render the family vulnerable to witchcraft. In our culture many of us have been brought up not to tell the truth to elderly great-aunts who invite us to admire their new hats. But each of these codes embodies an acknowledgement of the good of truthfulness. So it is also with varying codes of justice and of courage.

The inescapable character of such goods is a matter of the role in human life of the qualities that embody them, the virtues of being honest, just and courageous. A society that does not recognize these as virtues would necessarily lack the general features of human society. When we do find a culture, such as that of the Ik,² where this recognition is absent, we find something akin to a Hobbesian state of nature, not to a human society. This empirical confirmation of my thesis is strengthened by the discovery that the Ik once had genuine social bonds — and with them a recognition of the virtues — but lost these. To characterize this disaster by saying that the Ik lost both their social bonds and their recognition of the central virtues would be a mistake, for it would ignore the fact that to speak of the virtues just is to speak of certain key forms of social relationship. Virtues are parts of social structure, and moral philosophy and sociology ought not to be conceived of as distinct disciplines.

A certain tension exists between the moral history of our own culture as I understood it in the first section of this paper and the account of
the virtues which I have just given. The first account emphasized cultural variability and fragmentation; the second has emphasized the irreducible moral content of culture. It may help to avoid the appearance of incompatibility if I immediately underline one point that I have already made and add to it another. The point already made is that the central invariant virtues are embodied in very different codes in different cultures and a shared recognition of these virtues is compatible with wide-ranging disputes about codes. The second and new point is that the central invariant virtues are never by themselves adequate to constitute a morality. To constitute a morality adequate to guide a human life we need a scheme of the virtues which depends in part on further beliefs, beliefs about the true nature of man and his true end. But about these matters cultures have of course varied and disagreed.

To understand how this is so, consider those qualities which have been considered virtues in some times and places and not in others: thrift, humility, charity, authenticity and friendship are cases in point. To understand these qualities as virtues requires an appeal to certain beliefs which have flourished in some human cultures and not in others. If we believe in the so-called Protestant work ethic — work, save, invest — (as practiced by Venetian Catholics and Spanish Jews as well as by German, English and American Protestants, pace Max Weber), the presence or absence of thrift will be a crucial fact about individuals. If we accept that certain forms of marriage and virginity are the will of God, then chastity will become an important quality. It is only against the background of such over-all interpretations of human existence that such qualities appear to be or not to be virtues.

In characteristic human cultures, therefore, the standard list of the virtues will include some items which derive their status from the part they play in all human life and other items which derive their status from some more particular set of beliefs or forms of understanding, which is restricted to some, perhaps to only one, form of culture and social order. What gives each moral vision its uniqueness and its integrity is not just a question of what items are included in its particular list of the virtues, but also of what criterion is invoked to justify the selection of just those items rather than others. So ancient Greek moral thought and practice is pervaded by the notion of human beings as having a distinctive nature, specified in terms of that 'work' (ἔργον) and that 'end' (τέλος) which dis-
tistinguish human beings from gods, geese or granite. So the moral vision of the Renaissance man of action centers on the notion of 'virtu', a certain conception of human strength and energy. So the puritans of the sixteenth and seventeenth centuries gave an interpretation to the notion of a divinely ordained vocation which made both hard work and thrift virtues.

Such a criterion will determine not only which items are included in the list of the virtues, but also how they are ranked in importance. Courage is accounted a virtue in almost all societies, but it has a very different place in the heroic societies whose life is reflected in the Iliad or in the Icelandic sagas from its place in any Christian scheme.

The traditional medical virtues are clearly not to be derived in any simple way from the invariant human virtues. To count them as virtues we need to appeal to certain special beliefs about the specific kind of value we place on the preservation of human life, about the special character of the physician-patient relationship and about professional autonomy. The difficulty about the traditional medical virtues is two-fold: they have become problematic and they have become problematic in a culture which precisely lacks the means to solve moral problems. I have already indicated why I hold the latter thesis to be correct. Let me therefore turn to the former.

I want to argue that just as the traditional medical virtues had a special status, so those virtues have become problematic in a special way. There is a social process by which what have been virtues in one social and cultural context can become vices in another. I am not here referring to the process which I have already noted whereby what are believed to be virtues in one social order come to be believed to be vices in another, as the quality which Aristotle counted as a virtue under the name of magnanimity came to be considered by the early Christians the vice that is the counterpart to their virtue of humility. I am referring to a process whereby what actually were virtues turn into what actually are vices. Before I turn to the history of the traditional medical virtues, let me list a number of ways in which this may happen.

IV

The first is the case where a disposition valuable for its own sake, and valued for its own sake, as any genuine virtue must be (it may of course
also be valued for further ends that it serves) comes to be valued only or primarily for its employment as part of a technique. Sometimes, for example, social workers are taught to become ‘friends’ with their clients in order to gain their confidence so as to manipulate them more effectively. Now it is of the essence of friendship as a virtue that one cannot become a friend from such a motive and with such an intention. What the social worker is being taught is to do and to speak as a friend would do and speak, but in such a way that what is produced is a counterfeit version and not authentic friendship. It is because the social worker’s version is a counterfeit of the virtue and one calculated to deceive the innocent that it is a vice and not merely a neutral quality.

Aristotle when he discusses courage distinguishes true courage from military courage. Military courage is certainly not a vice, but because it is acquired and exercised as part of the technical training of a soldier it is not to be confused with a virtue which always belongs to a man qua man and not qua social worker, soldier or possessor of some other set of technical skills.

A second way in which a virtue may become a vice is when a change in the nature of the effects of a certain type of action transforms the character of that type of action. The giving of systematic poor relief to wage-laborers in England in the early seventeenth century, as a system institutionalized by a Poor Law and controlled by the local Board of Guardians, first had the effect of keeping wages low – for if the parish paid a near subsistence minimum the farmer could pay his laborers less than he would otherwise have had to; and then became a means to this end, so that the actions involved in poor relief were now informed by the intention of providing a stock of cheap wage labor. An unintended but very general effect led the action of assisting the poor to be transformed into the action of contriving their maximal exploitation. A virtue became a vice.

A third way in which a virtue may become a vice is when a quality valued for its own sake is made available for sale. Alexander Gerschenkron has described how in the initial stages of modernization and especially in the eighteenth century a new type of entrepreneur emerged whose transactions were based on much larger quantities of fixed and variable capital than previously and whose enterprises were essentially long-term. Unlike his mercantile predecessors, he found himself having recurrent
transactions with the same customers, debtors and creditors. Up to this point the rule, *Caveat emptor*, had tended to dominate commercial transactions; the entrepreneur did not need to convince those who were buying from him that he was reliable, if he would probably never trade with them again. The new entrepreneur, however, had to acquire a reputation for honesty and to acquire it he had to do by and large what honest men do. Would it therefore be true to say that entrepreneurs became honest? The answer, as Kant saw clearly, is ‘No’, and not only because ‘honesty’ became part of the technical skill of the entrepreneur. It is because what is exchanged for money and valued insofar as it can be exchanged for money cannot be a virtue. It follows, as the Marx of the 1846 manuscripts saw clearly, that free market capitalism has a striking tendency to destroy the virtues and a progressive tendency. It is not just that money is very bad for us; it is also the case, as Robin Farquarson put it, that “Marijuana is not addictive; money is.”

Fourthly, a virtue may become a vice or simply a non-moral quality by a change in its relationship to a role which it partially defines. In traditional, patriarchal societies reciprocal loyalty between superiors and inferiors is central to the social bonds. To value loyalty as a virtue just is to value those bonds. But when the virtue of loyalty is invoked in modern corporate organizations it is characteristically part of an attempt to undermine the impersonal, bureaucratic standards of such organizations and to substitute adherence to persons for adherence to rules. Such adherence may be a good or bad thing depending on the circumstances and the nature of the relevant persons and rules; but it is certainly not a virtue as such.

We have then at least four types of case in which virtues can become vices, or if not vices, at least problematic qualities: the type of case where what was a virtue is transformed into part of a set of technical skills, that where a change in the effects of the practice of a virtue transforms in time the intentions with which it is practiced, that where what was a virtue becomes a marketable commodity, and that where a change in the structure of roles changes the character of the human qualities involved in the role playing.

I now want to consider if and how far the traditional medical virtues have
turned to vices. I want to begin by considering three social presuppositions of the practice of the traditional medical virtues. The first is technological. The practice of medicine has for most of its history been carried on in societies where human life is immensely fragile and vulnerable and where the technical means to safeguard it have been very limited. High infantile mortality rates, low expectations of life for surviving adults, extremely limited predictive powers in framing prognoses, all underlie the ordering of medical priorities embodied in different versions of the Hippocratic Oath. Medicine would have been a quite different form of social practice if *either* life was to be preserved only if health could be restored or life was to be preserved only if grave pain and suffering were to be avoided or health was to be restored only if in so doing pain and suffering were not to be increased. That ordering of medical priorities which places a supreme value on life is made more intelligible by considering the social background which it originally presupposed.

A second presupposition of the practice of the traditional medical virtues was the existence of a shared and socially established morality. The physician could assume that the patients' attitudes towards life and death would be roughly the same as his own, and vice versa. Hence the patient in putting him or herself into the hands of his or her physician could feel that he or she was not relinquishing his or her moral autonomy.

A third presupposition of the practice of the traditional medical virtues was that the activities of the physician or surgeon took place within a given social order, but were not themselves able to shape or be responsible for shaping that order. Medicine could not be understood in its traditional perspective as a social practice competing with other social practices for scarce resources and offering debatable criteria for their distribution.

None of these presuppositions is now warranted and it is social change that has destroyed their warranty. Technological change has made of the preservation of human life a very different issue. Moral change has made of the trust which the patient ought to express in the physician a very different issue. Changes in the scale and the cost of medical care as well as political and economic change in society at large have made the distribution of medical care into a very different issue. In each case what was a virtue has become at best problematic, at worst a vice. Consider once more the ways in which virtues become vices.
There is first the case where the effects of a practice change so that the character of the relevant actions change. This is what happened to the medical practice of making the preservation of human life an overriding goal. Consider two kinds of change. It is now the case, as it used not to be, that this goal involves the systematic preservation of the old long after they can function as genuine human beings. It is now the case, as it used not to be, that this goal involves systematically increasing the proportion of hopelessly crippled infants and helplessly decaying old people to healthy adults and children. Any agent who knowingly participates in producing such effects systematically, as many physicians do, does great harm and wrong. What was a virtue has become a vice, but not an unproblematic vice. For the physician now finds himself in a tragic dilemma. Consider the case of recently born crippled infants where heroic efforts may preserve *either* a needless bundle of distorted and suffering nerves and tissues *or* – sometimes against all probable calculation – a human child, physically imperfect but with real potential, perhaps even a Helen Keller. (I consider the case of infants rather than of the old, because the collapse of the extended family has left most of us with a deep inability even to approach the problems of the old, an inability institutionalized in the way we, as a society as well as individuals, treat them.) Any rule which relieves the physician of the burden of extending suffering uselessly imposes on him the burden of taking innocent life wantonly; and no rule would be worst of all.

What has happened to place physicians in this dilemma is the result of the coincidence of two distinct histories of moral change. In the society at large our fragmented inheritance has resulted in abandoning us to a secular, liberal pluralism which leaves us resourceless in the face of moral problems; in the history of medical practice a change in its presuppositions has rendered what was virtuous vicious and what was unproblematic problematic. Thus parts of medical practice became morally problematic precisely at a time when we have minimal resources for the solution of moral problems.

As with the first of the three traditional medical values, so also with the other two. The trust which defines the relationship of patient to physician was based upon the presupposition of a shared, established morality. The physician could have a reasonable assurance that his patients' beliefs about suffering, death and human dignity were much the same
as his own; the patient could have a reasonable assurance that his beliefs would be respected. But in a liberal, pluralist moral culture the patient knows, not only that the traditional basis for this assurance is now missing, but that the physician has no special resources for the solution of the moral problems which arise in the course of a relationship to a patient. The parent of a helplessly ill child or a helplessly old person cannot know that the physician wills their good, because they cannot know what his conception of good is. Once again the physician is in a tragic dilemma: the invitation to trust which was once a sign of virtue becomes a sign of something else. The change in the structure of role-playing has changed the quality of the actions. A virtue has in a characteristic way become a vice. But the physician has no easy way out. The whole nature of medical care is almost unimaginable without a context of mutual trust; to simply abandon that mutual trust, because it is no longer warranted, would be destructive. To try to maintain it in its traditional forms is equally dangerous.

It is of course in this situation that market relations become significantly obtrusive in medical practice. Differential treatment is offered for differential reward; access to medical care is radically unequal. Here again the physician is, like everyone else, in a situation which he cannot escape. The demands of social justice and the demands of the physician for autonomy are in radical conflict. If members of the medical profession choose certain forms of specialization in research or in practice, they thereby determine the availability of certain patterns of medical care. If the freedom of physicians is safeguarded, the equal rights of citizens will be flouted. So the autonomy of the medical profession becomes a social vice, while the freedom of the physician remains an important value. Once again we have a dilemma which is almost intolerable.

VI

Hegel spoke of tragedy as “the conflict of right with right;” what makes any protagonist’s situation tragic is that he inevitably has to choose between wrong and wrong. It is with this in mind that I have spoken of the physician’s moral dilemmas as tragic. The moral resources of his culture, of our own culture, offer no solution for him. What matters most in a period in which human life is tragic is to have the strength to resist
false solutions. The characteristic temptation of the modern world is utilitarianism. For utilitarianism in all its versions aspires to provide a criterion, a way of judging between rival and conflicting goods to maximize utility. But the goods and the rights which define our contemporary conflicts are incommensurable. There is no higher criterion. There is no neutral concept of utility.

The medical profession ought not therefore to look for solutions to philosophical theorizing; what philosophy has to tell them is precisely why they cannot hope for solutions. For a philosopher to try to go beyond this would be for him to misunderstand either the present situation or the scope and limits of his discipline. A philosopher offering positive moral advice in this situation would be a comic character introduced into a tragedy. Imagine Socrates introducing himself with advice for Antigone or Creon, or Plato trying to counsel Philoctetes, Neoptolemus and Odysseus. Yet to understand even this is perhaps to transform the perspective in which the moral problems of medicine are viewed; and such a transformation can only be effected by philosophy.

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