PROFESSIONAL ETHICS AND THE CONCEPT OF 'DOUBLE MORALITY'

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities

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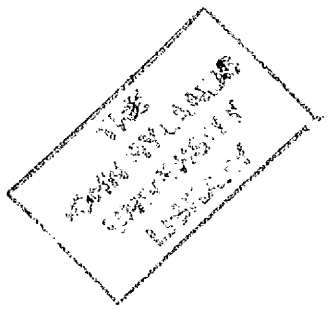

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ABSTRACT

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Professional ethics often asks for a kind of behaviour which is at odds with basic moral requirements, or it imposes moral restrictions which are not to be found in ordinary everyday interactions. Therefore, the individual professional must develop a sort of 'double morality', that is, he must learn how to use different sets of moral rules depending on whether he finds himself in a professional context or not.

In the field of medicine there is a very rich and powerful professional culture – what I refer to as 'the god of Medicine' – which is inherent in the physician's personality, influencing and often guiding his behaviour and actions. A detailed analysis of the physician's profile is provided, which shows that a physician has many peculiarities compared to laypersons, and these justify indeed the development of a separate *role morality*; however, the physician has also a lay side, outside his professional life, and this side asks for a more ordinary behaviour and, therefore, the parallel existence of a *common morality*. Thus it can be said that by alternating between these two kinds of morality, the physician actually uses what I describe as *double morality*.

Theoretically this view seems correct, and there are some cases which support it. For example, killing and telling lies is morally acceptable for a physician but not for a layperson, while refusing provision of services before securing payment, is morally acceptable for a layperson but not for a physician. Therefore, the concept of double morality seems to be very useful for the effective management of these cases. However, some other cases are also examined, which show inefficiencies of the concept. The paradox of religious physicians, the issue of professional caring, and some instances of medical etiquette question double morality's worth, while issues of confidentiality, defensive medicine, and the case of a physician who falls ill suggest that the whole theory of double morality is probably wrong.

Nevertheless, some elements of the theory can still be used to form a refined concept of double morality. With the implementation of some ideas coming from the theory of virtue, and by shifting the emphasis from medicine as an institution to the individual physician, the concept of double morality acquires a new meaning; it seems best to describe it as a constant merge of two moralities together within the individual, rather than as a continuing alternation between them. This new approach aims at stressing the importance of each physician's individuality. A unique and authentic medical personality deals much more effectively with specific moral problems than a physician who tries to separate completely his personal from his professional self. And in this sense, this refined concept of double morality understood as a merge becomes something quite important for physicians to be aware of.

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PREFACE

Upon the completion of his controversial experiments, Stanley Milgram published a book, where he described the idea of an automaton which imitates human modes of behaving:

> The design of such an automaton, if it is to parallel human function, must be sufficiently flexible to allow for two modes of operation: the self-directed (or autonomous mode), when it is functioning on its own, and for the satisfaction of its own internal needs, and the systemic mode, when the automaton is integrated into a larger organizational structure. Its behavior will depend on which of the two states it is in.[1]

Milgram's view is certainly interesting, but it needs to be challenged. Can human beings function like automatons, and alternate between two separate modes of behaving? In this thesis I shall take this view into consideration and apply it to the case of health care professionals, with an emphasis on physicians. Medicine can be seen as a 'larger organizational structure' where every individual physician is integrated when his mode of operation is the systemic one; but there is also the self-directed mode, as the individual physician certainly has a life beyond his profession. Based on this assumption, and focusing on the field of medical ethics, a new concept can emerge: the concept of double morality. Can physicians retain a double morality, which consists of role morality and common morality, and which allows them to function in one way when dealing with medical situations, and in a different way when dealing with ordinary life situations?

In an attempt to provide the answer, the thesis shall be divided into three parts, which consist of ten chapters. Part I will set out the problem of 'double morality'. More specifically, Chapter 1 will offer some general explanations concerning what role and common morality are, the

[1] Stanley Milgram, *Obedience to Authority: an experimental view* (London: Tavistock Publications, 1974) p. 132.

definition of the terms 'role' and 'layperson', and some remarks about the essence of professions, as well as a reason why I lay emphasis on physicians, disregarding in a way other health care professions. Chapter 2 will deal exclusively with the physician, explaining why it makes sense to apply the concept of double morality to his case, and introducing the other new concepts which shall be used throughout the thesis – the *model physician*, the *god of Medicine*, and the *ideal physician*. In chapter 3 I shall develop the theory of double morality, reviewing relevant approaches and theories, and marking their differences. Part II shall deal with specific examples, which reveal that the approach, while promising, does not work in a satisfactory way. In more detail, Chapters 4, 5, and 6 will examine cases where the theory of double morality can be applied; however, while in chapter 4 this theory seems to function, chapter 5 casts great doubt upon it, and chapter 6 clearly shows its inefficiency. Then in chapter 7 the problems of this theory will be analysed, and the non-functional ideas will be rejected. Finally, Part III shall identify a new starting point, and replace the concept of 'double morality' with a more satisfactory one. More specifically, Chapter 8 will trigger a search for new ideas by examining a virtue-based approach to morality. In chapter 9 the cases which have been discussed shall be explored under the perspective of virtue. And finally, in Chapter 10, the new theory of double morality will be analysed, which is quite distinct from Milgram's automaton and its two modes of operation.

The fact that such a great part of this thesis is devoted to a concept which shall be eventually rejected might be surprising. However, I need to do this for two main reasons. First, I need to assume that the concept of double morality is valid in order for its investigation to be as deep as possible; this is suggested by Wittgenstein, who uses a quite peculiar example:

> If I am inclined to suppose that a mouse has come into being by spontaneous generation out of grey rags and dust, I shall do well to examine those rags very closely to see how a mouse may have hidden in them, how it may have got there and so on. But if I am convinced that a mouse cannot come into being from

> these things, then this investigation will perhaps be superfluous.[2]

Therefore, it is important to assume that the theory of double morality which shall be presented can function well, and test this assumption as thoroughly as possible afterwards. The second reason why I need to examine the concept of double morality so much is because it shall help me identify its weaknesses and remove them, before offering a new and refined concept. To put it differently, it is necessary for the deconstruction of the first theory to be done, in order to clear the thesis of any problematic ideas, and be left therefore with a more concrete working body, which the second theory shall be based on. So in my view it is sound to introduce the concept of double morality for the purpose of rejecting it.

Before proceeding, it should be noted that I shall be constantly using the pronoun 'he' to refer to the physician. This is done intentionally, but not in any phallocentric or anti-feministic sense; it is done out of respect for linguistic traditions, and also for purposes of clarity and continuity.

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[2] Ludwig Wittgenstein, *Philosophical Investigations* [translated by G. E. M. Anscombe] (Oxford: Basil Blackwell, 1974, first published in 1958) p. 26.

PART I

The problem of 'double morality'

Chapter 1

STARTING POINTS

In this brief chapter I shall provide a general idea about the thesis's orientation, the assumptions which have to be made, and some of the concepts which shall be used later on. I emphasise: only a general idea shall be provided. Therefore, it is to be expected that some questions which may come up shall stay unanswered in this chapter. But I do believe that, as the thesis proceeds and more details are added, all the concepts which are not immediately apparent shall be fleshed out and become clear by the end.

The main concepts addressed in the thesis are those of common and role morality, and I shall discuss them first – without exhausting them however. I shall then explain my approach to the concept of 'role' and exclude many possible roles that could be explored. This shall leave only the role of the physician to be discussed, but this discussion shall not properly start until the next chapter. Finally, the concept of 'the layperson' is explained; but this can happen only if there is constant reference to the concept of 'the physician'.

I) Morality's relation to roles

It is probable that morality is influenced by certain roles, but it is very difficult to think of morality solely as role-based. So I find it necessary in this section to provide an explanation as to what exactly the term 'role morality' means, and what 'roles' we are interested in. But first, I will examine a more basic concept, the one of 'common morality'; it is more basic, because, it applies to all.

Common morality

Despite the spirited efforts of philosophers of all ages and civilisations, there can be no certainty as to the origins of morality. Is morality just a social necessity? Is it based on the instinct of survival, or rather on emotions? For some it is entirely artificial, and for others it is natural, and implicit in human nature. Perhaps it stems from God's will; or maybe its roots are to be found in society's demands. All these very important considerations have troubled so many thinkers, and in so many ways, that they have become inherent in every moral philosophy, and a source of great difficulty, as our thoughts about the origins of morality stay incomplete. It is therefore a great pleasure and relief to ascertain that they need not to be contemplated in the present thesis. All I need in order to commence this project is a confirmation that, although we do not know its origins, a certain morality which is shared by every individual truly exists. It does not have to be a morality which everyone practices, but one that everyone acknowledges, at least theoretically.

Bernard Gert has recently devoted a book to the notion of common morality,[1] and I find myself in agreement with most of its positions. In it, he defines common morality as 'the moral system that thoughtful people implicitly use when making moral decisions and judgments'[2] – that is, something which is shared by all moral agents, and which must be, in a way, assimilated in them, so as they can use it implicitly. Furthermore, Gert believes that 'the existence of a common morality is supported by the widespread agreement on most moral matters by all moral agents'[3] and that 'areas of widespread agreement are the result of some universal facts about human nature.'[4] Therefore, according to Gert, the quality of being human is sufficient to provide us with common morality.

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[1] Bernard Gert, *Common morality: deciding what to do* (New York: Oxford University Press, 2004), available from Oxford Scholarship Online at http://dx.doi.org/10.1093/0195173716.001.0001, accessed 5/2/2007.
[2] *Ibid.*, p. 4.
[3] *Ibid.*, p. 8.
[4] *Ibid.*, p 12.

Even though this last statement certainly needs further support, I believe that such a morality is nevertheless real, and that every individual is aware of it. To be sure, there are those who deny that 'widespread agreement' or any other kind of universal moral knowledge can ever be possible, even universal moral intuitions.[5] But, on the other hand, some philosophers strongly support this view. Hardimon, for example, states:

> We correctly regard ourselves as having duties – including the duty not to murder, lie, or coerce – that are *independent of* our roles and statues: duties that apply to people generally. It might also be added that there is nothing specifically modern about the idea that we have such duties. The traditional "thou shalt nots" are duties of this kind.[6]

One could argue that the "thou shalt nots" have mainly historical value, that they do not offer any kind of moral guidance anymore, and that, in our age, we cannot have universal moral duties so easily. Nevertheless, as Baldwin remarks:

> Despite our ignorance of our duty, we can be confident that general adherence to common sense morality is a necessary condition of the existence of 'civilised society' which is itself a necessary condition of the existence of any great good.[7]

Therefore, 'notwithstanding the current incommensurability of notions of the good, the effort to seek a morality grounded in our common humanity should not be abandoned.'[8] This morality, therefore, must not be a very detailed one, because details differ between various civilisations, cultures, and individuals; 'the ideas that seem so self-evident to us ... would seem quite strange to other peoples in other times.'[9] So this morality must consist of some very basic moral elements which are common everywhere, and which form the undetectable basis of every

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[5] James Wilson, 'Moral Intuitions' *Proceedings of the American Philosophical Society* **140** [1] (1996), 65-76.
[6] Michael Hardimon 'Role Obligations' *The Journal of Philosophy* **91** [7] (1994) 333-363, at 340.
[7] Thomas Baldwin, 'The Indefinability of Good' *The Journal of Value Inquiry* **37** (2003), 316.
[8] Edmund Pellegrino & David Thomasma, *The Christian Virtues in Medical Practice* (Washington, DC: Georgetown University Press, 1996) p. 17.
[9] James Rachels, *The End of Life* (New York: Oxford University Press, 1990, 1986) p. 7.

other collective or personal morality. Mary Warnock calls it *public morality*, within which '... all humans are equal, whatever their individual characteristics.'[10] I shall be referring to it as common morality, like Gert does, and its essence will be revealed as the discussion proceeds.

Role morality

Common morality can be found in every individual. It is the groundwork for one's moral development; the groundwork stays the same, but this development can vary interestingly between individuals, as it is subject to many influences. Diderot has noted that every social role has its exceptions to the general code, which he describes as *moral idioms*; there is a standard conscience just as there is a standard grammar, and then there are moral idioms just as there are grammar idioms in every language.[11] So there is a common moral groundwork, and then various personal moral developments. However, for some people there is another kind of moral development, independent of common morality's groundwork. A supplementary morality can come into existence, in order to deal with aspects of one's social functioning which are not to be found in lay people. As Kadish & Kadish remark:

> In his role a person may be a doctor, a judge, a senator, a mail carrier, but he is also a person with his own aspirations and ethics. Thus not one but two sets of considerations, broadly speaking, guide his conduct. The first consists of ... reasons based on the constraints of his role tempered by whatever discretion recourse to role ends may afford him. The second consists of reasons that he may recognize as an individual but that in his role he cannot take into account ...[12]

What they refer to as 'reasons' actually has the meaning of 'moral considerations', and we see that these are different for the individual and different for his role, and also that they are separated. In other words,

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[10] Mary Warnock, *An Intelligent Person's Guide to Ethics* (London: Duckworth, 1998) p. 75.
[11] Denis Diderot, *Rameau's Nephew* [translated by Leonard Tancock] (Harmondsworth: Penguin Books, 1978) p. 61.
[12] Mortimer Kadish & Sanford Kadish, *Discretion to Disobey: A Study of Lawful Departures from Legal Rules* (Stanford: Stanford University Press, 1973) p. 27.

when one occupies a special role in society it is possible to develop a new morality, parallel to one's common morality; I shall be referring to this morality as *role* morality. The roots of role morality are easier to be traced than those of common morality. One needs simply to examine the corresponding social role, its requirements, and its creators. It can then be understood why the role occupiers have to function in one way rather than in another, and role morality can then be seen as an important and necessary aspect of a role.

What roles are we interested in?

'*Role* is not a well-defined and well-developed moral idea'[13] and 'the range of things that can properly be called roles is remarkably heterogeneous and wide.'[14] But even though every social activity can be described as a role, it would not fit our purpose to assume such an abstract approach to it. There are roles which come without any special kind of role morality and, in a sense, they are not proper roles. 'Roles obligate certain choices to back them up; otherwise these roles dissolve.'[15] For example, one could say that being a cashier at a supermarket corresponds to a social role. But then what could the cashier's role morality be? A determination not to give short change to the customers probably; but this is too simple, it cannot be said to create a special, supermarket cashier morality. Besides, it applies to every individual who deals with any kind of financial agreements, so it could be said that the determination not to give short change is part of our common morality. In order for a social role to qualify as a proper role, two main criteria need to be satisfied: first, that role has to be important, in the sense that it can influence society's well-being. I respect cashiers of course, but I do not think that the way they choose to exercise their duties can make a big difference in society, apart from lead to occasional

[13] Arthur Isak Applbaum, *Ethics for Adversaries: The Morality of Roles in Public and Professional Life* (Princeton, New Jersey: Princeton University Press, 1999) p. 46.
[14] Hardimon, *op. cit.*, at 334.
[15] S. Buetow, G. Elwyn, 'Are patients morally responsible for their errors?' *Journal of Medical Ethics* **32** (2006), 261.

complaints. And, second, the role has to be governed by a certain continuity. When the cashier's working day is done, there is absolutely no need to continue to act as a cashier. He can be a normal individual, entirely separated from his occupational role. And there is no need for other people to continue to refer to him as a supermarket cashier when he is out of his working place, because as a cashier he does not possess any special attributes which stay with him all the time.

So what we are interested in is roles which are strong enough to create a role morality for the individuals who occupy them. In general, these roles 'seem to switch off ordinary moral constraints, requiring us to do things that would otherwise be wrong.'[16] MacIntyre refers to them as *characters*: 'a special type of social role which places a certain kind of moral constraint on the personality of those who inhabit them in a way in which many other social roles do not.'[17] It would seem perhaps that this discussion leads to the definition of a profession, and its dissociation from mere occupations. But a strong social role can also refer to situations where no work or special knowledge is involved. The role of the father, for example, is a strong role which comes with a role morality of its own, derived from the special relationship which exists between a father and his children. The same is true for the role of the friend; friendship allows some special moral liberties, or imposes some special moral requirements. There is a variety of other public roles which, without being considered as professional roles, can create a role morality nevertheless. But this essay aims at describing the aspects of a professional role, the one of the physician. Therefore, the concept of role morality in this thesis shall be confined to the professional area.

II) Professional roles

It also seems necessary to mention some issues arising from our reference to the notion of 'professional roles'. The terms 'profession' and

[16] Judith Andre, 'Role Morality as a Complex Instance of Ordinary Morality' *American Philosophical Quarterly* **28** [1] (1991), 73.
[17] Alasdair MacIntyre, *After Virtue: a study in moral theory* [2nd edition] (London: Duckworth, 1985) p. 27.

'professionalism' are often used in a careless way, causing much confusion as to what their essence really is. More clarity is certainly needed with regards to this problem, but this is not the main concern of the present thesis. However, since these terms are going to be mentioned throughout the thesis anyway, I shall endeavour to offer an opinion as to how I define them and in what way I use them.

What is a profession?

A profession is a special type of occupation. There has been extensive debate as to how exactly to define a profession.[18] For our purposes, we need to understand the difference between social and professional roles, and also for reasons of clarity as to what 'professionalism' and 'professional ethics' are about. But how do we decide what occupations fall into the category of professions? This is not an easy question to answer, but a step in the right direction would seem to be to focus on the most traditional professions, which qualify most effortlessly, and see what characteristics they have in common. And which professions are the most traditional ones?

> In the Anglo-Saxon world at the beginning of the nineteenth century, the recognized gentlemanly professions were, in practice, only three: divinity, and its recent offshoot university teaching; the law, which filled, with the exception of architecture, most of the relatively prestigious specializations that could be considered 'professional' before the industrial revolution; and the profession of medicine.[19]

What exactly do these traditional occupations have in common, so that they all count as professions? I would say that their members possess a certain amount of specific knowledge, which gives them some specialised social skills and the corresponding power within society. Priests and university teachers are spiritual leaders; judges and lawyers

[18] See, for example, Stephen Latham, 'Medical Professionalism: A Parsonian View' *The Mount Sinai Journal of Medicine* **69** [6] (2002), 363-369, at 363.
[19] Magali Sarfatti Larson, *The Rise of Professionalism* (Berkeley and Los Angeles: University of California Press, 1977) pp. 4-5.

make sure – ideally – that justice is delivered; and members of the medical profession are in control of health and, probably, of life itself. If used correctly, these powers can serve and benefit society; but if they are used in the wrong way, that is, selfishly, they can do harm. So the professional man is the one who uses his powers correctly, for the benefit of all, and not selfishly. Indeed, 'it has been suggested that professions are to be distinguished from other occupations by their *altruism* which is expressed in the "service" orientation of professional men.'[20] Therefore, a professional role, like the one of a lawyer or a physician, has to entail the element of altruism, and the assurance that the role holder shall not use his power for selfish reasons which could harm society's interests. In order to achieve that, the notion of *professionalism* has to supplement any given profession.

Professionalism and professional ethics

'The qualities of what constitutes professionalism are not always constant and indeed not always clear.'[21] Nevertheless, I would like to make the assumption that professionalism can be best described as a means of controlling a profession's power. A teacher, a lawyer, or a physician may belong to certain professions, but if they lack professionalism, they cannot be approached as proper professionals. Professionalism means commitment to a *calling*, that is, 'the treatment of the occupation and all of its requirements as an enduring set of normative and behavioural expectations.'[22] Indeed, society expects professionals to use their power in an appropriate way, according to some ethical standards which are defined by the profession itself. This means that professions are self-regulated to a large extent, and this happens in various ways. For example:

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[20] Terence J. Johnson, *Professions and Power* (London: The Macmillan Press Ltd., 1972) p. 13.
[21] Wilbert E. Moore, *The professions: roles and rules* (New York: Russel Sage Foundation, 1970) p. 3.
[22] *Ibid.*, p. 5.

> One prominent way in which professional associations operate as agencies of self-regulation is in the development of codes of conduct. What these amount to are private systems of law.[23]

These codes of conduct are part of a more general ethical framework, the one of professional ethics.

If we accept what was said before on roles and role-based moralities, then professional ethics teaches professionals their role morality. Since they hold these special powers in their hands, they cannot be left with common morality alone, or simply be allowed to develop this common morality in whatever way they think; they need a special, role morality. This means that they also have to make compromises, and lead lives different to those of laypersons. As Swick notes, 'a profession becomes a way of life with moral value.'[24] There has to be a separate morality for the professionals, one that makes sure that they make proper use of their knowledge and skills, instead of abusing them. This professional morality is constructed through a complex process which, among other things, includes lessons, professional guidelines, special bodies of regulation, and, what matters most, the influence of role models and ideals.

Professionalism anticipates many problems in our days, hence the need for the development of projects such as Harvard's 'Good Work Project'. As its leading figure, Howard Gardner, states: 'it is tempting to posit a golden age – a time when professionals *were* professionals, and the vast majority exemplified the highest values of the domain.'[25] This implies that professional morality is compromised in various ways, and that it needs to be re-evaluated. 'It is often quite difficult for individual professionals to uphold the standards of their calling ... a new covenant must be formed between professionals and the society in which they

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[23] *Ibid.*, p. 116.
[24] Herbert Swick, 'Toward a Normative Definition of Medical Professionalism' *Academic Medicine* **75** (2000), 613.
[25] Howard Gardner 'Compromised Work' *Daedalus* **134** [3] (2005), 47.

live.'[26] I hope that the present thesis can play even the smallest of parts in this effort that takes place.

To sum up: within a profession, professional ethics creates professionalism in theory, and applied professionalism creates proper professionals. This last statement seems a little arbitrary, but at this point it needs to be so, and the reason is offered at the end of this chapter.

Medicine as the most important profession

By acquiring a professional role and the role morality that necessarily goes with it, professional individuals are expected to fulfil the purpose they serve as effectively as possible. The higher the purpose, the stronger the professional role is; and the stronger the professional role is, the more the professional's personality is affected.

In today's extensively secular Western society, the purpose of spiritual leading has lost much of its meaning. In a Muslim country, perhaps an Imam can use his power to ignite wars; but Western priests, except for the leaders of some marginal faiths, are becoming more and more ceremonial necessities instead of spiritual leaders whose words of wisdom will influence the believers' way of life. On the other hand, transmission of knowledge is always important, but academic teachers do not seem to be much more different than laypersons, mainly because of their diversity. A poet and a nuclear scientist can both be academic teachers in different departments. What do they have in common, apart from teaching in a class? Nothing comes to mind. It seems that this vagueness causes the academic profession to lose much of its coherence, and, consequently, its moral importance. To be sure, academic professionals are as morally important as ever; but this fades when we move from the individual approach of the professional to the vague notion of the academic profession.

[26] Howard Gardner 'The Ethical Responsibilities of Professionals' *Good Work Project Report Series*, Number 2, 1998 (updated 2001), p. 5, available from http://pzweb.harvard.edu/eBookstore/PDFs/GoodWork2.pdf, accessed 14/10/2007.

So this leaves only two areas which create strong professional roles clearly acknowledged by modern society: law and medicine. Role morality makes much more sense when it refers to the two main professions emerging from these areas: the lawyer and the physician. Being the most important, these two professions anticipate the greatest professionalism-related problems. For example, 'the clear message to law students is that lawyer professionalism, and indeed ethics in general, is either irrelevant to their lives or something to be deployed instrumentally to further their self-interest.'[27] And as for the other great profession, 'there is cause for alarm about the current state of professionalism in medicine.'[28] The problems with professionalism shall be explored later. For the time being, let me just explain why medicine is a much more important profession than law, and why my thesis is almost exclusively devoted to medicine.

Quite simply, medicine's purpose is very different to law's, because the reality of health promotion is natural, while justice is a constructed reality – of course, Aristotle describes a 'natural just', but he separates it from 'legal just'[29] which is what lawyers deal with. Illness can exist outside society, but injustice cannot. Physicians resemble lawyers, who also owe their livelihood to an evil, but the difference is that the evil which lawyers deal with is not a natural one.[30] It is as if physicians fight against an external enemy, while lawyers fight an internal one; moreover, it appears that lawyers often engage in civil wars. Without underestimating the importance of law and justice, I think we can say that the physician's role is a much more authentic one, as the purpose of medicine is more natural, clear, and more sacred in any case. Justice, being a social construction, is a very complicated concept. Health, on the other hand, is plain and simple, and it is only when it becomes too

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[27] David Wilkins 'Redefining the "Professional" in Professional Ethics: An Interdisciplinary Approach to Teaching Professionalism' *Law and Contemporary Problems* **58** [3/4] (1996) 241-258, at 246.
[28] Laurence McCullough 'The ethical concept of medicine as a profession: its origins in modern medical ethics and implications for physicians' *Advances in Bioethics* **10** (2006) 17-27, at 18.
[29] Aristotle, *Nicomachean Ethics* [translated by Christopher Rowe] (New York: Oxford University Press, 2002) 1134b, p. 169.
[30] I. Bamforth, 'Knock: a study in medical cynicism' *Medical Humanities* **28** [1] (2002), 17.

institutionalised that it starts losing its straightforwardness. This does not mean that medicine exists as a natural institution; it is necessarily shaped by the society of which it is a part, but it also plays an important role in shaping society's norms and values.[31] Therefore, it is both easier and more essential to examine the role of the physician and the role morality that comes with it. And this is what this thesis is all about.

Other health care professions

Before proceeding, I need to clarify an issue. It is understandable why a concept of role morality is not as important in other professional areas as it is in health care and law; I have also explained why I choose to deal with health rather than justice, excluding in this way law professionals from the discussion. So now one might want to ask – and if not, I have to ask myself – why this thesis deals exclusively with physicians, as there are other health care professionals who also appear to have a role morality which deviates from their common morality: I mainly refer to nurses. Is it not true that the nurse's role is strong enough to create a role morality? Do not nurses undergo special training and moral reconstruction just like physicians do? Does not nursing qualify as a profession? If the answer to these questions is affirmative, then why is it that this thesis selectively honours physicians?

There are three points which need to be made: first of all, it is not certain that nursing can be a profession as much as medicine is. Even though today it is self-regulated and widely acknowledged as a profession,[32] there are writers who doubt whether its essence – that is, caring – can be compatible with professionalism, and argue that nurses should reject the term 'profession'.[33] This means that the nurse's role is surely exceptional, but it nevertheless cannot be compared to the physician's when it comes to its social importance. Second, nurses often

[31] David Greaves, *The Healing Tradition: Reviving the Soul of Western Medicine* (Oxon: Radcliffe Publishing, 2004) p. 131.
[32] Nina Fletcher, Janet Holt, Margaret Brazier and John Harris, *Ethics, Law & Nursing* (Manchester: Manchester University Press, 1995) p. 2.
[33] A. Williams, B. Sibbald, 'Changing roles and identities in primary health care: exploring a culture of uncertainty' *Journal of Advanced Nursing* **29** [3] (1999), 737-745.

assume a 'doctor-nurse' role,[34] which means that their profession borrows many elements from medicine. Therefore, a big part of the following discussion can apply to the nursing profession as well, regardless of my constant focusing on physicians. To be sure, despite being so close to each other, these two roles are very different, and I am not implying that by discussing only one of them I can cover the other satisfactorily. But the physician's role, as it shall be shown, has so many more aspects than nursing, that its discussion shall provide much more information. In addition to that, my third point is that the physician's role has a very lengthy tradition which provides a sufficient culture in which every physician can be embedded, while nursing is relatively new as a profession – according to Wilson, before Florence Nightingale, nurses were 'dowdy, illiterate, and often drunken sluts';[35] therefore, without a culture as rich as medicine's, members of the nursing profession cannot sufficiently separate themselves from laypersons. I hope that this explains why this thesis is mainly a discussion of physicians, and not of any health care professional. If not, I doubt there is anything else I could say. It is not my intention to become engaged in a discussion of problematic aspects which abound in the relationship between physicians and nurses.

III) Physicians and laypersons

The physician's role shall be compared to the layperson, and its role morality shall be compared to the layperson's common morality. Therefore, it would be useful to explain first what exactly a layperson is and how a physician differentiates himself. Let me first engage in the easier task, by defining the term 'layperson' and adapting it in order to function for this thesis.

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[34] Jonathan Montgomery 'Doctor's Handmaidens: The Legal Contribution' in Shaun McVeigh and Sally Wheeler (eds.), *Law, Health & Medical Regulation* (Aldershot: Darmouth Publishers, 1992) p. 141.

[35] T. G. Wilson, *Victorian Doctor* (Wakefield: EP Publishing, 1974, first published in 1942) p. 18.

The layperson

It would seem that a layperson is a primitive individual, deprived of every other quality apart from the very basic ones, the ones which are to be found in every person. But such a person does not exist; it would have to be someone with absolutely no occupation, purposes, and any kind of personal development or possibility for development. It would have to be someone within society, but without any actual links to it; because, by being someone's friend for example, he would acquire the role and the qualities of a friend, overcoming the neutrality of the layperson. So it is only by comparison that one can be regarded as a layperson. In our case, we take medicine to be the point of reference. Therefore, what I shall refer to as 'layperson' is a layperson from the physician's point of view. A lawyer, for instance, is not really a layperson; quite the opposite, he is a professional. But when it comes to medicine, the same individual becomes a layperson, no matter how well developed and sophisticated he really is.

Accordingly, we have to adopt a similar approach to common morality. Aristotle wondered what would be the good of the human being's function, irrespective of any particular social roles and corresponding functioning in which one could be engaged.[36] The good which resides in the human being's function must be what I refer to as common morality; something which can be found in everyone, as everyone is a human being. But in a society everyone has also many other qualities apart from being human. Common morality is something very basic, which cannot go beyond the mere quality of being a member of the human race; it is the baseline, or 'default' against which we initially assess anyone's behaviour, regardless of his or her station in society.[37] As noted earlier, however, common morality is also groundwork. An individual's personal morality can be developed in various ways, but it is always based on that groundwork; and it is only role morality which can

[36] Aristotle, *op. cit.*, p. 101.
[37] David Luban, *Lawyers and Justice: An Ethical Study* (Princeton: Princeton University Press, 1988) p. 110.

be entirely separated from it. Therefore, amending the definition of common morality's concept a little, we can say that it is every morality which is based on the common groundwork. Complying with a common morality does not mean that an individual does not seek any good apart from the very basic ones; it rather means that there are some moral elements which he cannot possess unless he acquires a certain role which brings these elements with it. Common morality therefore shall be anything but role morality, or, to put it better, the potentiality for anything but role morality – because we cannot take each and every layperson's actual personal moral development into account, it is better to refer to potential moral development instead.

A first look at the medical profession

Common morality can be anything but the physician's role morality, and the layperson can be anything but a physician; this is a convenient statement, but it remains incomplete until I specify what the physician's role morality and the physician are. I would like to be able to say that, as the layperson is a non-physician, a physician is correspondingly a non-layperson – but obviously it is necessary to be more precise. Therefore, the next task is to define the term 'physician' and to try to understand the physician's personality.

This is not particularly simple; for what I have to do is to discover the features which are common to every physician, while it is clear that, when we think of specific physicians, what is more obvious is differences and not similarities. There are good and bad physicians; hard-working and more relaxed; poor and wealthy; and so on. Furthermore, some physicians are confined by their specialties or their working areas and they are not able to fulfil the higher purposes of medicine like their colleagues do. For example, a general surgeon in a busy hospital can save one or more lives everyday when at work, while a cosmetic surgeon in Hollywood must content himself with adding some aesthetic details to starlets' looks – and making a lot of money of course. What these two physicians have in common is only a medical degree and a license to

practice. Also, some more impersonal specialties, like the one of public health, lack a lot of moral considerations which abound in more personal interactions between doctor and patient. Clearly, there are a lot of important differences between physicians. This is why Jochemsen and ten Have think that it is necessary to make a distinction between 'real medicine' and 'elective medical interventions'.[38]

Therefore, I am going to describe just a *model* of the physician without considering any specific details. 'A model can be understood as an attempt to make apparent *some* of the essentials of a complex reality.'[39] Hence individual physicians approach this model to different degrees and the more they approach it, the more they differentiate themselves from laypersons. Even if this model can never be completely satisfied in real life, it surely offers some insights into the physician's personality, from which it is easier afterwards to explore the physician's role morality. Perhaps full comprehension is impossible for someone who is not a physician; but a greater level of objectivity can be expected, and besides, even physicians themselves find it difficult to define the essence of their role.[40] 'The profession of medicine is currently at a crossroads between the private, autonomous, personal practitioners of the past and future physicians, whose role is not yet clear.'[41] Indeed, at this point it is rather difficult to understand what medical role, medical professional, or medical professionalism mean. The next chapter, therefore, is devoted to an effort at understanding the physician's role by constructing a model, as well as by discussing some concepts which try to explain the medical profession and its peculiarities.

[38] Henk Jochemsen and Henk Ten Have, 'The Autonomy of the Health Professional: an Introduction' *Theoretical Medicine and Bioethics* **21** [5] (2000), 406.
[39] Edmund Erde, 'The Inadequacy of Role Models for Educating Medical Students in Ethics with some Reflections on Virtue Theory' *Theoretical Medicine* **18** (1997), 33.
[40] Zosia Kmietowicz, 'Doctors struggle to define the essence of being a doctor' *British Medical Journal* **326** (2003), 1352.
[41] Jeff Solomon, Jennifer DiBara, Sara Simeone, and Dan Dillon 'Opportunities and Obstacles for Good Work in Medicine' *Good Work Project Report Series*, Number 8, 2000, p. 3, available from http://pzweb.harvard.edu/eBookstore/PDFs/GoodWork8.pdf, accessed 14/10/2007.

Brief clarification

Before proceeding, it seems appropriate to make a clarification, so as to be best prepared for the following chapters of the thesis. Up to this point, I have made several assumptions which shall facilitate the discussion on physicians and their double morality. Most of them can be excused, but the one referring to professionalism and professions is particularly troubling. It appears that what I believe is that, in essence, 'role morality' is another term for 'professionalism'. In fact, even if we had a clear and universal view as to how to define 'professionalism' (and not the personal view which I used earlier), we would still have to test the compatibility of professionalism, or even the whole notion of 'profession', with the theory of double morality which shall be explored, and which contains the notion of 'role morality'. But this cannot happen, at least not until the theory of double morality has itself been tested and validated; and this shall be taking place gradually. Therefore, disturbing as it may be, professionalism shall be the same thing as role morality for now. But when the time comes, I shall re-examine its essence, and possibly propose an alternative approach to its correct use.

Chapter 2

THE LAND OF MEDICINE

In this chapter I shall explore the main character of this thesis, the physician, and the nature of his profession. To do that, I will call into play the concepts of the *model* physician, the *ideal* physician, the *god of Medicine* and this god's *servants* – all these expressions shall be fully explained and shall then be used for the rest of the thesis. I should note though that these concepts are considerably fragile, and based largely on assumptions which shall be tested at some point. So even if one disagrees with the way physicians and medicine are treated here, one should not hasten to reject the perspective of this thesis which is developed gradually in the chapters to follow. In any case, there have been so many ideas and opinions on the being of this profession that some more cannot make such a big difference so as to deserve total rejection.

I) What Makes Physicians So Special?

Apart from exploring the physician's personality, it is also useful to construct a model physician for the purpose of understanding what it is that is so special about physicians so as to make them worthy of a separate role morality entirely of their own. The following discussion of what the physician is moves away from morality and it seems to deviate from this thesis' course, basically because of its considerable length. But it is a necessary deviation as it is needed to establish the physician's special status and dissimilarity. If this fails, then this thesis is groundless, and there is no reason why I should continue troubling myself about writing it.

Thinking in terms of gains and losses

In order to learn what a physician is one could proceed in various ways; one could think in terms of ethical reconstruction, of responsibilities, of social status, or of some other, ostensibly unimportant, elements. However, thinking in terms of something specific could hide from one many aspects of what one intends to explore. It is to be hoped that the approach that I propose here shall entail every aspect of the physician's role; I shall consider it in terms of gains and losses. What does one have to gain should he become a physician, and what does one have to lose? It may be a wrong approach perhaps; many would say that medicine should not be so computational, and I tend to agree with them. But let me remark that the point here is not to weigh the advantages of a physician against the disadvantages, and decide whether becoming a physician is a good thing; the point is to entail as many details as possible in our constructing of the model physician. And this method of proceeding seems to be so rational, that it might succeed in presenting the complete picture.

A difficulty comes up if we try to define what constitutes a gain and what a loss. Something that is clearly an advantage from one point of view could be a disadvantage from another point of view, and we know that our society abounds in points of view. Personally I am not a physician, and what I consider to be a loss can be viewed as a gain from a physician's point of view. But as noted above, the purpose here is to discuss as many issues as possible, and not to reach a verdict as to whether being a physician pays or not. I believe therefore that it shall not matter if a physician, or anyone else, would not agree with my perception of gains and losses. Finally, I should also note that gains and losses are not detached; one gain can be linked to another, like self-respect can stream from high status, and a loss can be the result of another loss, like social isolation being the result of lack of time – without implying that isolation is entirely due to lack of time. But presently the links between any gains and any losses are of no interest anyway.

Having clarified these issues, I can start constructing the model.

Some gains

It is certain that medicine can offer a lot to the individual who chooses to serve it, and it seems that people recognise it. This is evident when we consider the growing numbers of applicants for medical school places, giving a ratio of 1.97 applicants for every place in Britain,[1] while medical schools in the United States must review more than 500000 applications every year.[2] Despite the unwarranted pessimism that medicine is declining in popularity as a career and that the supply of applicants in the near future will be barely meeting the demand,[3] the physician's profession is among the most highly valued ones; this means that the advantages are either far more than the disadvantages, or that they are more visible than the disadvantages. In any case, everyone tends to link the physician's profession to its gains, as the widespread belief is that it is a good profession. But as usual, what happens on the scene is not as interesting as what happens behind the curtains. The fact that the medical profession's gains are so obvious makes them less interesting than the less obvious losses. Therefore, I shall mention some gains briefly, in order to concentrate on losses afterwards, which, in my view, constitute the most important issue.

a) Wisdom

The poet Thomas Gray has remarked that 'When ignorance is bliss, 'tis folly to be wise.'[4] Proponents of hedonism who want to maximise this world's happiness should try perhaps to put into practice this remark by finding a way to render ignorance the standard disposition of individuals.

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[1] Samuel Leinster, 'Applications have increased again for second year running' *British Medical Journal* **326** (2003), 161.
[2] Harrison Gough, 'How to...select medical students: a second look' *Medical Teacher* **26** [5] (2004), 479-480.
[3] I. G. McManus, 'Medical school applications – a critical situation' *British Medical Journal* **325** (2002), 786-787.
[4] Thomas Gray 'Ode on a Distant Prospect of Eton College' in Arthur Johnston (ed.), *Selected Poems of Thomas Gray and William Collins* (London: Edward Arnold Publishers, 1967) p. 26.

But that would be the end of all kinds of knowledge and consequently of medicine, which is practice based on knowledge – that is, medical wisdom, the power to heal via knowledge and technique.[5] Of course anyone may have access to knowledge, even medical knowledge by studying the correct books, but it is much more difficult to gain wisdom. The physician's knowledge is conditionally useful, and it becomes wisdom, provided that it is used by the physician; laypersons that happen to have access to knowledge without knowing how to make use of it remain in a sense ignorant, as their knowledge is pointless.

The physician's knowledge is immense, due to the extensive studies he has to complete as a student, his everyday experiences, as well as to his position as a professional, which allows him to learn a lot about people's lives and human nature in general. Even if Thomas Gray and some Hedonists can point out that all this knowledge amounts to less happiness, the fact remains that knowledge is power, and medical knowledge can mean power over issues of life and death. The privilege of the physician to have this power and the required wisdom – and authority – to use it correctly is an indisputable gain that medicine can offer exclusively.

It needs to be remarked that sometimes physicians' knowledge falls short, as medical science naturally has its limits. But medical wisdom, which originally comes from medical knowledge, is able afterwards to cover up any knowledge's inefficiencies. Physicians have always tried to retain the image of the wise person even when they had no solid grounds for it, and they have succeeded. For example, this is the tricky advice that Arnald of Villanova has to offer to physicians of the 13th century:

> If by hard luck you come to the home of the patient and find him dead and somebody perhaps says: 'Sir, what have you come for?' You shall say that you have not come for that, and say that

[5] John McMillan & Lynley Anderson, 'Knowledge and Power in the Clinical Setting' *Bioethics* **11** [3&4] (1997), 265-270.

> you well knew that he was going to die that night but that you wanted to know at what hour he had died.[6]

The model physician always knows what to do to demonstrate wisdom. Gogol's account of physicians in *The Overcoat* is another fine example:

> ... when the doctor arrived and felt his pulse, all he could prescribe was a poultice – and only then for the simple reason that he did not wish his patient to be deprived of the salutary benefits of medical aid ... After which he turned to the landlady and said: 'Now, don't waste any time and order a pine coffin right away, as he won't be able to afford oak.'[7]

Physicians have been following practices like these for centuries. They have the knowledge and the ability to use it wisely; but even when there is nothing that their science could do, they still manage to look wise. So the first detail to be added to the model physician is wisdom; the physician's personality is the one of a wise person.

b) High Status

A physician is a very important person in every society. Respect comes quite naturally for anyone who possesses knowledge, provided that this knowledge can be demonstrated of course. But the physician is traditionally in a better position because, by dealing with matters of health, and by being in a position to save a life in his everyday routine, he is widely recognised as someone worthy of respect. This recognition changes the way society sees someone once he is a physician, but also changes the way that the physician sees society, and, what is more important, himself. It is normal for a physician to feel that he belongs to society's elite, especially when he considers that modern society is, in Ivan Illich's words, a 'medicalized' society, where physician's influence extends almost everywhere:

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[6] Arnald of Villanova 'On the Precautions That Physicians Must Observe' in Stanley Reiser, Arthur Dyck, and William Curran (eds.), *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Massachusetts: The MIT Press, 1977) p. 13-4.
[7] Gogol, *Diary of a Madman and other stories* [translated by Ronald Wilks] (Harmondsworth: Penguin Books, 1972, first published in 1842) p. 101.

> Medical bureaucrats subdivide people into those who may drive a car, those who may stay away from work, those who must be locked up, those who may become soldiers, those who may cross borders, cook, or practice prostitution, those who may not run for the vice-presidency of the United States, those who are dead, those who are competent to commit a crime, and those who are liable to commit one.[8]

All this power gives to the medical profession an extremely high status, which is certainly transferred to the profession's representatives.

Szasz understands that the physician's status is probably much higher than necessary and remarks: 'People should respect physicians for their skill but should distrust them for their power.'[9] Illich also notes that medicine is so powerful that it disables people from doing or making things on their own: '... when hospitals draft all those who are in critical condition, they impose on society a new form of dying.'[10] There has been an attempt to demystify the medical profession in recent years but it is not yet complete, and probably shall never be. Physicians did not agree with Illich's views when he was alive;[11] it is very unlikely to do it in the future, and in any case, Illich probably does not care anymore. But even if everyone recognised that the extremely high status that it was attributed to physicians was based on society's medicalization and decided to put an end to it, then the medical profession would surely lose some of its importance, but it would remain very important nevertheless. Physicians would still be the ones responsible for health's promotion, and this is enough to guarantee reasonable levels of high status and respect.

Respect may even be derived from fear; either fear of the unknown secrets that the physician possess – which is pure fear leading to pure respect – or fear of illness – which is a bad fear, and it leads to a

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[8] Ivan Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (Harmondsworth: Penguin Books, 1990, first published in 1976) p. 85.
[9] Thomas Szasz, *The Theology of Medicine* (Oxford & Melbourne: Oxford University Press, 1979) p. xxii.
[10] Illich, *op. cit.*, p. 50.
[11] Robert Barnet, 'Ivan Illich and the Nemesis of Medicine' *Medicine, Health Care and Philosophy* **6** (2003), 273-286.

false respect, just because there is the thought that the physician may come in handy someday. But wherever respect comes from, the fact is that it exists. Physicians enjoy great respect and high status, even in cases where they do not deserve it personally, because their profession has great respect and high status. Therefore, in the model of the physician we have to insert these characteristics for sure.

c) Self-respect

It was noted earlier that, by becoming a physician, the way one sees oneself changes. The average physician is usually a very self-confident person with great levels of self-respect, no matter how big his achievements have been. It is only natural, since the physician knows some facts about himself that tend to create the image of a super-being. First of all, he knows that he was admitted in the school of medicine where requirements are traditionally high and competition between applicants is hard – and if we want to look further back, he knows that he has been a very good student at school (from the top 0.4% to the top 10%[12]). Then he knows that he managed to come through the medical school, a very difficult task indeed, if we consider that the average dropout rate for first year students only is 3.8%[13] and in general for students who begin a medical degree but fail to complete, both in the UK and elsewhere, is reported to be between 8% and 10%.[14] The physician knows that he is a member of an elite society with a noble cause; as Kennedy remarks, 'the doctor is categorised as the crusader constantly called upon to wage a holy war upon the enemy called disease...'[15] And he knows that the lives of many people, being what they value above all, may be or have been in his hands. But most importantly, he knows that

[12] Patricia Hughes, 'Can we improve on how we select medical students?' *Journal of the Royal Society of Medicine* **95** [1] (2002), 18-22.
[13] Wiji Arulampalam, Robin Naylor, Jeremy Smith, 'Factors affecting the probability of first year medical student dropout in the UK: a logistic analysis for the intake cohorts of 1980-92' *Medical Education* **38** [5] (2004), 492-503.
[14] Hughes, *op. cit.*
[15] Ian Kennedy, *The Unmasking of Medicine* (London: George Allen & Unwin, 1981) p. 20.

people know all these things about him, as they do so about every physician. Respect usually attributes self-respect.

The physician knows that his profession guarantees him a fixed profile – the one we are exploring actually – behind which he can hide any uncertainty and any weakness of his own. The traditional role of the physician is the one of the hero, not being afraid of death and disease and being ready to sacrifice himself to the good of the others, like Dr Rieux in *The Plague*.[16] Even the greatest coward acquires this heroic image when he becomes a physician, because this is what society expects of him. Many people do not know whether they are cowards or not, as they can lead a normal modern life without many chances to test their courage. But the physician, by virtue of his image, is automatically a hero without having accomplished any heroic deeds. There can be times where the heroic image shall be tested – extraordinary circumstances like war, natural disasters or epidemics come to mind. If the physician is truly brave he will prove it, and self-respect shall be augmented. If he is a coward behind the physician's role, the image of the hero shall be under serious doubt, along with self-respect. But a big test like that is rather rare and self-respect is usually quite secure for the physician. This is another gain that medicine has to offer.

d) Material benefits

The rule says that the physician is economically in a better place than most of his fellow people; society recognises the need for physicians to be paid satisfactorily so as not to worry about material things and to be able to concentrate on their noble tasks. In addition, the number of medical schools is limited and medical associations always control the number of licensed physicians, so as not to have physician surplus and consequent unemployment. George Bernard Shaw remarked too early that medical practice is governed not by science but by supply and

[16] Albert Camus, *The Plague* [translated by Stuart Gilbert] (Harmondsworth: Penguin Books, 1960, first published in 1947) p. 74.

demand;[17] and even though, as some people believe, medicine incessantly labours to destroy the reason for its own existence,[18] there can be no doubt that there will always be a demand for medical services. And if we also consider the physicians' monopolistic position in the health care area as described by Arrow,[19] we can be sure that the model physician never worries about money.

In practice the situation differs to a certain extent. Physicians seem to adopt a material point of view and care about money quite often. Later on, in Chapter 4, I shall discuss why they do it and how it is possible. But for the time being, suffice it to say that if sometimes they ask for more money it is not because they really need it, but probably because they feel 'overworked and undersupported'[20] and assume that their important and hard work should be compensated even better than it presently does. This does not mean that the medical career is not in any case a very prosperous one.

e) Personal Satisfaction

Above all, people choose to become physicians because they like medicine. They like to be in a position to help, to save a life, to feel the gratitude of their patients and to enjoy all the gains which were mentioned before. Medicine is not simply a job, but a calling, and whoever enters that area does it because he really wants to, and not by accident as it can happen with many other choices.

But often personal satisfaction does not last for long while all the other gains we discussed are in a sense more permanent. Could it be that the real world's insurmountable difficulties, coupled with a deeper understanding of the situation in medicine, destroy physicians' idealism and let them easily down? Let us check the profession's disadvantages

[17] George Bernard Shaw, *The Doctor's Dilemma (Preface on Doctors)* (Harmondsworth: Penguin Books, 1966, first published in 1911) p. 68.
[18] Kennedy, *op. cit.*, p. 18.
[19] Kenneth Arrow, 'Uncertainty and the welfare economics of medical care' *American Economic Review* **53** [5] (1963), 941-73.
[20] Richard Smith, 'Why are doctors so unhappy?' (editorial) *British Medical Journal* **322** (2001), 1073.

to see whether this is possible; usually, by 'deeper understanding' we merely mean 'taking losses into account as well'.

Some losses

Sometimes losses seem to be the same everywhere; someone with a totally different occupation could have the same losses as a physician, like anxiety or lack of time and personal freedom. Therefore, it could be said that most of the gains of medicine are unique, while the losses are the ones of a normal occupation. However, on the one hand, some very unique disadvantages can be found in medicine, and on the other hand, what makes losses in medicine important is their unexpectedness. One can discuss the physician's gains normally enough, as the fixed positive image of the physician's profession implies many of them. However, when it comes to losses, one who is not prepared finds it hard to believe that there can be so many serious disadvantages. Besides, it is possible that a negative approach can be more enlightening and reveal more aspects of what is explored. This is why it is necessary to scratch the surface of losses much more than the one of gains, if any real understanding of the physician is to be expected.

a) Lack of time

The physician's career usually imposes great constraints on his free time. Of course free time depends on the position one holds, on one's specialty and on the area in which one works. But for the model physician free time is seriously threatened. When at home, a physician may have to work by talking on the phone with his patients; or he might have to wake up in the middle of the night if anything extraordinary occurs. It is true that the physician has some time of his own; but it seems that it is only borrowed time. Medicine, being the lender, can ask for it at any point. Harris has a good point when he mentions the cricketer: '... playing cricket is (if anything is) always a cricketer's business, it is what he is trained for, it is his vocation. But that does not

mean that he is obliged to play in every match, or every time someone turns up wishing to see him play.'[21] But then he immediately adds: 'Perhaps this analogy misses an important point, that medicine is special, and its specialness just consists in its role in saving life and in healing or caring for health and in the special priority we give to all these things.'[22]

Furthermore, perhaps this discussion on the physician's time is groundless, because a physician's and a layperson's perception of time may differ widely. In comparing nurses and physicians, Skjorshammer makes the following observation: 'To nurses, time seems to be spread out linearly, in a way that makes it possible to divide time and control the use of time. To physicians, time seems to come in terms of tasks. Their challenge is not to portion time, but to prioritise the most urgent tasks at hand.'[23] If he is right, then it is impossible to talk about physicians' time in any conventional way. The model physician's professional demands have such an impact on him that he loses not only his free time, but also the normal understanding of time. As I cannot enter a physician's mind, I am not able to further explore this observation, but it surely enhances the view that physicians live in a world of their own, making it very hard for outsiders to understand them.

b) Stress and psychological damage

'Someone in a lecture last week said that if you do not have a complete sensation of panic once a week, then something is wrong,'[24] a medical student reports. Stress could be attributed to the lack of time; but it is also the result of the great responsibility that the physician's profession entails. Many occupations entail great responsibilities of course, but it certainly makes sense that the preservation of health should be the

[21] John Harris, *The Value of Life: An Introduction to Medical Ethics* (London: Routledge & Kegan Paul, 2002, first published in 1985) p. 52.
[22] *Ibid.*
[23] Morten Skjorshammer, 'Co-operation and conflict in a hospital: interprofessional differences in perception and management of conflicts' *Journal of Interprofessional Care* **15** [1] (2001), 16.
[24] Daniel Egan 'Learning Experiences' *Medscape Med Students,* World Wide Web (http://www.medscape.com/viewarticle/481438), accessed September 30, 2004.

greatest of all; this is because most of us would be ready to value health above anything in our lives, given that we could think about it for a moment. It is true that other occupations also deal with health in a way. A pilot has to be sure that the passengers aboard his plane retain their health status as it is, instead of ending up crashed and burnt in a terrible accident. And so does the architect who draws the plan for a stable house instead of one that would fall down upon its inhabitants; the chef who cooks carefully; and so on. But all these people deal with health indirectly. The pilot cares mainly about his plane, the architect about his house and the chef about his food. It is only the physician who, not only deals with health and life directly, but also starts with a serious handicap, as he usually deals with people whose health is already fragile. And this gives him, if not greater responsibility, then a very special kind of responsibility; consequently, the physician's stress is a very peculiar one, as he is directly responsible for his patients' health and life. Furthermore, one needs to keep in mind the above-mentioned continuity which characterises professional roles. The physician remains a physician for twenty-four hours a day, and part of his stress stays with him, as his patients are still somewhere out there. The pilot, despite the popular belief that he has one of the most stressful occupations, would never had any more worries after his plane has landed and his passengers have left it.

The physician's stress is enhanced by at least three additional factors; first, the increased risk of legal claims against physicians have made them anxious not only to do right but mainly not to do wrong, as mistakes seem to be unforgivable – a more detailed account of the situation shall be provided in chapter 6, where I discuss the practice of defensive medicine. Second, continuing education raises more difficulties with keeping knowledge in medicine and specialty current, especially as some patients have an increasingly sophisticated knowledge-base.[25] Progress is very fast in health care area and physicians need to be professionally updated. But this seems impossible:

[25] S. M. Bruce, H. M. Conaglen and J. V. Conaglen, 'Burnout in physicians: a case for peer-support' *Internal Medicine Journal* **35** (2005), 272-278.

in 1996, Haines estimated that there were 20000 medical journals and two million articles were published each year, meaning that general physicians would need to digest 19 original articles daily in order to keep up to date.[26] A radical reduction of these absurd numbers since 1996 is highly unlikely; probably they have been further augmented, adding even more stress to the physician's profile. And third, psychological damage can be inflicted, as physicians – and other health care professionals – in their routine confront suffering and death. However professionally detached they manage to be, they still are human beings; for example, 'those who care for the dying in any setting frequently find that the nature of the work confronts them with their own unresolved feelings about future personal death and their past experience of other losses.'[27] Even if it is not easily shown, the factor of psychological damage has to be always considered as a threat to physicians.

To be sure, the model physician can cope with stress. For those who find difficulties, advices are given by professionals[28] and studies have been carried out focusing on what the best defences against stress are.[29] Overall, it seems that there are ways for physicians to deal with it effectively. But this does not mean that it does not exist, or that is does not count as a disadvantage – in fact, it is very well documented.[30] Being a physician is an extremely stressful business, despite the fact that it eventually works out.

c) Hard work and exhaustion

The model physician is a very hard working individual. The shifts can be very exhausting, especially when it comes to a hospital on duty. In recent

[26] Andrew Haines, 'The science of perpetual change' *British Journal of General Practice* **46** (1996), 115-119.
[27] Peter Speck 'Spiritual Issues in Palliative Care' in Derek Doyle, Geoffrey Hanks, Neil MacDonald (eds.), *Oxford Textbook of Palliative Medicine* [2nd edition] (New York: Oxford University Press, 1998) p. 811.
[28] Geoffrey Riley, 'Understanding the stresses and strains of being a doctor' *Medical Journal of Australia* **181** (2004), 350-353.
[29] See, for example, I. C. McManus, B. C. Winder, D. Gordon, 'The causal links between stress and burnout in a longitudinal study of UK doctors' *The Lancet* **359** (2002), 2089-90.
[30] See, for example, Niku Thomas, 'Resident Burnout' *JAMA* **292** [23] (2004), 2880-9.

years there has been a decrease in physicians' working hours, but they still look out of the ordinary; the median workweek of primary care doctors in 2004 was 50 hours for urban areas and 55 hours for rural areas.[31] Residents are in a worse position; recent restrictions in the United States set 80 duty hours as the limit[32] but many residents report that they frequently work outside their program.[33] The British pre-registration year is also frightening, as this description shows: 'They find themselves skivvies of all hours, on whose heads, shoulders, and sleep the whole complex dross of running frontline hospital medicine has been allowed to settle ... what was meant to be the culminating year of a university education turned out to be comparable to the life of a Victorian chimney boy.'[34] The extremely hard work does not last throughout their whole life otherwise many physicians would suffer from physical and mental breakdown – to say nothing of the increased risk of motor vehicle crashes associated with extended work shifts which a relevant study suggests[35] – long before they reached their pensionable age. But what they go through during their early years must be enough for the rest of their lives – and besides, there are some workaholics who tend to work more than less as the years go by.

At the end of the day, it is only natural for the physician to feel exhausted. To be sure, many other occupations contain the element of exhaustion too. But the physician's exhaustion holds a very special place, because there seems to be no easy escape. Observers have reported that physicians now starting their careers say that they want to lead richer and fuller lives than their predecessors; but older physicians insist that they cannot do that and be good doctors, and that 'one has to

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[31] Ken Terry, 'How hard are you working? Lifestyle issues, an aging workforce, and more women are all affecting physicians' hours and the number of patients they see' *Medical Economics* **81** [19] (2004), 30-4.
[32] Kirsten Lund, Ruben Alvero, Stephanie Teal, 'Resident job satisfaction: Will 80 hours make a difference?' *American Journal of Obstetrics and Gynecology* **191** [5] (2004), 1805-1810.
[33] De Witt C. Baldwin, Steven Daugherty, Ray Tsai, Michael Scotti Jr, 'A National Survey of Residents' Self-Reported Work Hours: Thinking Beyond Specialty' *Academic Medicine* **78** [11] (2003), 1154-1163.
[34] Anon. 'Doctors to be: kingdom or exile?' *The Lancet* **340** [8826] (1992), 1009.
[35] Laura Barger, Brian Cade, Najib Ayas, John Cronin, Bernard Rosner, Frank Speizer, Charles Czeisler, 'Extended Work Shifts and the Risk of Motor Vehicle Crashes among Interns' *New England Journal of Medicine* **352** [2] (2005), 125-134.

lead a masochistic life to practice medicine.'[36] Other workers exhaust themselves aiming at personal benefits, and this perhaps justifies their willingness to do it, and makes it easier for them. But a physician exhausts himself for others; it is a noble cause and, at the same time, a trap.

e) Aesthetic distortion

Another loss that his professional role brings upon the physician is the one of beauty. A major discussion on aesthetics cannot be achieved here – especially if the one who has to do it is me; but it is certain that our aesthetic taste functions constantly, whether one finds oneself either at the art gallery or at the city dump. When one does not work there is no problem of course, as the choice of the surrounding objects and environment largely depends on his taste. But when at work, one is obliged to deal with whatever exists in his working environment. There are some lucky persons who happen to work in ideal environments, dealing with beautiful objects. Others do not have this good fortune, but at least they have taste-neutral working conditions. The majority of physicians, on the other hand, have the great misfortune to work in hospitals or health centres. These are in general ugly places, with functional, but tasteless, working spaces; and the context of illness (which abounds in hospitals of course) is not exactly beautiful: disfigurements, disabilities, hives, wounds, pained expressions, catheters and other medical devices, and death.

Now one could say that modern art has redefined the concept of beauty and that aesthetics is really a matter of taste, or that beauty can be found everywhere, even in things that we may call 'ugly', as long as, according to Kant's interpreters, we give a 'beautiful description' of these things[37] – so even a hospital and its containing could be beautiful in this way. This does not look right; would Kant be able to describe in a

[36] Lynne Lamberg, '"If I work hard(er), I will be loved." Roots of Physician Stress Explored' *JAMA* **281** [1] (1999), 14.
[37] See, for example, Avner Baz, 'What's the point of calling out beauty?' *British Journal of Aesthetics* **44** [1] (2004), 57-72.

beautiful way, for example, a patient's projectile vomiting? We must have, at the very least, some second thoughts about that. The purpose of beauty is to tame people by making them forget their certain destiny and other unpleasant issues. This cannot happen in a place where people go only when they do not feel well and where death wanders constantly around. Physicians and other health care professionals may be used to hospital sights, but this does not make them less repulsive. There is intrinsic ugliness, with which the physician deals every day.

Leaving aside the issue of ugliness, a different aspect of the physician's aesthetic reform can be found in his change of perception, his professional medical gaze. As Foucault notes, 'the structure, at once perpetual and epistemological, that commands clinical anatomy, and all medicine that derives from it, is that of *invisible visibility*.'[38] This means that the medical gaze plunges into the space that it has given itself the task of traversing.[39] The physician learns to have a scientific, 'absolute' and 'closed' perception,[40] which is a necessary element of his practice. However, the beauty of this world lies in the surface and in the unscientific gaze; Mona Lisa ceases to be beautiful when it is scientifically explored until the point where we perceive only a canvas with various colours of paint on it. But perhaps this is exactly what the physician has to do; 'The ever-open world of ordinary perception with its undetermined horizons – by its very structure impossible to exhaust – has been replaced by an unambiguous law of discourse...'[41] The physician ceases to have the ability of the ordinary person to perceive something as beautiful without trying to explore it and question it, go beneath the surface in other words.

Some people disagree:

> I have never heard of a gynaecologist who lost his interest in women merely through the hazards of his profession; his

[38] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* [translated by A. M. Sheridan] (London: Routledge, 2000, first published in 1963) p. 165.
[39] *Ibid.*, p. 136.
[40] Christian Hick, 'The art of perception: From the life world to the medical gaze and back again' *Medicine, Health Care and Philosophy* **2** (1999), 129-140.
[41] *Ibid*, at 135.

> gynaecological scrutiny of patients in his office and his interest in a specific woman in his home remain on different psychic levels.[42]

So in the above passage it is implied that the physician manages to retain a dual perception, the scientific and the ordinary one; but we will later see how difficult this can be.

f) Isolation

Society needs and respects physicians; but whether it assimilates them with ease or not is a different issue. Judging from the gains which were considered earlier, it can be said that medicine elevates the individuals who serve it. However, there is the circumspection that perhaps it elevates them far too much, to the point that it cuts them off from the rest of society by turning them into doctors. I do not mean that they are outcasts. They belong to society and they get much respect for what they do. But sometimes it looks as if they represent a necessary discomfort. Physicians are different and laypersons often have the image of a 'weird creature' linked to them. On the other hand, physicians who see their task as of extreme importance compared to others feel perhaps that they can have nothing in common with laypersons. In this way there is a dual isolation; the 'normal' laypersons tend to isolate the 'odd' physicians, and the 'superior' physicians tend to isolate themselves from the 'inferior' laypersons – if they could isolate laypersons and not themselves it would be better for them, but they are by far outnumbered.

Let me consider how physicians isolate themselves first. The factors of hard work and limited free time play a part of course; when a profession imposes such a heavy workload on an individual it is only natural for him to be less sociable than other, more debonair, members of society. But apart from that, it looks like physicians do not care to be sociable anyway. This assumption is based on nurses' and other health care workers' testimonies mostly; they work with physicians and they are

[42] Edmund Bergler, *Laughter and the Sense of Humor* (New York: Intercontinental Medical Book Corporation, 1956) p. 1.

together all the time, so there are no more excuses like time constraints for them. However, researchers note that there is little interest in the medical community in interprofessional relationships and that they prefer more distance from others.[43] Multi-disciplinary teams in health care face many problems of functioning[44] and it has been suggested that one of the main reasons is physicians' attitudes. Hudson argues that medicine, as opposed to nursing, is a 'full profession', and that the physician's professional identity is so strong and different that it makes it difficult for them to see non-physicians as equal;[45] consequently, they fail to find common points and communicate – and this line of argument can surely be extended beyond hospitals and their multi-disciplinary teams to simple socialising with other members of society.

But the biggest problem lies in the other way of isolation, where it is society which isolates physicians. Again, their heavy workload and the way their profession fills their lives so much surely play an important role: 'Outside of work, they don't have much to talk about. Others view them as bland and dull.'[46] But it is also the very nature of their profession that is isolating. Harper notes that this begins in the physician's student years, when he first learns how to break some social taboos:

> Although becoming a physician means status and doing good, it also means having license to break conventions that blind others. Society's ambivalence towards this extraordinary role has been evident since the Middle Ages, when medical students were set apart from other students and rumoured to indulge in debauchery.[47]

Indeed, the Middle Ages must have been cruel for physicians: 'The natural but unreflecting sentiment of horror with which anatomy is everywhere regarded by the populace, was unfortunately sanctioned by

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[43] Elaine Larson, 'The impact of physician-nurse interaction on patient care' *Holistic Nursing Practice* **13** [2] (1999), 39.
[44] See, for example, Jeanie Molyneux, 'Interprofessional teamworking: What makes teams work well?' *Journal of Interprofessional Care* **15** [1] (2001), 29-35.
[45] Bob Hudson, 'Interprofessionality in health and social care: the Achilles' heel of partnership?' *Journal of Interprofessional Care* **16** [1] (2002), 7-17.
[46] Lamberg, *op. cit*, at 13.
[47] Gordon Harper, 'Breaking taboos and steadying the self in medical school' *The Lancet* **342** [8876] (1993), 913.

the highest authorities of the Roman Church. Absolutely necessary for the general good as that branch of science indisputably is, it was reprobated by some of the Fathers in the strongest and most unqualified terms ...'[48]

We do not live in the Middle Ages; yet this does not mean that in modern times there cannot be found some hangovers of old ways of thinking. Indeed, to an ordinary member of the society the physician may appear as the useful, yet extraordinary and weird creature, who seeks to break taboos which all cultures observe: to touch the living, to dissect the dead, to cause pain, to seek out the deviant, the deformed, the disfigured, the diseased and the dying, and to 'disrespect' people by asking them to undress, or by thinking of them physiologically and psychologically.[49] Notwithstanding that these are necessary aspects of medicine they remain socially questionable and often obstruct the physician's sociability. Illness has always been considered to be abnormal; society isolates what seems to be abnormal, and with it, those who deal with the abnormal. The model physician sees what most people do not want to see, and does things that laypersons feel they could never do. It is clear that he is not one of them.

To further establish that the physician is weird and that society isolates him, one should also consider a final point: 'The patient's illness provides the occasion for the doctor's moment of glory ... The doctor can be most fully a doctor only when others have trouble. Perhaps this ambiguity in the moral aura of the value has something to do with the public's ambivalence towards doctors.'[50]

g) Permanence

It was mentioned earlier that it would not be wise to refer to every social activity as a 'role', and that a proper role should be governed by a certain

[48] Robert Southey, *The Doctor &c* (London: G. Bell & Sons, 1930, first published in 1848) p. 289.
[49] Harper, *Op. cit.*
[50] H. S. Becker, B. Geer, E. C. Hughes, A. L. Strauss, *Boys in White: Student Culture in Medical School* (Chicago & London: The University of Chicago Press, 1961) pp. 237-238.

continuity. This does not only mean that the physician stays a physician after his shift is done, but also that there is no way back. A physician describes one of his colleagues as follows:

> He lived in a chair at the nursing home, his withered hands holding an AMA news he could no longer read or understand. Yet even in the home, he was not 'Jim' or 'Bill' like the other patients; he was 'Dr. Glass' until he died in his sleep, and he is 'Dr. Glass' still, for his tombstone proudly portrays 'MD' after his name.[51]

The model physician never stops being a physician. Retired physicians demand equality with their younger colleagues and the right to be allowed to prescribe at least for themselves and close family.[52] Surely some are no longer able to practice medicine, but it seems that they are willing to go through revalidation frequently in order for their skills to be ascertained.[53] And even if their competency is questioned, they can opt for a second medical career, like writing or teaching, or participation in medico-legal assessments. The nature of medicine does not confine physicians to only a certain type of activities: 'creativity and scientific output do not suffer the ill-effects of ageing (indeed some are amplified) and many doctors can realize unfulfilled creative potential during retirement and provide personal satisfaction and, for some, economic reward.'[54] Some might say that for physicians this is an obvious advantage and not a disadvantage. But the fact that they can remain in the area of medicine and be physicians even after they are retired is a proof that medicine transforms them irrevocably. Sometimes it seems that they have no other choice: once they have become physicians they can never quit. It is like being addicted to the science of medicine, and addictions are always a disadvantage.

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[51] H. J. Van Peenen 'Are we always? When do we stop?' in Michael LaCombe (ed.) *On Being a Doctor* (Philadelphia: American College of Physicians, 1995) p. 162.
[52] See, for example, M. D. Vickers, 'Revalidation of the retired: bad faith and a worse decision' *Journal of the Royal Society of Medicine* **95** [1] (2002), 46-47.
[53] Michael Vickers, 'Revalidating retired doctors' *British Medical Journal* **323** (2001), 701.
[54] C. Peisah and K. Wilhelm. 'The impaired ageing doctor' *Internal Medicine Journal* **32** (2002), 458.

The above suggestion could be wrong. Perhaps the medical identity stays indeed with the physician until the end of his life, but there may be intervals to the profession's continuity. There can be instances in a physician's life where his identity does not make a difference. Or maybe it always does? Is the physician always the 'weird creature' or there can be times when he is a normal layperson? These questions shall be answered later on. But whatever the answer may be, it shall not change the fact that there is no way back in the medical profession; the physician model is a perpetual physician.

What the above discussion offered

Through the above discussion of gains and losses and the many issues which were considered, a model physician was constructed. We now have an image of what a physician is and this image can accompany us for the rest of the thesis. In addition, we have an image of what the layperson is not, which is also going to be useful. And I believe that the peculiarity of the physician's role has been established by the above discussion, which justifies this thesis' purpose of existence; therefore, it can carry on. After seeing what the physician looks like, it is time to see what the *good* physician looks like. In the next section, we move from a *model* physician to an *ideal* physician, and this shall be where the physician's role morality enters the conversation.

II) Medicine as a God

Basically the description of the ideal physician entails the attitudes, behaviours and actions which are considered to be right for a physician. And how does the physician learn what the right is? Who is to decide how the ideal physician should be like? The profession of medicine is self-regulated; this means that decisions as to what is right and what is wrong come from the inside of the profession. Usually the laypersons'

expectations of a 'good physician' are remarkably modest;[55] outsiders basically care about good technical skills, the avoidance of errors, confidentiality,[56] and some matters of etiquette, like a warm greeting from the physician. Therefore, it is the profession itself which has to decide what the ideal physician is. It shall be easier for me to explain how this happens if I introduce the notion of the *god of Medicine* and regard physicians as this god's servants. There have been other gods of Medicine of course, like Asclepios of the ancient Greeks for example; but the one we deal with here is different, and I shall immediately explain what I mean by that.

What exactly is the god of Medicine?

Every religion has one or more gods. A mortal and, in general, whoever is not a god is not allowed to try to be like one; this is blasphemy, sin, and sacrilege, and it invokes terrible penalties. Prometheus, Adam and Eve, and Lucifer amongst others can confirm this, and it is not necessary to remember in detail what happened to them at this point. A god therefore is not a role-model, but someone who gives the orders and decides what happens next, and in order to do that, a god sometimes suggests some role-models to humans. Jesus Christ, for example is a very popular role-model, proposed by the Christian God as exemplifying a type of ideal morality. Christ's ideal ethic refers of course to common morality, as the Christian God is the God of everything and everyone. He is a God who is not specialised. He is a generalist, or a common god, to put it differently. The god of Medicine, on the other hand, deals exclusively with medical issues. His dictates are addressed only to physicians and they refer to medical, not common, morality. The role-model provided by this god would be the ideal physician, whose example every mortal physician should try to approach as closely as he can, by following as nearly as possible what the god of Medicine dictates is

[55] Carol Levine, 'The good doctor: the carer's perspective' *Clinical Medicine* **4** (2004), 244.
[56] Jean Peters, I. C. McManus & Allen Hutchinson, '*Good Medical Practice*: comparing the views of doctors and the general population' *Medical Education* **35** [Suppl. 1] (2005), 52-59.

appropriate. 'If you look at the history of medical ethics and medical morality you will find, by and large that it consists of a series of *a priori* statements of what ought to be done, statements of moral principles.'[57] These *a priori* statements are part of the rich medical culture, and the ideal physician should be aware of, and observe, each one of them.

There is an obvious difficulty here, for one cannot be sure as to what the god of Medicine finds to be an appropriate *a priori* statement without any clear guidance. There are no Ten Medical Commandments, and there is not a gospel about the life of the ideal physician. However, if one belongs to the medical profession and accepts the god of Medicine as his master, he knows what is to be expected, except in very original or complicated cases. Through various procedures and influences, the image of the ideal physician is shaped interactively, little by little. There is a certain medical culture – a 'healing sub-culture' as Helman describes it[58] – to which physicians are accustomed, some more and some less, consciously or subconsciously. The more they manage to immerse themselves in this culture, the more they tend to approach the ideal physician. What follows is an attempt to identify the sources from which this medical culture streams, that is, understand where the essence of the god of Medicine comes from; and this has to be relevant to one's medical education.

When the medical student begins his studies, he must have an image of how he will emerge from medical school. Many of them already have a relevant background as they come from medical families, but this often does not mean a lot. Many others have no such background, and their vision is based on the image of the physician that the layperson has in mind. This image usually does not go beyond certain aspects of medical etiquette – that is, the appearance of a physician – and some indefinite ideals about the goodness of the medical profession's mission. But as Hughes notes, 'the medical aspirant's conceptions of all these things are somewhat simpler than the reality...they may be somewhat

[57] Edmund Pellegrino, 'Toward a Reconstruction of Medical Morality' reprinted in *The American Journal of Bioethics* **6** [2] (2006), 65.
[58] Cecil Helman, *Culture, Health and Illness* [4th edition] (Oxford: Reed Educational and Professional Publishing, 2000, first published in 1984) p. 79.

distorted and stereotyped as among lay people. Medical education becomes, then, the learning of the more complicated reality ...'[59] Thus the important aspect of the construction of the ideal physician's image cannot begin until the prospective physician has entered the medical school. Once they are in, students undergo a form of *enculturation* whereby they gradually acquire a medical perspective that will last throughout their professional life.[60] Two interrelated spheres of influence can be identified; the formal curriculum and the informal or hidden curriculum.[61]

a) Formal Curriculum

This deals basically with matters of technical information and the transmission of technical skills, and from a scientific point of view, it is considered to be the most important aspect of medical education. To be sure, all medical schools now have a more expanded horizon of courses rather than purely scientific ones; medical ethics for example, is clearly established in the UK as a core component of the medical curriculum.[62] But the prevailing sentiment is 'a rather limited and task-oriented view of ethics, a view in which ethics exists as a tool and therefore as something external to the core of medical practice and the physician's identity.'[63] In some cases, medical ethics courses consist of a list of principles, as presented mainly in the celebrated book by Beauchamp and Childress,[64] supported by some relevant legal cases and decision-making examples. However, this approach of its own is insufficient,[65] as the values which shape medical decisions are not necessarily overt, nor do they

[59] Everett Cherrington Hughes, *Men and Their Work* (London: The Free Press of Glencoe, 1958) p. 120.
[60] Helman, *op. cit.*
[61] Frederic Hafferty and Ronald Franks, 'The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education' *Academic Medicine* **69** [11] (1994), 861-871.
[62] Teachers of medical ethics and law in UK medical schools, 'Teaching medical ethics and law within medical education: a model for the UK core curriculum' *Journal of Medical Ethics* **24** (1998), 188-192.
[63] Hafferty and Franks, *op. cit*, at 864.
[64] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* [5th edition] (New York: Oxford University Press, 2001, first published in 1979).
[65] Charles Erin 'Who Needs the "Four Principles?"' in Matti Hayry & Tuija Takala (eds.), *Scratching the Surface of Bioethics* (New York: Rodopi, 2003) p. 88.

necessarily operate as clear-cut and discrete principles.[66] There is something which cannot be officially taught or fully explained, a certain medical culture which dictates what the right decisions are, and this is to be found in the informal, hidden curriculum. Due to its mainly technical character and the absence of serious ethical considerations and significant ethical teaching, the formal curriculum is not governed by this culture – the god of Medicine – and it is not influential as to what constitutes good medical practice, apart from technical competence. 'The conventional wisdom has remained that values are passively "caught" rather than actively "taught",'[67] and this is what the hidden curriculum is about.

b) Hidden Curriculum

According to Hafferty, what falls outside the formal curriculum is an 'unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students'[68] and also 'a set of influences that function at the level of organizational structure and culture.'[69] Coulehan and Williams refer to it as 'tacit learning' and they think that it is 'more powerful than explicit learning not only because it is reinforced more frequently but because it relates to *doing* rather than saying.'[70] One does not have to be a medical student to be affected by it; the hidden curriculum starts functioning at college, but it can be continued throughout the physician's whole career. An interpersonal form of teaching, for example, can take place even without proper official students, as long as there is a role-model physician collaborating with some younger, or generally less

[66] See, for example, Veronika Wirtz, Alan Cribb, and Nick Barber, 'Understanding the Role of the "Hidden Curriculum" in Resource Allocation – The Case of the UK NHS' *Health Care Analysis* **11** [4] (2003), 295-300.
[67] Jeffrey Burack, David Irby, Jan Carline, Richard Root, Eric Larson, 'Teaching Compassion and Respect: Attending Physicians' Responses to Problematic Behaviors' *Journal of General Internal Medicine* **14** [1] (1999), 49.
[68] Frederic Hafferty, 'Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum' *Academic Medicine* **73** [4] (1998), 404.
[69] *Ibid.*
[70] Jack Coulehan and Peter Williams, 'Vanquishing Virtue: The Impact of Medical Education' *Academic Medicine* **76** [6] (2001), 600.

distinguished, ones. Studies suggest that the majority of medical students are influenced by role-models[71] and some educators believe that good role-modeling suffices for ethics education of doctors;[72] it is evident that the role of role-models is very important in medical culture, even though it is not governed by any formal rules. Apart from the importance of role-models, medical students agree that other hidden teaching agendas govern their education.[73]

These unofficial lessons take place outside formally identified learning environments: in the elevator, the corridor, the lounge, the cafeteria, or the on-call room.[74] But this does not mean that a hidden influence is not present even in formal educational ways; for example:

> Physicians in training acquire their self-images by 'testing' their emerging roles on patients; watching patients' responses; and ultimately 'accepting' themselves as physicians, largely because patients do.[75]

If this is right then physicians learn subconsciously what they should be like even through their patients' behaviour, which means that valuable informal lessons can be taught even by patients.

Another issue that should be considered is the adoption of story-telling as a method of informal education. Stories have long been used as a method of cultural transmission,[76] while the narrative nature of illness experience has always been appreciated as an answer to the limits of clinical methods' objectivity.[77] Brody has even made a silent recommendation to replace courses in medical ethics with courses in

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[71] See, for example, William Basco Jr., and J. Routt Reigart, 'When Do Medical Students Identify Career-influencing Physician Role Models?' *Academic Medicine* **76** [4] (2001), 380-382.

[72] Edmund Erde, 'The Inadequacy of Role Models for Educating Medical Students in Ethics with some Reflections on Virtue Theory' *Theoretical Medicine* **18** (1997), 31-45.

[73] Heidi Lempp and Clive Seale, 'The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching' *British Medical Journal* **329** (2004), 770-773.

[74] Hafferty, *op. cit.*

[75] Delese Wear, 'On White Coats and Professional Development: The Formal and the Hidden Curricula' *Annals of Internal Medicine* **129** [9] (1998), 735.

[76] David Stern, 'The Development of Professional Character in Medical Students' *The Hastings Center Report* **30** [4] (1999), S26-S29.

[77] See, for example, Trisha Greenhalgh, 'Narrative based medicine: narrative based medicine in an evidence based world' *British Medical Journal* **318** 1999, 323-325.

medicine and literature.[78] But even if one is not prepared to go quite so far, it remains a fact that medical culture can be spread by narrating some parables about great cases or legendary doctors, or maybe a funny anecdote. Bearing in mind the physician's special powers – because of his special knowledge and his social role – to construct stories,[79] it is understandable that a purely informal medical story may be much more powerful and influential than formal, evidence-based medicine teaching and medical statistics.[80] So it is true that lessons coming from the hidden curriculum can be taught anywhere.

Therefore, it must be clear by now what I mean when I refer to the god of Medicine. Let me summarise: this god is a kind of medical culture which cannot be embraced by someone who does not belong to the profession of medicine. Prospective physicians have their first contact with it when they enter the medical school, but its transmission continues throughout their whole career. The medical values are realised by physicians passively to a big extent, rather than being actively taught. This culture – the god of Medicine – stays with them and influences their decisions as to what constitutes good medical practice, or, to put it differently, what an ideal physician would do. It is what Merton would refer to as 'medical conscience' or 'the physician's superego'.[81] The will of the god of Medicine is the same with the ideal physician's conduct, as this ideal is shaped by the existing medical culture. Physicians should try to approach the ideal as much as possible. Their medical culture, which they have adopted mainly via the continuing hidden curriculum, tells them what the ideal is in any given situation. This means that they always have in mind role-models, stories, and even patients' reactions and attitudes, which they teach them how they should behave. A full understanding of the medical culture and the hidden curriculum is

[78] Howard Brody, *Stories of Sickness* (New Haven: Yale University Press, 1987) p. 183.
[79] *Ibid.*, p. 182.
[80] Thomas Newman, 'The power of stories over statistics' *British Medical Journal* 327 (2003), 1424-7.
[81] Robert K. Merton, *Social Theory and Social Structure* (New York: The Free Press, 1942) p. 605.

perhaps impossible[82] and so it is also impossible to understand exactly what the god of Medicine is; but this is what has always been the case with every god throughout history.

What is the ideal physician?

The ideal physician is the role-model that the god of Medicine proposes for his servants, characterised by an artificial simplicity. It is based on the model physician that was explored earlier; it has the same characteristics as the model, but in addition, the ideal physician is also governed by the physician's role morality – in other words, he is the model physician with right conduct as an extra feature. The ideal physician reflects the medical profession's highest values and represents the perfect professional whom the imperfect mortal physicians should have as their conduct's guide. Even if nobody has ever seen him, every physician keeps an image of him in mind. This image, even though it is personal, is to a great extent similar for every physician; after all, they are a remarkably homogeneous group.[83] But in order to look at this image and define the ideal physician one needs first to understand what medicine's goals are, what this profession has as a mission, and what medical professionalism is. We agreed that there are some values which the god of Medicine dictates in the hidden curriculum, but what are these values? I shall make an effort to give some answers, but their validity cannot be warranted.

The most important observation is that the ideal physician is *not* the spotless professional. We need to keep in mind that the physician of today has many professional responsibilities which traditionally have nothing to do with the medical profession; he has to be a manager or an employee, a writer, a teacher, a team-leader, and, in general, the profile of the third millennium physician is presently not very clear.[84] However, these extra roles have not been embodied in the medical culture yet – in

[82] Hafferty, *op. cit*, at 406.
[83] Wear, *op. cit.*, at 736.
[84] Olaf Gjerlow Aasland, 'The physician role in transition: is Hippocrates sick?' *Social Science & Medicine* **52** (2001), 171-173.

other words, they are not recognised by the god of Medicine. '"Professional" and associated words and terms have a wide range of uses and interpretations in contemporary language,'[85] but physicians tend to relate medical professionalism to the clear practice of medicine, and keep it separated from the complementary bureaucratic and managerial tasks, even though the borderline between medicine and the larger health care systems of which it is a part is by no means always clear.[86] Therefore, we should view the ideal physician as a healer who deals exclusively with the practice of medicine, and not as a manager or in any other modern position. Medical professionalism should be kept as a notion to be used with medicine's traditional goals such as promoting health and preventing disease, relieving pain and suffering, treating diseases and saving lives,[87] and all the ethical issues which are relevant to these goals. The other tasks are part of the physician's work, but they do not belong to the profession's nature; and professionalism must be clearly grounded in that nature.[88]

There is no point in reciting the characteristics of the ideal physician, his virtues and his professional profile. All these shall be discussed in later chapters, where I shall be dealing with specific situations and physicians' reactions to them. Besides, I could not say of any set of behaviours to be ideal without oversimplifying a very complicated issue, and studies which try to evaluate professionalism – without any satisfactory results – can support this.[89] I could not say that the perfect professional follows the General Medical Council's guidance *Good Medical Practice*;[90] and I would not dare to make my own list of behaviours which constitute good medical practice. 'There are recipe books and formulas in life, but we all know that these are sometimes –

[85] Sean Hilton & Henry Slotnick, 'Proto-professionalism: how professionalisation occurs across the continuum of medical education' *Medical Education* **39** (2005), 59.
[86] D. Callahan, 'The Goals of Medicine: Setting New Priorities' *The Hastings Center Report* **26** [6] (1996), S1-S26.
[87] *Ibid.*
[88] Herbert Swick, 'Toward a Normative Definition of Medical Professionalism' *Academic Medicine* **75** (2000), 612-616.
[89] See, for example, David Stern, Alice Frohna & Larry Gruppen, 'The prediction of professional behaviour' *Medical Education* **39** (2005), 75-82.
[90] Guidance from the General Medical Council, *Good Medical Practice* (London, 1995).

perhaps frequently – not enough. Reality is too evasive to be wholly captured by them.'[91] The ideal physician is not simply the one who follows the guidelines, or observes with punctuality the Hippocratic Oath; perhaps this is society's ideal physician, or the ideal in a layperson's mind – in other words, what the public needs to be kept satisfied. But for the profession itself, with its medical culture and the continuing hidden curriculum which are inaccessible to outsiders, the ideal physician is far more complex. And this is why it is better to proceed gradually and reveal what the ideal physician would be like separately in specific circumstances, which are discussed in Chapters 4, 5, and 6.

Does this mean that the ideal physician cannot be viewed as a whole and that his image must be taken by instalments? Is there always a right conduct, or what is right and seems ideal under certain circumstances is subject to change? Furthermore, does someone who engages in 'good practice' necessarily become a 'good practitioner'?[92] There is an important distinction to be made here, namely whether the image of the ideal physician is constructed by following a virtue-based approach, or, what has recently dominated the discourse of bioethics, the obligation-based approach.[93] This question is derived from the doubt which many experts express: that professionalism, regarding those qualities which defy measurement, cannot be taught.[94] Indeed, if we accepted a virtue-based physician like the one that Pellegrino proposes,[95] it would mean that some physicians could never meet the ideal requirements if their personality were not appropriate. Through the hidden curriculum the ideal physician can be demonstrated perhaps, and these physicians can learn what it is; but it may be the case that they will never be able to reach the ideal themselves. I shall refrain from

[91] Peter Duncan, Alan Cribb & Anne Stephenson, 'Developing "the good healthcare practitioner": clues from a study in medical education' *Learning in Health and Social Care* **2** [4] (2003), 189.
[92] *Ibid.*
[93] *Ibid.*
[94] Ronald Harrison Fishbein, 'Professionalism and "the master clinician" – an early learning experience' *Journal of Evaluation in Clinical Practice* **6** [3] (2000), 241-243.
[95] Edmund Pellegrino, 'Professionalism, Profession and the Virtues of the Good Physician' *The Mount Sinai Journal of Medicine* **69** [6] (2002), 378-384.

examining this point and the virtue-based approach for the time being; but I promise to get back to it in Chapter 8.

Then one might ask what the use of the ideal physician is. Like Jesus Christ who represented a radical and almost impossible morality, so has the ideal physician been sent by the god of Medicine on the physicians' earth just to be ignored. Christian philosophers argue that a less drastic and more practical morality would be better[96] and the same should apply to the case of Medicine's Jesus, that is, the ideal physician and his role morality. As Mackie notes, 'to identify morality with something that certainly will not be followed is a sure way of bringing it into contempt.'[97] However, constant effort to become better requires motivation and constant motivation requires infinite ideals – otherwise, the effort to become better should come to a stop at some point. The ideal physician could never be realised in some mortal physicians' practice, but this does not diminish his importance and the value of his almost impossible morality as a guide. 'To become a professional in the fullest sense of the word, a "good doctor" ... is not a process that happens quickly, not a goal that can be accomplished in the sort term. Years are required.'[98] There must be a lot of good doctors, who have already accomplished much of this process; but they can become infinitely better, and this is something useful for them to know. And finally, let me mention one remark from Max Weber: 'To the Catholic the absolution of his Church was a compensation for his own imperfection.'[99] If we make an analogy of this observation to the case of physicians, can it express a need for imperfect physicians to keep something absolute in mind, an image of an ideal physician and an ideal Medicine? If there is such a need, then the concept of the ideal physician is surely useful.

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[96] Ronald Preston 'Christian Ethics' in Peter Singer (ed.) *A Companion to Ethics* (Oxford: Blackwell Publishers, 1993) p. 99.
[97] J. L. Mackie, *Ethics: Inventing Right and Wrong* (Harmondsworth: Penguin Books, 1977) p. 132.
[98] Julia Connelly, 'The Other Side of Professionalism: Doctor-to-Doctor' *Cambridge Quarterly of Healthcare Ethics* **12** [2] (2003), 180.
[99] Max Weber, *The Protestant Ethic and the Spirit of Capitalism* [translated by Talcott Parsons] (London: George Allen & Unwin, 1930, 1976, first published in 1905) p. 117.

This is an incomplete and feeble defence, yet it allows me to use an idealistic approach as long as it seems to serve the thesis' purposes, and I shall postpone the detailed discussion of whether such an approach can be justified until I explore more fully the ideal physician in part II. Perhaps until then it makes sense to discuss good medical practice bearing in mind an ideal physician.

Physicians as servants

> *Mine*, what does this word signify? Not what belongs to me, but what I belong to ... My God is not the God who belongs to me, but the God to whom I belong, and so again, when I say my native land, my home, my calling ...[100]

The above reflection by Kierkegaard captures the spirit in which I suggested earlier that we should start regarding physicians as *servants* of the god of Medicine. Without of course mentioning any particular individuals, I have described the model physician as an isolated 'weird creature' which causes uneasiness to society's normal people; he is perpetually trapped in his role, with a different aesthetic perception and even a different notion of time. The role of the physician is so strong that it demands the individual's devotion. Their profession, far from being *theirs*, actually owns them. 'Devotion to medical service is so important that physicians must avoid even the appearance that they are primarily devoted to their own interests rather than to the interests of others.'[101] But who are these 'others'? A sensible man would answer that the others are the patients. But perhaps the physician in the end does not serve patients', but rather *medicine's* interests – which Dr Knock describes as superior to both the patient's and the physician's interests.[102]

Various writers mention the power of the professions to shape newcomers and acknowledge that professional socialisation is a process

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[100] Soren Kierkegaard, *Either/Or (Vol. I)* [translated by David Swenson and Lillian Swenson] (New Jersey: Princeton University Press, 1944, first published in 1843) p. 338.
[101] M. K. Wynia, S. R. Latham, A. C. Kao, J. W. Berg, L. L. Emanuel, 'Medical professionalism in society' *New England Journal of Medicine* **341** [21] (1999), 1613.
[102] Jules Romains, *Knock ou Le Triomphe de la Medecine* (London : Longmans, 1963, first published in 1929) p. 73.

through which individuals are socially constructed and largely shaped into conformity;[103] but few have recognised that often, 'one's self-image becomes restricted and restrained by one's professional image.'[104] The physician's peculiarity lies in the fact that he belongs to his profession; he becomes the servant of the god of Medicine and the image of the ideal physician haunts his existence. If medicine can be regarded as a religion, then it must be assumed that it abstracts something from the physician. Feuerbach notes that 'to enrich God, man must become poor; that God may be all, man must be nothing ... but what he takes from himself is not lost to him, since it is preserved to God.'[105] This seems to be exactly the same with what takes place in the physician's interaction with his profession. Each individual physician considers medicine to be the most important aspect of his life and devotes himself to it. It is as if the quality of being a physician is enough to describe someone – and perhaps there is not much left to be said anyway, because the physician may truly be just a physician: 'For many, the whole prospect of becoming a doctor is enough of an achievement and goal, so other talents are no longer cultivated and many are forgotten ... [physicians] have become narrower people.'[106] The god of Medicine abstracts from the physician until he restricts his self-image and possesses his personality; then the physician becomes the god's servant.

What is of big interest is that physicians do not see themselves as servants;[107] their profession enjoys great levels of autonomy and self-regulation, so they tend to automatically consider that they are autonomous and self-regulated as individuals. This is true as far as their interactions with external society are concerned, but it appears that they do not question very often the internal interactions which take place

[103] Lynn Clouder, 'Becoming professional: exploring the complexities of professional socialization in health and social care' *Learning in Health and Social Care* **2** [4] (2003), 213-222.
[104] Connelly, *op. cit.*
[105] Ludwig Feuerbach 'The essence of Christianity' reprinted in John Portman (ed.) *In Defense of Sin* (New York: Palgrave, 2001, first published in 1841) p. 16.
[106] Sarah Elise Finlay, Monica Fawzy, 'Becoming a Doctor' *Journal of Medical Ethics: Medical Humanities* **27** [2] (2001), 92.
[107] Frederic Hafferty, 'What Medical Students Know about Professionalism' *The Mount Sinai Journal of Medicine* **69** [6] (2002), 385-397, at 392.

between their profession and them. As I shall explain in the next chapter, they tend to use the profession's established moral values which the god of Medicine dictates – that is, their role morality – without pondering over the nature of these values adequately, but still thinking nevertheless that they act independently, just because their profession is independent. American and Canadian studies support this view by showing that there is a strong likelihood of a decrease in stage of moral development for medical graduates compared to their state of personal moral awareness before entering medical school;[108] and even if the methods used to measure moral development are questionable, these studies surely suggest that physicians tend to rely to their profession rather than to themselves, without even being aware of this fact. This can be explained if we admit that they surrender to medicine, devote themselves to it completely, and acquire the state of servants. As I suggested in the previous section, there is no way back for the physician.

Conclusion

I have given an account of what the physician is and what the process of becoming a good one is – good from the professional's point of view, because the relations between professional medical culture and lay medical culture have varied a great deal.[109] I did this without considering any specific physicians or any specific moral problems which they could anticipate and which would test their goodness, because I intend to describe in the next chapter how the physician's morality functions in theory before facing it in practice in chapters 4, 5, and 6 of this thesis. It must be clear by this point that the physician is a peculiar member of society for whom common morality is not enough. The physician's role has sufficient gravity to create a separate role morality for its holders. In other words, the god of Medicine tells his servants what the right conduct is by demonstrating an ideal physician to them. But then does this mean

[108] Johane Patenaude, Theophile Niyonsenga, Diane Fafard, 'Changes in students' moral development during medical school: a cohort study' *Canadian Medical Association Journal* **168** [7] (2003), 840-4.
[109] Hughes, *op. cit.* p. 117.

that the physician who is devoted to his profession completely abandons the common morality which normally every individual has? Is my suggestion that the physician is a 'weird creature' and unlike normal laypersons, true? The following chapter, by explaining the theory of *double morality*, deals with a different possibility.

Chapter 3

THE THEORY OF DOUBLE MORALITY

For the physician who is devoted to the god of Medicine, role morality should prevail over common morality in order to deal with the unique nature of his profession. The moral system of his world, the hospital, is quite different from that of the lay world.

> In the hospital it is the good people, not the bad, who take knives and cut people open; here the good stick others with needles and push fingers into rectums and vaginas, tubes into urethras, needles into the scalp of a baby; here the good, doing good, peel dead skin from a screaming burn victim's body and tell strangers to take off their clothes.[1]

The above passage refers to only one aspect of the transformation which medicine inflicts on the physician's thinking and his way of relating to events and people. There are various other circumstances where what the physician has to do would be considered unethical outside the medical setting, and he can even feel compelled to behave at odds with the regular perceptions of reasonable people.[2] The physician's role morality conflicts with the layperson's common morality in many instances, but the medical setting prevents anyone from thinking that what the physician does is wrong. Patients may wonder how physicians are able to act in certain ways and recognise that they have a different moral vision,[3] but to condemn them would be to condemn the entire medical profession.

What happens to the physician outside the medical setting is a different issue, which needs careful consideration. If they retain their role

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[1] Daniel Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics* (Chicago: The University of Chicago Press, 1996) p. 12.
[2] Kevin Gibson, 'Contrasting Role Morality and Professional Morality: Implications for Practice' *Journal of Applied Philosophy* **20** [1] (2003), 17-29.
[3] Arthur Frank, '"How Can They Act Like That?" Clinicians and Patients as Characters in Each Other's Stories' *Hastings Center Report* **32** [6] (2002), 14-22.

morality it means that their common morality is permanently disabled. But is this possible? Behind the most devoted servant of the god of Medicine there still must be a human being; a layperson who, outside the medical setting, would never think of cutting people open or telling strangers to take off their clothes. It must be true that 'medical training *above all else* involves the transmission of a distinctive medical morality'[4] and that medical training is not just learning about becoming a physician but also about how to 'cease' to be a layperson;[5] but there must be some traits of the old – pre-medical – personality of the physician. It is only the ideal physician who can be completely a non-layperson, and as it was said earlier, many physicians approach the ideal but it is almost impossible to actually reach it. The physician can be seen as a servant, and medicine is his life's most important aspect, but this does not turn him into an alien; a 'weird creature' of society perhaps, but still, an individual within whom two cultures, lay and professional, interact.

This chapter explores this interaction between the physician's common and role morality. I shall name their co-existence *double morality* and I shall discuss in detail what this means and how it works. But first, I shall briefly review existing material which deals with these issues.

I) Existing Work on Double Morality and Relevant Material

There are not many resources dealing with the issue of double morality and most of them only mention it without attempting any further analysis, while others seem to regard this concept from a different point of view and appear to be irrelevant to the present discussion. However, it is important to know what the bases of double morality are; furthermore, some of the passages referred to below can provide good starting points for speculation about special aspects of the issue. Thus it is necessary

[4] Frederic Hafferty and Ronald Franks, 'The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education' *Academic Medicine* **69** [11] (1994), 863.
[5] *Ibid*, at 865.

for this brief review to be carried out, even if it could be seen as another deviation.

The resources are divided in three categories. First, there are those which deal with double morality in general; second, there are those which concentrate on more specific areas where double morality can be found. The health care area and the physicians are excluded from this section, which is only fair, since they are the main body of interest in every other part of the thesis. Finally, there are the resources which are related to specific thinkers who, even though they do not mention a clear problem of double morality in their writings, certainly deal with important concepts involved with it.

General Resources

In the preface of this thesis I mentioned Milgram's description of an automaton, which parallels human function by functioning in two modes: the self-directed and the systemic one. Apart from Milgram's work, there is a number of general resources which provide interesting thoughts on the issue I am examining here. In what follows, some of them are discussed in brief in order to have a better idea of existing material on the current issue of concern.

a) The variable good of the *Nicomachean Ethics*

Aristotle's works merit in-depth analysis, which experts have regularly provided. As far as I am concerned, these experts have never spoken explicitly of a notion of double morality being present in his ethical writings; nevertheless, there is the ascertainment that he considers the good to vary, depending on the sort of activity that a person engages in[6], where for example he says that the good is one thing in medicine and

[6] I. P. Nikoloudis, *Introduction to Aristotle's Nicomachean Ethics* (Athens: Cactus Editions, 1993) p. 33 [in Greek].

another one in generalship.[7] Bearing in mind the difficulties that an interpretation of Aristotle entails, I believe that a certain kind of double morality can be traced in the *Nicomachean Ethics*, based on this notion of variable good. Aristotle tries to identify the ultimate good beyond all the separate practicable goods. The passage which seems to be of great interest is the following:

> For, just as for a flute-player, or a sculptor, or any expert, and generally for all those who have some characteristic function or activity, the good – their doing well – seems to reside in their function, so too it would seem to be for the *human being*, if indeed there is some function that belongs to him.[8]

It is evident that he wants to separate the human being from any activity or sphere of expertise that could distract him from the pure good, that is, the good related directly to his function as a human being, and not as a doctor, a flute-player, or a sculptor. It would have been better if he could also have provided a satisfactory answer with regards to this function, as after all these centuries people are still looking for the answer. It would also have been better if he had discussed this double relationship of someone to the good – and morality in general – in terms of both a professional and a human being, but he did not do this either. However, I believe that the basis of what I have called double morality within the same person – one for the professional and one for the human being (or the layperson, who as such has no acknowledged functions) – lies in this work by Aristotle. There shall be the opportunity to refer to it again at a later point.

b) The Prince

Niccolo Machiavelli's ideas have received much attention, notwithstanding the fact that they have been considered to be immoral by many. Machiavelli presents the necessary, in his view, abilities with

[7] Aristotle, *Nicomachean Ethics* [translated by Christopher Rowe] (New York: Oxford University Press, 2002) 1097a, p. 100.
[8] *Ibid.*, 1097b, p. 101 [my emphasis].

which a prince should be equipped in order for his reign to be successful. Among them, the concept of double morality prevails – but in such a way that it is normal to assume that the successful prince has to be a two-faced, sneaky arriviste. For example:

> Therefore, it is necessary for a prince, if he wants to maintain his position, to develop the ability to be not good, and use or not use this ability as necessity dictates.[9]

It is certain that, if this piece had been written by a modern thinker, it would not have made too much sense; the notion of 'good' is under continuous attack, and it seems reasonable to say that a virtue, or what is considered to be one, can be damaging to people who possess it, while a supposed vice can be extremely valuable. Therefore, from a more modern point of view, Machiavelli's points can be more coolly examined and appreciated.

The qualities of a prince do not constitute the subject matter of this thesis (even though the attitude towards some physicians contains elements of royalty); moreover, Machiavelli did not refer to the prince's private life as opposed to his public one. Nevertheless, it remains interesting to follow his line of thought: the prince has to have some moral qualities, which he chooses to use or not, depending on the situation; in this way they can be useful, while if one kept to them all the time, they would be harmful. But even when he chooses not to use them, he must be careful to appear as if he still had them – perhaps this is the point which has disturbed some men of integrity. To sum up:

> ... you must remain mentally prepared, so that when it is necessary not to have these qualities you are able, and know how to assume their opposites.[10]

I think that this is the core of the concept of double morality in which I am interested, with one difference: sometimes, and maybe most of the

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[9] Niccolo Machiavelli, *The Prince (and other political writings)* [translated and edited by Stephen J. Milner] (London: Everyman, 1998, first published in Everyman in 1908) p. 89.
[10] *Ibid.*, p. 97.

times, one is not mentally prepared; the switch from one set of moral rules to a different one can happen without the understanding or the will of the person in question. But we will deal with this in greater depth later on.

Let me just remark that the ends justified the means for Machiavelli and nobody can safely contradict him in this; therefore, his ideas can remain open to discussion for many centuries to come. In our case, there shall not be such a seductive simplicity; the physician is far more sophisticated than the prince – or at least he should be – and there are no doctrines referring to ends and means. This presupposes that safer conclusions can be extracted, as more analysis is allowed. In the end, double morality shall be clearly judged to be right or wrong as a concept, while Machiavelli's double morality will carry on creating controversy – just like, since we talked about princes, the controversy about USA's foreign policy, which demands a dual ethos: one for them, and one for the rest of the world.[11]

c) Weber's double ethic

Max Weber has referred briefly to a kind of double morality. Certainly his primary concern was not to understand the way individuals were able to be ethical in both their professional and their private lives; however, he used the notion of double morality for two separate purposes, which are worth mentioning.

The first one was the understanding of the spirit of capitalism and the explanation of how it managed to thrive:

> At all periods of history, wherever it was possible, there has been ruthless acquisition, bound to no ethical norms whatever. Like war and piracy, trade has often been unrestrained in its relations with foreigners and those outside the group. The

[11] Robert D. Kaplan, *Warrior Politics: Why Leadership Demands a Pagan Ethos* (New York: Random House, 2002) p. 147.

> double ethic has permitted here what was forbidden among brothers.[12]

Of course, this double ethic was not among Weber's explanations as to why capitalism came to such a success; but this passage shows an attempt to state that the separation of one's private and professional life was a necessary procedure in order for progress to be achieved. In other words, according to Weber, capitalism, together with its positive and negative features, owes much to a double ethic which some professionals found of extreme usefulness.

The second purpose was an effort to save individualities in a bureaucratic society. As Wolfgang Mommsen notes, Weber was very concerned about it:

> Without doubt Weber's point of perspective was very much one of an individualistic liberal who observed with some despair that the process of rationalization and bureaucratization seemed irreversible, and that it was likely to put in jeopardy the very sort of individualistic life which he believed to be the core of Western tradition.[13]

It seems that, towards the end, Weber realised that social science should have as its task to make people aware of their own values, and to make them face the inevitable conflict between them which occurs depending on the circumstances. Every individual should be more conscious of his presence in the bureaucratic society, and be able to understand how to save his individuality in accordance with the bureaucratic values – which were absolutely necessary for every rational person. Weber's sociological work intended to help individuals towards a double morality, by enabling them to 'choose rationally between different sets of values in any given situation, which required the making of decisions.'[14]

Not being a sociologist, I will not further analyse Weber's views, but they are still extensively under discussion. To the best of my

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[12] Max Weber, *The Protestant Ethic and the Spirit of Capitalism* [translated by Talcott Parsons] (London: George Allen & Unwin, 1976, first published in 1905) p. 57.
[13] Wolfgang Mommsen, *The Age of Bureaucracy: Perspectives on the Political Sociology of Max Weber* (Oxford: Basil Blackwell, 1974) p. 5.
[14] *Ibid.*, p. 110.

knowledge though, he was the first modern thinker who tried to describe a system of double morality for every professional in modern societies; and for that reason alone, it seemed indicated to refer to him.

d) 'My Station and its Duties' by F. H. Bradley

Bradley tries to find out what the ideal morality should be and when someone can be called moral. After stating that morality lies in self-realization, he wonders how one can achieve that. 'To know what a man is you must not take him in isolation ... what he has to do depends on what his place is, what his function is, and that all comes from his station in the organism.'[15] Then he constructs his approach, which he calls 'My station and its duties':

> ... 'my station and its duties' teaches us to identify others and ourselves with the station we fill; to consider that as good, and by virtue of that to consider others and ourselves as good too. It teaches us that a man who does his work in the world is good, notwithstanding his faults, if his faults do not prevent him from fulfilling his station.[16]

The message is quite clear, but is it possible to confine a man to his station and his duties? Bradley considers this question, but goes on to say that a man who does not try to realize himself in his own community will not be perfectly realized in any particular station.[17] In other words, for Bradley personal morality and social institutions cannot exist apart.[18]

Therefore, he appears to reject double morality, but strictly in favour of one's professional role. He comes to an apparent conflict with Aristotle, who was looking for the good of the human being (the layperson behind any roles), and he does not acknowledge any universal moral rules which could be attributed to the layman: "'my station and its duties" holds that *unless* morals varied, there could be no morality; that a

[15] F. H. Bradley, *Ethical Studies* [2nd edition] (London: Oxford University Press, 1962, first published in 1876) p. 173.
[16] *Ibid.*, p. 181.
[17] *Ibid.*, p. 205.
[18] *Ibid.*, p. 188.

morality which was *not* relative would be futile ...'[19] He fails to support this view in a consistent manner, but his approach is certainly interesting. The concept of double morality should perhaps be rejected indeed, but to do that exclusively in favour of professional morality appears to be too simple a solution. However, self-realization is a key issue on which I intend to elaborate later in the thesis.

e) Papagounos on double morality

A short discussion on double morality can be found in *Texts in Ethics* by Georgios Papagounos. In it, he poses the question whether it is possible for multiple sets of moral rules to exist for the same person in such a way that each set corresponds to a different type of action in which the person in question engages in.[20] Among others, he mentions the examples of a physician who takes someone's life away by switching off a life support machine, and of a judge who deprives someone of his freedom by sentencing him to imprisonment.[21] Papagounos seems to acknowledge that these cases refer to general rules, which the physician and the judge are allowed to violate on account of their professional identities; and that, outside the professional context, the moral rules which guide their actions would be completely different, relying on more general rules. He then discusses how these general rules are formed, a quite complicated issue where no satisfactory answers exist.

It is obvious that Papagounos's text does not aim to provide an extensive analysis of double morality issues. He does not seem to question the implications and the impact that the alternation of moral rules depending on contexts would have on the personalities of the professionals; and when he discusses some special moral dilemmas, he provides an incomplete answer. For example, he mentions the case of a midwife who has the professional duty to participate in an abortion and whose religious beliefs condemn this procedure. According to him, the

[19] *Ibid.*, p. 189.
[20] Georgios Papagounos, *Texts in Ethics* (Athens: Papazisi Editions, 1999) p. 62 [in Greek].
[21] *Ibid.*, p. 63.

midwife has waived her right to deny participating, as she has chosen to become a midwife and work in a hospital; she should have chosen a professional context which would not create conflicts with her religious beliefs.[22] But there are obviously more aspects of the problem to be considered here, as well as in issues related to multiple sets of moral rules in general. My labour shall be oriented towards these directions.

Resources related to specific areas

Having discussed some general resources, I shall now concentrate on three specific areas of interest before coming back to medicine and the physician. These areas of interest are the military, the world of business, and, most interesting of the three, the legal profession.

a) Military morality and the killing of human beings

In the old days, there was no need for double morality to exist as a concept in the military, as the 'idea of a machine-like army, based on strict and passive obedience to orders ... reigned unchallenged until the First World War.'[23] This is no longer the case, as 'professionalism distinguishes the military officer of today from the warriors of previous ages.'[24] To be sure, double morality had always existed in the army, but only as a *fact*, that is, an unreflective application, and not as a *concept*. For a soldier, it is always necessary to adopt different moral rules in the battlefield in order to be able to oppose basic morality so much as to kill another human being. However, this fact had never been given much consideration until the soldier's personality became important, and this is what I mean by saying that double morality did not exist as a concept. And how did the soldier's personality become important? Mainly through the more general augmentation of public awareness and sensibility as society was evolving, but also through some observations which were

[22] *Ibid.*, p. 67.
[23] Nico Keijzer, *Military Obedience* (Alphen aan den Rijn: Sijthoff & Noordhoff, 1978) p. 37.
[24] Samuel P. Huntington 'Officership as a Profession' in Malham M. Wakin (ed.) *War, Morality, and the Military Profession* (Boulder: Westview Press, 1979) p. 12.

made within the military, like the discovery that the great majority of men on the front line never fired their guns in World War II.[25] These tendencies led to debate.

Keijzer mentions the contradiction between the official norms of the military organization and the values of normal civil life:

> The soldier is therefore subject to ambiguous demands. The commandment 'Thou shalt not kill' belongs to the system of civil values. The military man however must, also in peacetime, be prepared to kill ...[26]

The solutions which he identifies as functional all refer to double morality, in the sense that the civil set of moral rules has to be sometimes abandoned in order for the military self to be realised. More specifically, he speaks of shifting the moral responsibility to higher authority ('order is order'),[27] fusing with the group,[28] fleeing into work (which shuts their consciousness off from disturbing stimuli),[29] or reappraising the situation, which does not change the objective situation, but distorts the interpretation of it.[30] All these techniques help double morality to emerge, by oppressing the basic – that is, the layperson's – morality.

Huntington tries to suggest that this is not the case: 'The soldier cannot surrender to the civilian his right to make ultimate moral judgments. He cannot deny himself as a moral individual.'[31] But then he has to admit: 'Only rarely will the military man be justified in following the dictates of private conscience against the dual demand of military obedience and state welfare.'[32] So much for not denying himself as a moral individual. Sarhesian and Gannon have little more to say: 'individual conscience and "individuality" comprise a basic ingredient of professionalism; otherwise the profession will become detached from

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[25] Michael Walzer, *Just and Unjust Wars* [3rd edition] (New York: Basic Books, 2000, first published in 1977) p. 139.
[26] Keijzer, *op. cit.*, p. 58.
[27] *Ibid.*, p. 47.
[28] *Ibid.*, p. 62.
[29] *Ibid.*
[30] *Ibid.*, p. 63.
[31] Samuel P. Huntington 'The Military Mind' in Malham M. Wakin (ed.) *War, Morality, and the Military Profession* (Boulder: Westview Press, 1979) p. 44.
[32] *Ibid.*

society ...'[33] but, 'we feel that there are few, if any, military men who realistically accept such a position.'[34] So it seems that double morality prevails in the army.

Walzer states that 'the war itself isn't a relation between persons but between political entities and their human instruments,'[35] while Rodin refers to 'the two levels of war', between states in one level, and between persons in another.[36] In my view, Rodin is right, but perhaps the military profession asks of the individual that he 'come out' of himself and acquire a 'bigger' ethic, the one of his state. The above mentioned writers who draw the line between basic and military morality are also right, but it remains a fact that, in order for military morality to function, the basic morality has to remain silent – and become active again when the officer is off duty. This is how double morality works and this is what those dealing with military ethics imply in the above passages.

One would say that soldiers certainly do not seem to bear any resemblance to health care professionals. So perhaps this review of double morality in the military profession was unreasonable. However, the military profession is a very important one, which qualifies as a 'true' profession; therefore, an analogy with the medical profession can be found here. And, besides, there is the idea that physicians are the soldiers of medicine, committed to it like the soldiers are committed to the state; and like soldiers, they can 'come out' of themselves and acquire a bigger ethic, the one of medicine – in other words, a physician can acquire the medical morality but at the same time become a servant of the god of Medicine.

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[33] Sam C. Sarhesian and Thomas M. Gannon 'Professionalism: Problems and Challenges' in Malham M. Wakin (ed.) *War, Morality, and the Military Profession* (Boulder: Westview Press, 1979) p. 137.
[34] *Ibid.*
[35] Michael Walzer, *Just and Unjust Wars* [3rd edition] (New York: Basic Books, 2000, first published in 1977) p. 36.
[36] David Rodin, *War and Self-Defense* (New York: Oxford University Press, 2002) p. 122.

b) Businesspersons' submission to business

In general, ethics in business appear to be more 'loose' than in other areas. As Arrow certifies when he compares physicians to businessmen: 'Behavior that we would regard as highly reprehensible in a physician is judged less harshly when found among businesspersons.'[37] Apparently there are some advocates of ethical dualism who, applying one set of ethics in the marketplace and another in the home, expect employees to lay aside personal values and to focus solely on generating corporate profits; and this ethical dualism can go unnoticed, if we accept the view that business ethics is 'loose'. But it would not be safe to accept this view; business ethicists have identified the problems which could be created and have tried to offer more insights. Gustafson, for example, warns that ethical dualism's doctrine in fact is that 'what is legal, is ethical' and defends a holistic view, where personal and business ethics coincide.[38]

Norman Bowie also discusses the problem in his *Business Ethics*. Bowie, influenced by Bradley, deals with role morality by starting from the basics: 'Our roles are not limited to jobs ... Part of being a good person is carrying out the obligations and responsibilities of his or her various roles.'[39] However, he points out the limitations of role morality in business ethics, first when he considers the conflict of a person's role-related responsibilities, and then when he wonders whether there is a higher morality that supersedes role morality in any of its forms.[40] The answer to this question is interesting: 'Many businesspersons consider loyalty the chief duty of any employee.'[41] And if loyalty requires immoral actions, then there should be more universal moral norms to supersede the duties associated with one's role – but Bowie notes that some

[37] Kenneth Arrow 'Business Codes and Economic Efficiency' in Tom Beauchamp & Norman Bowie (eds.) *Ethical Theory and Business* [5th edition] (New Jersey: Prentice-Hall, 1997, first published in 1979) p. 124.
[38] Andrew Gustafson, 'In Support of Ethical Holism: A Response to "Religious Perspectives in Business Ethics"' *Business Ethics Quarterly* **10** [2] (2000), 441-450.
[39] Norman Bowie, *Business Ethics* (Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1982) p. 5.
[40] *Ibid.*, p. 13.
[41] *Ibid.*

empirical research shows that businesspersons do not follow universal norms but role-dictated moral principles, which results in cases of business immorality.[42] Clearly, this loyalty to the employer which is required creates many problems, probably because it is set in the wrong context. Double morality can be found in business ethics as a conflict between role-morality and common (universal) morality; and when role morality prevails, as it seems that it often does, the moral outcome is uncertain.

c) Lawyers' moral vacuum when defending criminals

It is widely assumed that lawyers regularly behave in ways which are unethical[43] and so the field of legal ethics must be expected to be quite vast. When it comes to particular areas of this field, it can be noticed that one of its main interests has always been to defend the lawyers who defend criminals. How can an honest lawyer defend someone when he knows that person is guilty? The classic answer was perhaps this: 'I am free to advance a bad rule, because if it is truly bad, the judge will not accept it.'[44] But, on second thought, responsibility cannot be waived just like that. Lawyers clearly face deeper ethical dilemmas regularly, but they either consider their personal morals irrelevant, or they manage to amend them somehow.[45] In any case, they act for their clients no matter how evil these clients seem to be, giving the impression that they are able to work in a 'moral vacuum'. But there are always those who see a problem with that, and they argue that these lawyers are as evil as their clients. George Warvelle has put it like this:

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[42] *Ibid.*, p. 15.
[43] Richard O' Dair, *Legal Ethics: Text and Materials* (Edinburgh: Butterworths, 2001) p. 89.
[44] Jonathan Wallace 'Can Vs. Should' *The Ethical Spectacle* **3** [7] (1997), World Wide Web (http://www.spectacle.org/797/should.htm), accessed April 3, 2004.
[45] Debra Lamb 'Ethical Dilemmas: What Australian Lawyers Say About Them' in Stephen Parker and Charles Sampford (eds.) *Legal Ethics and Legal Practice: Contemporary Issues* (New York: Oxford University Press, 1995) p. 233.

> ... a man cannot continually stand as an apologist for crime and a defender of criminals without having his own moral sensibilities sadly blunted.[46]

Others have a different opinion; Pepper for example says that 'a good lawyer can be a good person; not comfortable, but good.'[47] So what is there that can justify a criminal defence lawyer?

Richard Wasserstrom, after admitting that 'the lawyer's world is a simplified moral world, often amoral, and more than occasionally, an overtly immoral one,'[48] recognises that the lawyer's role leads to a role-differentiated behaviour:

> ... it is the nature of role-differentiated behavior that it often makes it both appropriate and desirable for the person in a particular role to put to one side considerations of various sorts – and especially various moral considerations – that would otherwise be relevant if not decisive.[49]

Then, in accordance with what has been said about physicians' devotion to medicine, he says that one's professional role becomes one's dominant role, and that many persons become their professional being.[50] But this view, which he does not develop any further, means that common morality is entirely abandoned. This point needs elaboration.

David Luban provides a more complete answer which, though unsatisfactory for him, has influenced many people dealing with legal ethics. In his *Lawyers and Justice*, he first analyses the theory of role morality based on Bradley's remarks, in order to apply it afterwards to lawyers, and he specifically uses the example of the criminal defence lawyer:

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[46] George W. Warvelle, *Essays in Legal Ethics* [2nd edition] (Chicago, 1920) p. 144. [also available from: http://galenet.galegroup.com/servlet/MOML]
[47] Stephen Pepper, 'The Lawyer's Amoral Ethical Role' *American Bar Foundation Research Journal* **11** [4] (1986), 635.
[48] Richard Wasserstrom, 'Lawyers as Professionals: Some Moral Issues' *Human Rights* **5** [1] 1975, 2.
[49] *Ibid*, at 3.
[50] *Ibid*, at 15.

> ... conflicts sometimes arise between 'common morality' and 'role morality' – for example, when a lawyer's role morality demands that she bend her talents and ingenuity toward getting a guilty, violent criminal back out on the street. When such conflicts arise, the theory asserts that role morality must take precedence.[51]

Based on roles, he finds the concept of 'common morality' problematic, just like Bradley before him: 'That role is the Bohemian, the noble savage, Mr. Natural, the man or woman beyond roles.'[52] Then, unlike Bradley, who thought that role morality should always prevail, he rejects the theory of role morality, stating even that it is frightening to contemplate it,[53] and that 'our roles do not exhaust ourselves.'[54] However, he acknowledges that the tension he describes between role morality and common morality is real, though it cannot be straightforwardly resolved in favour of one or the other.[55] He concludes by examining the criminal defence lawyer once again:

> [It] is one of the clearest cases of a role occupant who will often find that the justifications of the role are so crucial that they override all but the most stringent demands of common morality.[56]

And finally he offers his personal answer: 'nothing permits a lawyer to discard her discretion or relieves her of the necessity of asking whether a client's project is worthy of a decent person's service.'[57]

The tension between role morality and common morality is actually what double morality is about. Luban appears to think that it is too easy for a professional to act morally just by giving priority to his role morality when he is in his professional role, and he urges the criminal defence lawyer to use her discretion when trying to resolve the tension between the two moralities. It is certain that, however influential he has

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[51] David Luban, *Lawyers and Justice: An Ethical Study* (Princeton: Princeton University Press, 1988) p. xx.
[52] *Ibid.*, p. 115.
[53] *Ibid.*, p. 122.
[54] *Ibid.*, p. 111.
[55] *Ibid.*, p. 125.
[56] *Ibid.*, p. 145.
[57] *Ibid.*, p. 174.

been, not every lawyer is willing, or able to follow Luban's sensible dictates; as a result, many criminals remain free. This is perhaps an indication that the concept of double morality has weak points, even if we admit that the prevalence of the role morality's element should always be questioned; but there shall be enough space for all these issues to be carefully examined.

Relevant Material

In this section, I shall briefly mention some very interesting pieces of work by Hart and Casey, where they discuss the notion of responsibility as it is attached to one's role. An extensive discussion, although it would be very useful in general, cannot take place at this point, as it would fall out of the scope of this thesis. However, the ideas expressed here shall find their way in later parts of it, either to support or to oppose the theory of double morality.

a) H.L.A. Hart's various types of responsibility

In his essay 'Responsibility and Retribution',[58] Hart describes four types of responsibility. First, there is 'role-responsibility', where a person occupies a distinctive place in a social organization and, consequently, he is responsible for the performance of the duties which are attached to it.[59] Second, there is 'causal responsibility', which means that a person, an event, or a thing, are responsible for outcomes which they caused.[60] Next, we have 'liability-responsibility', dealing with blameworthiness, and which can be either 'legal' or 'moral', with the former being much stricter than the latter.[61] And finally, there is 'capacity-responsibility' which forms the condition that, if a person has certain normal capacities such as understanding, reasoning, and control of conduct, then this person can

[58] H.L.A Hart, *Punishment and Responsibility: Essays in the Philosophy of Law* (Oxford: Clarendon Press, 1968) pp. 210-237.
[59] *Ibid.*, p. 212.
[60] *Ibid.*, p. 214.
[61] *Ibid.*, p, 226.

be held 'responsible for his actions.'[62] Now it seems that what interests us most here is the concept of 'role-responsibility' and how this type of responsibility can, in a way, override other types, especially 'capacity-responsibility'.

Let me present the following, purely hypothetical, example; the appointed conductor of a philharmonic orchestra is suddenly deafened. Apart from managerial duties, his role as a conductor also entails the duty of conducting the orchestra in public concerts. But, since he is deaf, he cannot perform this specific duty anymore. There is an obvious problem here. We notice that his role-responsibility remains intact, while his capacity-responsibility does no longer exist. And, under certain circumstances, if the conductor does not want to inform others of his problem, or if he does not want himself to acknowledge it, no-one will know that capacity-responsibility is lost in this case. There may be bad reviews on this orchestra's public performances, but this is normal and it frequently happens even in cases where conductors have excellent hearing.

We cannot deny that the most essential responsibility here is capacity-responsibility, and not role-responsibility; nevertheless, the most dominant one is the latter. This shows how powerful roles can be, and how misleading at the same time. And, even though it is not sufficient to prove it, it certainly supports the view that role morality cannot simply trample common morality whenever there is a conflict, because something as essential as 'capacity-responsibility' could be overlooked. But I will come back to these points in more detail.

b) Casey's actions and consequences

Another thinker who pays particular attention to roles and responsibility is John Casey. He discusses Hart's views and also makes a distinction between various types of responsibility.[63] What he has to say about roles

[62] *Ibid.*, p. 227.
[63] John Casey 'Actions and Consequences' in John Casey (ed.) *Morality and Moral Reasoning: Five Essays in Ethics* (London: Methuen & Co. Ltd., 1971) p. 178.

is very interesting, as he seems to acknowledge that there can be no moral judgment of a person occupying a role, unless we have first decided what exactly this role is. Hence, using the medical role as an example, he concludes:

> We cannot then settle the argument by looking for a description of what the doctor does which is neutral as regards his role or responsibility, but only by deciding what we think *is* the medical role and its relation to the various other roles and responsibilities a man may have.[64]

Taking this view into account, the most important remark is that we also need to consider the relation of the medical role to the various other roles a man may have; that is, within the same individual, the role morality of the physician to the common morality of the layperson (which we defined as anything but the physician). And, furthermore, he clearly makes the point that our conception of a role is not as morally important as the role holder's conception;[65] this appeal to self-realisation needs to be properly explored.

All these shall be discussed in due time. Nevertheless, it is worth noting that Casey's views can certainly be challenged. For instance, as John Harris notes, 'Casey believes that what he calls "a man's role" defines what sort of agent he is, and what are his responsibilities and obligations, *prior* to any particular case,'[66] and this is, of course, sometimes true. In addition, the importance of one's personal conception of one's role has to be questioned; otherwise, a man's own interpretation of his role-based duties can arbitrarily limit his responsibility for consequences.[67] So it seems that, at least at this point, a *standard* role morality should be used instead of Casey's *personal* role morality. I do not reject this personal conception of the role completely; but for the time being, I do not think that it can stand as it is. Before we can reconsider, there has to be a lengthy discussion of the way the medical role

[64] *Ibid.*, p. 189.
[65] *Ibid.*, p. 194.
[66] John Harris, *Violence and Responsibility* (London: Routledge & Kegan Paul, 1980) p. 33.
[67] *Ibid.*, p. 34.

functions, and of what the notion of "role" entails. If this is not done, then, in Harris' words, we are simply trying to make this notion 'do more work than it can bear.'[68]

II) Explaining Double Morality

The theory of *double morality* asserts that it is possible for both common and role morality to exist within the same individual – in our case, the physician. Common morality and its personal developments exist separately from the physician's role morality which is based on the dictates of the god of Medicine. Every physician has acquired the model physician's personality to a certain extent, and every physician tries to approach the ideal physician's morality as much as possible – provided that they respect their profession of course. And it is also true that their role has a powerful influence on the role-holders, making them look like servants of their profession. But, according to the theory of double morality, this does not mean that the layperson which existed before the physician has gone; he is still there and still being developed, in parallel with the physician, in a kind of alternative universe. When we talk about the ethos of the physician, we have to bear in mind that behind his professional identity there is an ordinary human being. The physician obeys the god of Medicine and becomes a servant, but the layperson relies on humanity's common moral ground to decide on what is right and wrong. So when the time comes for a decision or an action to be taken, the individual has to choose which part of him should decide or act, depending on the circumstances. If it is the physician, then role morality is what guides his conduct, and if it is the layperson, then common morality is enough. Double morality is not self-existent; it does not have its own essence. It is rather the ability to choose between role and common morality.

[68] *Ibid.*, p. 36.

Why not multiple moralities?

To avoid a prospective objection, it is better to explain why this theory considers the possibility of only two moralities alternating with each other instead of many; for one could say that there is no common morality which can be compared to the physician's role morality, because common morality has to be too primitive since it is based on the most fundamental human qualities, while role morality is based on the highly sophisticated medical culture. Therefore, if we wanted to be consistent, we should talk about the interaction of the physician's role morality with the various other moralities that an individual physician has, by virtue of his qualities; he can be a citizen of a country who respects its laws, a parent who has a special relationship with his children, a member of a religion with a particular dogma, and so on. If we consider all these qualities of the individual, we should acknowledge that the theory should be the one of *multiple moralities* and not simply of double morality.

However, two issues need to be recalled; first, it was established in the previous chapter that the physician's role is a very peculiar one, which justifies a separate role morality for it. We cannot assume that there is a separate role morality to correspond to every quality that an individual may have. Furthermore, all the other qualities can be found in anyone, whether they are physicians or not, but the same is not true for the qualities of the physician. And second, I have mentioned that common morality is a basic groundwork on which various moral developments can take place until a distinct personal morality is constructed for each individual. For example, a religious moral element and the special moral values which come with parenthood are both part of one's personal morality, but their roots are traced in common morality. And because I cannot consider everyone's personal morality, all these moral possibilities are classified as common morality, and this morality is then compared to the physician's role morality, which has a different moral groundwork, the medical culture. The term *multiple moralities* would thus clearly be misleading.

Avoidance of moral conflict

It shall be obvious that often there is disagreement between common morality and role morality; in such cases, their values come into conflict and the individual has to choose whether he should act as a role-holder or as a layperson. Moral conflict is very common, independently of any role-related confrontations. The moral agent who faces a conflict of values has to weigh moral reasons, prioritise commitments, and make moral compromises in order to choose, if not the right course of action, then at least the one which seems less wrong. As Nagel notes, there are many perspectives which the same individual can use, and the fact that they reflect differences of a fundamental nature in their sources rules out a certain kind of pure solution to conflicts.[69] This means that, whatever the decision is, there cannot be complete satisfaction since some values have to be compromised. If this is the case, some writers argue, genuine moral dilemmas will, in fact, involve *insoluble* conflicts, as, from a neutral point of view, neither claim can be weightier than the other.[70] And Mackie admits that 'we must lower our sights a little, and look not for principles which can be wholeheartedly endorsed from any point of view, but for ones which represent an acceptable compromise between the different actual points of view.'[71]

Double morality aims at simplifying this procedure. It can be regarded as functioning at two separate levels, the professional level and the lay one; therefore, role morality's values do not conflict with common morality's values, because they never meet with each other, since they are situated in different levels. One could also say that in fact, it is not one person who has to take the decision alone and experience moral conflict, but two, the professional and the layperson; and there can be no conflict, since the professional's morality exists independently of the layperson's morality and the professional decides and acts

[69] Thomas Nagel, *Mortal Questions* (New York: Cambridge University Press, 1979) p. 134.
[70] See, for example, David O. Brink, 'Moral Conflict and its Structure' *The Philosophical Review* **103** [2] (1994), 215-247.
[71] J. L. Mackie, *Ethics: Inventing Right and Wrong* (Harmondsworth: Penguin Books, 1977) p. 93.

independently of the layperson. The individual can choose to silence the professional and let the layperson decide or vice versa. Then the problem is transferred to how the individual chooses whether he should adopt the professional or the layperson character in a particular instance. This does not mean of course that the moral conflict is solved. An external observer would note that the problem persists, perhaps because indeed, 'no conflict of values can ever rationally be resolved.'[72] But for the individual who takes the decision it is no longer visible, because he clearly chooses to be on one side rather than on the other; and, by doing so, he even forgets that there is another side. This is how moral conflict is avoided.

How to choose between moralities

The obvious answer would be to say that the physician acts as a physician when he finds himself in a medical setting and as a layperson when the medical setting does not exist. 'Effectively, we wear two "moral hats" – one for work and one for everywhere else.'[73] I think that, apart from obvious, this would also be the wrong answer, because, as has been emphasised, professions are not mere occupations, and their attributes do not behave like a hat which the professional can take off when the working day is done. This observation is particularly true for the medical profession, since it has been noted that medicine, as opposed to law, the clergy, and the other professions, deals with natural phenomena, inherent in human nature. Therefore, the medical setting surely plays an important role as to whether one behaves as a physician, but its absence does not presuppose that the individual automatically turns from the physician's to the layperson's status.

Then how does one choose between two moralities? Not being able to identify one single crucial factor which counts as decisive, I shall make the following hypothesis: the god of Medicine, the underlying medical culture in other words, which provides moral guidance for the

[72] Bernard Williams, *Moral Luck* (Cambridge: Cambridge University Press, 1981) p. 77.
[73] Gibson, *op. cit.*, at 17.

physician, appears whenever there is a need for the physician to behave as a physician. It is the individual who chooses what the appropriate morality is according to the situation, but it is the god of Medicine who actually decides when to make his appearance. To put it differently, the medical culture stays with the individual all the time, but for some of the time in a lethargic state; when the need to use it arises, there is an inherent mechanism within this culture which triggers its activation. It is probable that the individual physician does not control the coming of the periods where he is under the medical culture's influence. By acquiring it little by little throughout his life, he also learns – perhaps without being aware of this process of learning – when it is appropriate, and when it is useful to use this culture. The god of Medicine is self-controlled; he knows and decides when to come and guide the physician, even though it looks as if the physician is the one who summons him according to his needs.

The hypothesis is, then, that part of the physician's medical culture refers to when to use this medical culture without actually offering a choice to each individual physician once he has acquired it. Choosing between role and common morality becomes an issue of role morality, as if role morality had a will of its own which allows it to make its appearance whenever there is a need. The physician does not decide; he just knows when to adopt role morality, because this knowledge is part of his medical culture, to which role morality belongs. This hypothesis shall become clearer in the following chapters of the thesis where practical examples are discussed, and of course it shall be tested along with the rest of the theory of double morality.

Differences with similar theories

In the previous section I discussed Bradley's idea that personal morality has to be subjugated to one's station; 'certain circumstances, a certain position, call for a certain course.'[74] I also considered Luban's

[74] Bradley, *op. cit.*, p. 176.

disagreement that allowing role morality to prevail effortlessly over personal morality is a 'monolithic point of view' and that one must be prepared to break with the role.[75] Both these writers recognise a conflict between common and role morality and the difference is that Bradley offers a simple solution, while Luban simply rejects this solution. By contrast, the theory of double morality does not recognise a conflict because, as we have seen, it suggests that the two moralities are situated in different levels and they do not meet with each other. This is mainly the difference between double morality theory and every other theory which bears resemblance to it, but there exist other differences as well. I shall discuss some of these differences in a medical context.

a) Situational ethics

The moral theory which is closer to what I have described as double morality must be the one of *situational ethics* or the very similar one of *moral relativism*, which holds that 'a morality which was *not* relative would be futile.'[76] Adrian Rogers believes that situational ethics was the theory on which the medical profession based its response to recent changes of society's demands.

> [Instead of strict rules of ethics] we have developed what is most easily described as situational ethics: a system of ethics where there is no clear right or wrong behaviour but where every individual case and all its circumstances are adjudged by the doctor at the time of action ...[77]

This means basically that there is no uniformity of ethical behaviour to be found amongst physicians. However, even though Rogers does not mention the tension between common and role morality, this approach also implies that the physician is able to use either one at the time of action, according to the circumstances. There are many who are in favour of this approach; for example, Sir Douglas Black finds situational

[75] Luban, *op. cit.*, p. 127.
[76] Bradley, *op. cit.*, p. 189.
[77] Adrian Rogers, 'The restoration of medical ethics' *Journal of Medical Ethics* **10** (1984), 117.

ethics very useful because it opposes medical codes, which 'if they are to be sensible, can only define a minimum standard, whereas we should try to do better ...'[78]

The problems with codes of medical ethics are of no interest at the moment, but I should mention that their mission is to provide guidance as to the correct course of action, what one should do. And this is what situational ethics is also about, with the difference that it leaves more freedom to individuals to decide what to do – but always in a medical setting. The theory of double morality is different because it is not about what one does, but rather how one behaves according to the situation. The theory of double morality surely acknowledges the importance of particular situations and opposes strict ethical rules; but it does so in the context of which role is preferable instead of which action is better. The god of Medicine provides the physician's role morality which has the – supposedly – right answer; the physician then uses or does not use this morality, according to the situation.

b) Practice Positivism

This is a theory which Applbaum discusses in his book *Ethics for Adversaries*, without being a proponent of it.

> On this view, the concept of a practice does not impose any general content requirements or restrictions on the rules of all practices. The rules of a practice simply are what they are, not what they ought to be or what we want them to be ... We can criticize an entire role or practice from the outside, and ask if it is a morally permissible or worthy pursuit. But if practice positivism is the correct view of roles, then medical expertise can be put in service of a wide range of purposes without *internal contradiction*.[79]

[78] Douglas Black, 'In Defence of Situational Ethics, the NHS and the Permissive Society' *Journal of Medical Ethics* **10** (1984), 121.
[79] Arthur Isak Applbaum, *Ethics for Adversaries: The Morality of Roles in Public and Professional Life* (Princeton, New Jersey: Princeton University Press, 1999) p. 51 [my emphasis].

This theory has a clear resemblance to double morality, because 'to the extent that what the role is tracks what the role morally should be, the role is, in this sense, directly moralized,'[80] which, however, is not to say that physicians are free from the ordinary moral requirements that apply to all persons.[81]

As opposed to the theory of double morality, practice positivism accepts that there can be moral conflict between common and role morality; but it is so uncommon that it is insignificant. Michael Quinlan, proponent of the theory and the writer whom Applbaum contradicts, claims that these conflicts are very rare indeed, because the basic moral requirements of any human behaviour – one's personal morality, or what I refer to as common morality – are much more fundamental, and therefore role expectations cannot seriously threaten the absolutes of personal morality.[82] So, according to this theory, it seems that it is unlikely for a conflict to exist because, as opposed to Bradley's view, which acknowledged the role's powerfulness, common morality prevails over role morality whenever there is a doubt. But the theory of double morality does not say that one morality always prevails over the other; it just says that they function separately. Hence there is a big difference between practice positivism and double morality, even though we can say that they both accept that there is no actual conflict between moralities.

It is important to note that Applbaum presents a series of arguments which reject the theory of practice positivism. For him, the central question of role morality in the professions is this: 'How can an action that otherwise would be morally impermissible become permissible when performed within a role?'[83] The theory's answer is that there is no 'otherwise': the action, so described, does not exist apart from the practice, and so cannot be performed outside of the role.[84] And this is an inadequate answer, for it implies that the physician in a medical

[80] *Ibid.*, p. 54.
[81] *Ibid.*, p. 59.
[82] Michael Quinlan, 'Ethics in Public Service' *Governance : An International Journal of Policy and Administration* **6** [4] (1993), 543.
[83] Applbaum, *op. cit.*, p. 89.
[84] *Ibid.*

setting has absolutely nothing to do with the layperson that exists within the same individual; so this constitutes another difference between the theory of double morality and practice positivism.

c) The internal morality of medicine

It also makes sense to mention briefly the context in which Brody and Miller discuss the physician's decisions. What they have in mind when they mention the *internal morality of medicine* is very close to the concept of the god of Medicine; the internal morality of medicine is the moral framework consisting of goals proper to medicine, role-specific duties, and clinical virtues.[85] According to their theory:

> Physicians, by virtue of becoming socialized into the medical profession, accept allegiance to a set of moral values which define the core nature of medical practice ... The *professional integrity* of physician is constituted by allegiance to this internal morality.[86]

Then they identify cases where this internal morality is violated, like for example treating one's family, having sexual relationships with patients, and prescribing steroids for athletes. They also consider other cases which, without violating this morality, occupy nevertheless a borderline status in relation to it, like sterilisation or cosmetic surgery.[87] In doing so, they assert that a general morality which is applicable to all persons in society exists, and that the internal morality of medicine is complementary to this morality, but absolutely necessary for the physicians nevertheless.

Therefore their theory, which they defend against a considerable number of objections, has the same basis as the theory of double morality. However, according to their theory, the internal morality of medicine is not clearly separated from common morality; they rather

[85] Franklin Miller, Howard Brody, Kevin Chung, 'Cosmetic Surgery and the Internal Morality of Medicine' *Cambridge Quarterly of Healthcare Ethics* **9** (2000), 353-364.
[86] Howard Brody & Franklin Miller, 'The Internal Morality of Medicine: Explication and Application to Managed Care' *Journal of Medicine and Philosophy* **23** [4] (1998), 386.
[87] *Ibid.*

think that they are complementary to each other. The same is implied by Robert Merton when he describes one's internalised scientific conscience as one's *superego*.[88] In other words, being a physician simply means that the range of possible situations in which one needs to make moral decisions is extended, and the difference is one of scope rather than differing values.[89] Hence it is by respecting or violating the internal morality that the physician can adjust his behaviour; and because they assume that the internal morality of medicine contains values of indisputable worth for the medical setting, they conclude that a way has to be found to avoid its violation. They seem to ask too much; and by assuming that common morality is standard, their theory is at odds with the theory of double morality, which questions both moralities' values and is prepared to reject either one according to the circumstances in order to avoid moral conflict.

d) The Doctrine of Double Effect

This doctrine is old, and, some might say, outdated, as it needs strong beliefs, or even traditional Romeo-catholic forbiddances, in order to be applied.[90] However, as it shares some points with the theory of double morality, it is useful to discuss it briefly. The doctrine of double effect is quite simple; a 'good' act which has foreseeable 'bad' side effects is morally justified, provided that the intended end is the 'good' act and that the 'bad' side effect is unintended. This idea is rather useful in Palliative Care and in cases of terminal sedation.[91]

Thus explained, the doctrine does not appear to be closely related to the theory of double morality. However, the issue here is the shift of responsibility which takes place if one uses the doctrine of double effect. Bearing Hart's various types of responsibility in mind, there is neither *role* nor *liability* responsibility under the double effect perspective; there is

[88] Robert K. Merton, *Social Theory and Social Justice* (New York: The Free Press, 1942) p. 605.
[89] Stephen de Wijze, 'Dirty hands – doing wrong to do right' *South African Journal of Philosophy* **13** [1] (1994), 27-33.
[90] Mark Aulisio 'Double Effect' in Stephen Post (ed.), *Encyclopedia of Bioethics* [3rd edition] (New York: Macmillan Reference USA, 2004) p. 688.
[91] *Ibid.*, p. 687.

only *causal* responsibility. And, since causal responsibility applies equally to human beings and to actions, conditions or things,[92] it seems that the moral agent can, in a way, step out of his agency and 'blame' a certain condition for any unhappy side effects. This can remind us of double morality in many instances. For example, the soldier who kills the enemy can claim that he merely follows orders and that these orders are to 'blame' for the killing of the enemy; he intended to do good by following orders, and the killing is just a side effect – foreseeable, but unintended.

However, even though it appears that this doctrine has unlimited potential, it cannot be used in accordance with double morality. It is a wrong approach, for it implies that roles and agents do not matter, and focuses on actions as if these actions occur out of nowhere. This is not what the theory of double morality claims; it may indeed refer to a god of Medicine, who can trump the individual physician's common morality, but it never disregards the individual completely. The meaning of a role, which can be lost in the doctrine of double effect, is never absent from the theory of double morality.

Double morality's relation to mainstream theories

The theory of double morality may not be much of a moral theory. First of all, it does not provide recommendations as to what is right and wrong and offer guidance; nor does it attempt to discuss morality in depth. It rather tries to construct a system which explains how moral universes which are already made can co-exist, without questioning their values very much. In order to do that, many assumptions have been made which have been already noted. Put another way, the theory of double morality deals with questions which ask *how*, instead of *what* and *why*. It asks *how* it is possible for the physician to act in this way instead of *why* he acts this way or *what* is the proper way to act. But this does not mean that this theory is independent of proper moral theories. In the field of

[92] Hart, *op. cit.*, p. 214.

medical ethics two of these theories prevail; obligation theory and utilitarianism. A full analysis of them would be out of place; I shall just mention some aspects which are relevant to double morality.

a) Obligation theory

Kant is what comes to mind when one speaks of obligation theory and there is no need – or space – to discuss other important proponents of the theory. Immediately, we note that there is a problem with Kant's ideas if we relate them to double morality, for Kant's Categorical Imperative states that we should try for our actions to be based on what we could consider as a universal law;[93] and if moral rules have the characteristic of universality, then what is morally forbidden to one is forbidden to all, and what is morally obligatory for one is equally obligatory for all.[94] For Kant, morality begins with the rejection of non-universalizable principles;[95] but from this it follows that double morality is immoral, because it presupposes that there are different sets of moral rules for persons like the physician, who occupy special roles. Kant also asserts that science must be done from the 'standpoint of everyone',[96] denying the scientist's – and consequently the physician's – special moral status. Another of Kant's positions is that pure reason is where morality originates, and that free will is a necessary prerequisite of morality.[97] How, then, can an individual physician rely on medical culture for moral guidance? He should decide what to do using his reason and his free will instead of being servant to a despotic god of Medicine, and understand by himself what his obligations are. These are serious objections to double morality.

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[93] Immanuel Kant, *Groundwork of the Metaphysics of Morals* [translated and edited by Mary Gregor] (Cambridge: Cambridge University Press, 1998) p. 31.
[94] Roger Sullivan, *Immanuel Kant's Moral Theory* (New York: Oxford University Press, 1989) p. 165.
[95] Onora O'Neill 'Kantian Ethics' in Peter Singer (ed.), *A Companion to Ethics* (Oxford: Blackwell Publishers, 1993) p. 177.
[96] Sullivan, *op. cit.*, p. 111.
[97] Immanuel Kant, *Lectures on Ethics* [translated by Louis Infield] (London: Methuen & Co., 1930) p. 42.

However, I can make the following suggestions in defence of it: first, physicians in Kant's time were not as special as they are today, and many medical ethical problems could not be conceived. Therefore, if I can return to the physician the special status which I gave him in the previous section and which Kant took away for a while, there can be a medical Categorical Imperative exclusively for physicians, in the same way that there is a role morality exclusively for them. Maxims which can form universal laws can still be sought, but the context has to be a medical one; in other words, these laws have to apply to every physician, and not to every person. This view is in accordance with the god of Medicine and the role morality which applies to every individual physician. And, second, on the issue of free will and the individual's understanding of morality, I can note that the despotic god of Medicine does not truly exist as a lawgiver; as Kant himself notes, 'it is by our reason that we apprehend the divine will.'[98] Accordingly, the physicians can know the commands of the god of Medicine by their medical reason, and they can test them at any time. But in any case, the theory of double morality is by no means founded on, or directly influenced by any obligation theories.

b) Utilitarianism

Utilitariansim and its various branches claim that morality lies in maximising happiness in this world, and that all moral decisions should be directed toward that goal. Good consequences are all that matter. However, among others, there is the objection that we cannot give a satisfactory account of the goodness of actions in terms of the goodness of their consequences.[99] Opponents of the theory also argue that the demands of utilitarianism can come into conflict with the demands of justice and with human rights.[100] Justice and rights clearly belong to

[98] *Ibid.*, p. 40.
[99] See, for example, Alastair Norcross 'Good and Bad Actions' *The Philosophical Review* **106** [1] (1997), 1-34.
[100] James Rachels, *The Elements of Moral Philosophy* [3rd edition] (Singapore: McGraw-Hill, 1999) p. 111.

common morality; and since this is what mainly matters for laypersons which, compared to physicians, constitute the overwhelming majority, it is understandable that utilitarianism has received many attacks.

One of the modern proponents of the theory, J. J. C. Smart, admits that utilitarianism has consequences which are incompatible with the common moral consciousness, but he admits that he tends to take the view 'so much the worse for the common moral consciousness.'[101] This does not imply that common morality does not exist but rather that it can be overruled; it is therefore in accordance with double morality, which condemns absolute moral principles and favours switching between moralities. 'It is quite conceivable that there is *no* possible ethical theory which will be conformable with all our attitudes'[102] and 'no ethical system would be satisfactory to all men, or even to one man at different times.'[103] These are views clearly in favour of double morality, but it should be noted that the theory of double morality is not utilitarian. The physician's choice between common and role morality does not take place to maximise good or happiness; it happens out of necessity, because the physician is also a layperson.

In general, the two mainstream theories which are used in medical ethics do not impose any serious restrictions on the theory of double morality. Nevertheless, double morality's spirit is neither deontological nor utilitarian. Perhaps it is closer to utilitarianism, as approached by Smart in particular, but this does not mean that it can be described as such. Its relationship with the two main moral theories is neither one of collaboration nor one of opposition. This neutrality could be viewed as good, as many objections can be overruled. But being neutral is not always the best thing to do; we will see, later on, whether the theory of double morality can stand against criticism.

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[101] J. J. C. Smart 'An outline of a system of utilitarian ethics' in J. J. C. Smart & Bernard Williams, *Utilitarianism: For and Against* (New York: Cambridge University Press, 1995, 1973) p. 68.
[102] *Ibid.*, p. 72.
[103] *Ibid.*, p. 73.

Conclusion

I have now sketched the theoretical context for the concept of double morality. I referred to resources which constituted the basis for it; I explained the theory as fully as necessary; I compared it to other similar theories; and I also examined its relation to mainstream moral systems. Questions may still exist, which I hope shall be answered in the next part of the thesis, where I shall discuss practical applications. It is also very probable that strong objections to the theory may have been raised; and when the theory is put into practice these objections may become even more and stronger. I shall be dealing with them after presenting the practical examples. If they cannot be overcome, the theory of double morality shall simply be rejected. But I think that it is an interesting theory in any case.

PART II

Criticisms of 'double morality'

Chapter 4

CASES WHERE DOUBLE MORALITY SEEMS TO FUNCTION

The concept of double morality as described in the previous chapters can be used very effectively in the cases which I shall discuss here. First it shall be shown how a physician can bring himself in a position to end someone's life – a patient's or a convict's sentenced to death – by using double morality, as well as how he can participate in torture. Then there shall be a discussion on how the physician can use double morality in order to view medicine not only as a profession, but also as a business; that is, a job like all the others, where issues of payment need to be considered before the delivery of services. The final section shall deal with how double morality can be applied to dishonest attitudes which physicians tend to adopt when they think that it is in their patients' best interests.

I) Killer Medicine

In my view, there are two kinds of intentional killing; rational and irrational. The irrational kind of killing happens when the one who performs the action does not take the time to think properly of what he does, yielding feelings (like the rage of a cheated husband), following orders without further questioning them (as in the case of soldiers going to war), failing to see a more detailed context to the action (as in the case of a mobster who kills a rival mobster in anticipation of a gain, but without thinking further than that), or merely being misinformed (like an Aztec priest who sacrifices people in order to keep the sun rising). The rational kind of killing, on the other hand, takes place when the killer decides that, all things considered, it is the best that one could do – no matter whether this is actually true; the important thing is that a rational decision has been made. What we are dealing here with is only rational killing.

To be sure, even when a rational decision has been made, an exceptional morality is required in order to perform the action of killing. Common morality is clearly against the intentional killing of innocent human beings, as this is one of the basic premises of every society, and murder has always been considered a crime. A role morality, however, can override this basic premise; the executioner, for example, by virtue of his role, is not a murderer. But the case of the executioner is quite simple. Now there are complex cases where, whether it is legal or not, and whether it is justifiable or not, it is the physician who has to kill a human being, directly or indirectly, the very same professional who saves lives in his everyday routine. This killing can be based a) on medical decisions, or b) on political decisions. Can the physician's role morality help him where his common morality is strictly forbidding? Some instances where this can happen are presented below.

I just need to note that, in this discussion, I do not hold 'killing' to be different from 'letting die' (it is an interesting distinction but of no interest here), and that the issues of legitimate abortion, and of patients in a persistent vegetative state shall not be considered, as common morality remains unclear as to whether the termination of these lives constitutes killing.

Killing based on medical decisions

In this section, I shall examine three different issues: a) euthanasia, b) infanticide, and c) allocation of scarce resources. The third issue is related to indirect killing, as it basically deals with letting one die, when all cannot be saved, but this distinction between killing and letting die is presently of no interest, as it has already been discussed. All these three issues cause great moral uncertainty, and there is no way I can possibly exhaust their discussion; it is sufficient to explore an approach based on double morality, without denying that there are many more approaches and relevant problems to be considered.

a) Ending lives in a professional context

As we said, we are dealing with rational intentional killing, which means that, all things considered, a human being is believed to be better off dead; having accepted this, we need a physician to perform the act of killing. This is already troubling, as, for some, the role of the physician in particular should never entail any kind of ending a human life.[1]

To be sure, there are other roles which can be of assistance apart from the professional role. Let us consider the example of someone's role as a friend, and allow me to use an example taken from Greek mythology. When Hercules asked for euthanasia, there was no physician around. This great hero had put on a poisonous cape which he could not take off and which caused him immense suffering – a despicable manoeuvre designed by Nessus. Hercules was begging for someone to kill him, and everyone hesitated, until Filoktetes, one of Hercules's closest friends, performed the euthanasia by setting him on fire.[2] This makes sense, and, theoretically, the same can be expected in real life situations: people being killed by their closest friends or relatives if they wish to die, because nobody else would have had a deeper understanding of them, and therefore, nobody else could be as certain as possible that this would be the right thing to do. Moreover, nobody else would be willing to bear the burden of responsibility, which is shifted from the person who wanted to die to the person who killed, right after the former person's death. Common morality orders us not to kill another human being, first of all because we know that it is something which cannot be amended afterwards. The decision behind rational killing demands a high level of certainty about its rightness. The role of the friend, among other roles, can impose an exceptional morality for an exceptional circumstance and overcome the dictates of common morality. However, friendship is not an institution. 'When two individuals

[1] See, for example, Thomas Mappes 'Euthanasia and Physician-Assisted Suicide' in Thomas Mappes & Jane Zembaty (eds.), *Social Ethics: Morality and Social Policy* [6th edition] (New York: McGraw-Hill, 2002) p. 64.
[2] Catherine B. Avery (ed.), *The New Century Handbook of Greek Mythology and Legend* (New York: Meredith Corporation, 1972) p. 270.

become friends, a new friendship comes into being. Should they cease to be friends, their friendship will cease to exist; it cannot be resumed by anyone other than those particular individuals.'[3]

Can the role of the physician be used in the same way? Based on double morality's approach, the answer is that it can, with two main differences. First, for the physician it is not such an exceptional circumstance because he can often be faced with unbearable suffering in his professional context, whereas the death of Hercules was, for Filoktetes, a once in a lifetime experience; and, second, the physician cannot have a deep knowledge of his patients, let alone being friends with them, and this certainly makes it more difficult when it comes to assuming responsibility. However, the physician is not alone; his master, the god of Medicine, is with him, and it is easy to shift the responsibility to this master, who can handle it effectively. Common morality, which demands the highest level of certainty, is temporarily dismantled; role morality is used, which has the certainty of the powerful master on its side. The moral ideals of patient-assistance can override all other moral obligations (to avoid killing, to not violate laws, etc.)[4] and the physician can repeatedly kill human beings when he justifiably believes that it is the best thing to do. I do not have an opinion to share with regards to how appropriate this is; the important thing is that many physicians seem to believe that it is a good idea to end human lives when the suffering overcomes the will to live – otherwise there would not be calls from physicians for the legalisation of physician-assisted suicide.

But clearly, outside the professional context the physician cannot act in the same way and be morally justified. Physicians, being the god of Medicine's servants, have the privilege of holding the keys of life and death, but only when the situations place them into their hands. Without acting as someone's physician and without having a different exceptional role – whether this role is good or bad – which would justify killing, the layperson's common morality could never let such a basic moral

[3] Michael Hardimon 'Role Obligations' *The Journal of Philosophy* **91** [7] (1994) 333-363, at 336.
[4] Tom Beauchamp 'Justifying Physician-Assisted Suicide' in Hugh LaFollette (ed.), *Ethics in Practice: An Anthology* [2nd edition] (Oxford: Blackwell Publishers, 2002) p. 44.

commandment be violated. Take for example a group of religious fanatics who want to commit suicide; in fact, they are absolutely convinced that they must commit suicide, because their leader says so. From our point of view, presuming that we are sensible people, we might think that this is a very bad reason to die; but from their point of view, this is an excellent reason. Therefore, this group of people have very good personal reasons to commit suicide. Let us suppose that they ask Dr Kevorkian to help them. Even if they are not suffering, they may want to die more than any patient whom Dr Kevorkian has 'treated' in his career, as their personal reasons to die are very compelling to them. However, he would have to reject their request. When reasons are not medical, the physician's side is not present. So Dr Kevorkian, as a normal layperson of common moral sense, would have to refuse to kill some people who want to die based on non-medical reasons. It has to be noted, however, that there are some other, clearly non-medical reasons, which nevertheless trigger the use of the physician's role morality, and allow him to proceed with the killing, as happens in the case of capital punishment; these are institutional reasons and they shall be discussed later on.

b) Infanticide in a professional context

Common morality dictates that we should protect the vulnerable, such as defenceless infants. This may be based on primitive instincts related to the perpetuation of the species, because, if we do not protect the infants, there will be no generations to follow. But this impulsive dictate is also extended to the case of our relation with other species; this is why we generally feel the urge to protect, for example, a newborn kitten if it has lost its mother. I am not saying that we will protect it to the end, but I believe that most of us feel the urge anyway. There are of course some who do not feel like this at all, and who deliberately drown kittens as soon as they are born. And, furthermore, there is the case of the ancient Spartans, who would only allow fit infants to survive, and the case of the

ancient Romans, who would sometimes kill an infant if it happened to be a girl. These are instances of exceptional moralities.

Michael Tooley uses the example of the newborn kitten in his essay 'Abortion and Infanticide', where he argues that the kitten's death does not matter morally if we can assume that nobody cares about it and that the kitten is not self-conscious – therefore, as long as it does not suffer, there is no problem at all.[5] I believe that this view expresses another instance of exceptional morality. It is a rational, well-presented, moral argument by a famous philosopher. But rationality does not always work. If Tooley had found a newborn kitten by the dustbin, perhaps he could think that, since he is the one who found the kitten, he is the person for whom its death matters, and that he would feel guilt if he did not do anything. Or he could instinctively think that the kitten was self-conscious and suffering. He would then take it to his place to look after it. It is certainly a possibility, based on our common moral sense. But if Michael Tooley could clearly separate his impulsive common morality and his exceptional, philosopher's morality, and be able to choose the latter when finding kittens, his adopting of a defenceless, non-self-conscious being would never be a possibility.

Unlike kittens, newborn humans cannot be found on the street in our age; they can be found in hospitals, where health care professionals take care of them. It seems that these people are in a position to separate their moralities when it comes to protecting the vulnerable, the supporting case being the one of Dr Arthur.[6] Like in the case of euthanasia, I will not offer an opinion as to whether he was right or wrong when he prescribed 'nursing care only'; what is of interest is that he did it, and also that many physicians supported him, showing that they would also have done the same or that they had already done it. Laypersons,

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[5] Michael Tooley 'Abortion and Infanticide' in Peter Singer (ed.), *Applied Ethics* (New York: Oxford University Press, 1986) p. 83.

[6] The case of Dr. Arthur is about a paediatrician who was acquitted of the attempted murder of a newborn infant with Down's syndrome for whom he had prescribed dihydrocodeine and 'nursing care only' after the baby had been rejected by his mother. A discussion of the case can be found in several texts; see, for example, Raanan Gillon, *Philosophical Medical Ethics* (Chichester: A Wiley Medical Publication, published on behalf of the British Medical Journal, 1986) pp. 1-8.

on the other hand, using common morality, would try to find a solution for unwanted infants, and that is suggested merely by the tremendous public outcry which followed the case, and which was one of the starting points for modern medical ethics. But physicians could obviously go beyond common morality and, by virtue of their role, allow a vulnerable being to die without suffering – the appropriate drugs had been used in that case – instead of protecting it.

I think that it is highly improbable that Dr Arthur would have behaved in the same way if someone had left the same infant on his doorstep, thus making it part, not of his professional, but of his private life. Moreover, in case someone wants to argue that only practical difficulties would have prevented him from doing the same, I believe that he would not have even thought about it. This would have required an exceptional morality, like the one imposed by their culture in the case of the ancient Spartans, or maybe by poverty in the case of Hugo's *Miserables*. But if we disregard such cases, we know that when people found babies on their doorsteps they would look after them until they found a solution. It is a human tradition, necessity, or instinct perhaps; in other words, it is common morality. And we would have to think that there was something very peculiar and exceptional about Dr Arthur if he could overcome his common morality when not in his professional role.

c) Deciding who lives and who dies

One of the most popular moral riddles is that involving a lifeboat, when we have to decide whom among the shipwreck survivors it is best to sacrifice when all cannot be saved, and what criteria we should use.[7] Several theories offer answers but, for many, these answers are never entirely satisfactory, as justice is a very complex issue. When laypersons happen, by any chance, to ponder over riddles like this one, moral confusion is most likely to result; and then they are very glad that they do not have to think about these issues in their everyday lives, feeling sorry

[7] This well-known riddle can be found in Martin Cohen, *101 Ethical Dilemmas* (London: Routledge, 2003) p. 2.

for people who survive shipwrecks, and who have to take such difficult decisions in practice rather than in theory. However, physicians have a lot in common with shipwreck survivors. Given that health care resources are always limited, they have to decide how to allocate them all the time, and this quite often means that some patients survive while some others die. These decisions are not based entirely on medical criteria, which would probably make the process easier, but as Kilner remarks,[8] on social, sociomedical, and personal criteria as well; and nobody can be sure as to how to weigh these criteria. But this is not an insurmountable difficulty when double morality can be used.

Slipping off the morality of the confused layperson, and donning his white coat, the physician is in a position to make difficult decisions, and to harm some people, this being justified by his role, and morally authorised by the god of Medicine. Without being certain as to how to allocate resources, he can do it nevertheless, because an action must be performed, and science has to carry on, even if this means that an occasional injustice is the price to be paid (by others). He benefits some people, but he knows that at the same time he harms some others; yet this does not seem to matter morally for him, as no physician appears to be tormented by the contemplation of the different possibilities which would result from a different decision. And even if there is residual regret about some cases, physicians do not stop deciding who lives and who dies. Perhaps full expression of their regret is a luxury that they cannot afford, as they have to proceed with their job. Their role morality allows them to act as mere instruments; they are part of the circumstances and they make rational choices concerning other people's lives and deaths, because they have to do it. Without the white coat, they would not know what to do, because there would be no god to authorise their insufficiently contemplated decision. In other words, the unresolved dilemma for ordinary people of whom to (indirectly) kill finds a solution and a practical application, if an exceptional morality – like the physician's role morality – is used.

[8] John F. Kilner, *Who Lives? Who Dies?* (New Haven & London: Yale University Press, 1990)

One could argue that laypersons are also able to choose who lives and who dies. Some have the ability to solve moral problems straightforwardly. For example, the doctrine of double effect can be a very useful tool *for anyone*; they can focus on the good consequences of a decision and an action, and regard the unavoidable harm as a mere side-effect – how difficult can this be? This remark is missing the point, because ordinary people may have views that change according to the circumstances, but it is exactly the circumstances that are different, not the people. The case of the physician is exceptional because his entire self is subject to change according to the situation, his role and his morality, and not merely his views. And this is what double morality is about; as long as the layperson does not hold a special role, he can think about who should die, but he cannot cause the death. The shipwreck survivors could talk about whom to sacrifice for days without arriving at any satisfactory conclusions. But this would not do any good; eventually, and soon enough, they would *have to decide and act*, based on the exceptional morality which the survival race would impose on them. The physician functions in the same way. He needs to take action and, as Shaw's doctor remarks when he has only one portion of the life-saving drug, and two patients who need it: 'In short, as a member of a high and great profession, I'm to kill my patient.'[9]

Killing based on political decisions, and other ways to be of assistance to the State

There are two other circumstances where physicians have to act unethically in order to perform their duties if the state requires their professional assistance; the first is the case of the death penalty, still valid in some countries, and the second is the case of torture, which gained a lot of media attention recently, due to the 'war on terror' and its techniques. For the majority of the European population, these actions are unethical from both the common morality's point of view and the

[9] George Bernard Shaw, *The Doctor's Dilemma* (Harmondsworth: Penguin Books, 1966, first published in 1911) p. 137.

ordinary role morality's point of view, the one of the ordinary physician. However, there are also physicians with special roles, and special role moralities come with these roles, overcoming not only common morality, but even ordinary role morality. So let us forget about the god of Medicine for a while, and see in what other way double morality can function.

a) Facilitating the process of justice

John Stuart Mill had defended the death penalty on the grounds of its humanity to the criminal.[10] In some places of the world they agreed with him, and so people there can be sentenced to death instead of going to jail for the rest of their lives. In order to be even more humane to the criminal, the state employs physicians to administer painless lethal injections, and also to certify the resulting death. The physician's participation creates moral uneasiness – to others, that is, and not to the participating physicians; this is suggested by the fact that, despite the American Medical Association's, and most medical societies' disallowance of such participation, physicians are willing to be involved in lethal injections for capital punishment.[11] Perhaps they are not prepared to question the verdicts of justice, and they cannot deny their help without doing so; and, as the criminal defence lawyer whom we considered earlier would say: 'If I do not do it, someone else will.' Nevertheless, in this way they convey the idea that there are human beings totally without human value,[12] and then they kill them.

Writers who want to discourage this participation wonder how it can be possible that physicians act in such a way. 'Doctors' involvement in lethal injection (or any execution) creates a profound conflict of roles

[10] John Stuart Mill 'Speech in Favour of Capital Punishment' in Peter Singer (ed.), *Applied Ethics* (New York: Oxford University Press, 1986) p. 98.
[11] Neil Farber, Brian Aboff, Joan Weiner, Elizabeth Davis, E. Gil Boyer, Peter Ubel, 'Physicians' Willingness To Participate in the Process of Lethal Injection for Capital Punishment' *Annals of Internal Medicine* **135** [10] (2001), 884-890.
[12] Stephen Nathanson 'An Eye for an Eye?' in Thomas Mappes & Jane Zembaty (eds.), *Social Ethics: Morality and Social Policy* [6th edition] (New York: McGraw-Hill, 2002) p. 137.

that is morally unacceptable,'[13] writes, for example, Jonathan Groner, before stating that doctors are 'healers, not killers.'[14] Groner may be right about this latter point, but I would suggest that he is wrong in saying that there exists a conflict of roles. In the same way that a role morality prevails over common morality, a special role morality can prevail over a role morality. There is no real conflict; there is only alternation between a role and a special role, and their corresponding moralities. By adopting double morality techniques, it is possible for physicians to act as executioners and remain members of their well-respected profession.

b) Collaborating with the police and other social institutions

Recent developments and disclosures have brought up again the issue of torture in the civilised world. The physician's involvement in this procedure is of great value: he 'declares the prisoner fit to undergo the treatment, stops the torture if the victim's life seems to be in danger, sews up the wounds between one session and the next, erases the marks before a trial, declares a suspicious death to be from natural causes, and produces false certificates of good health.'[15] It is beyond a shadow of doubt that common morality is opposed to this treatment, and the doctrine 'the ends justify the means' is highly questionable in any case. The fact that many people in the United States following September 11th believe that torture is justifiable in the name of national security[16] certainly does not imply a moral upgrade for torture. Western physicians may never have to face a dilemma like that, as 'their professional obligations mirror their political obligations.'[17] But this is not the case in some Muslim states, where torture and corporal punishment

[13] Jonathan Groner, 'Lethal Injection: A Stain in the Face of Medicine' *British Medical Journal* **325** (2002), 1028.
[14] *Ibid.*
[15] Amnesty International French Medical Commission and Valerie Marange [trans. by Alison Andrews], *Doctors and Torture: Resistance or Collaboration?* (London: Bellew Publishing 1991, first published 1989) pp. 4-5.
[16] Vincent Iacopino, Allen Keller and Deborah Oksenberg, 'Why torture must not be sanctioned by the United States; it undermines humanity and does not make society safer' *The Western Journal of Medicine* **176** [3] (2002), 148-149.
[17] Michael L. Gross, 'Doctors in the Decent Society: Torture, Ill-Treatment and Civic Duty' *Bioethics* **18** [2] (2004), 188.

can often be used,[18] or, somewhat ironically, in the 'war on terror' where American physicians participate, facing conflicts between national policies and 'universally embraced multilateral principles of international law and ethics.'[19]

Amnesty International cannot accept doctors using their power in this way, and suggests that 'other doctors might be needed for them to preserve their consciences and equanimity during and after torture.'[20] However, under the perspective of double morality, this is not necessary; it has worked very effectively in a number of cases, and Nazi doctors constitute a classic example:

> Perhaps the single greatest key to the medical function of the Auschwitz was the technicizing of everything. That self could divest itself from immediate ethical concerns by concentrating only on the "purely technical" or "purely professional".[21]

Double morality functions, even though it can have wrong results. These Nazi physicians were, in fact, ordinary people in a role; and certainly the ideal physician was not what they had in mind when they acted like that. But sometimes the State, and the national interest, can also acquire the qualities of a god and control moralities. Double morality functions then as it was presented in the previous section on military morality, essentially by displacing moral responsibility: '... they believed a law or special order from Hitler stood behind the killing operation. Who were they to question the wishes of the Fuhrer?'[22]

The above discussion proves that physicians can become killers or torturers, either because they think that it is something that must be done, or because the State says that it something that must be done and they do not want, or they are not allowed, to question the State's

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[18] *Ibid.*

[19] Jerome Amir Singh, 'American Physicians and Dual Loyalty Obligations in the "War on Terror"' *BMC Medical Ethics* 4 [4] (2003), World Wide Web (www.biomedcentral.com/1472-6939/4/4), accessed March 12, 2005.

[20] Amnesty International French Medical Commission, *Op. cit.*, p. xiii.

[21] Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (London: Macmillan Publishers, 1987) p. 453.

[22] Bronwyn Rebekah McFarland-Icke, *Nurses in Nazi Germany* (New Jersey: Princeton University Press, 1999) p. 228.

authority. In either case, double morality can be very useful. In the first instance, when they want to kill someone based on medical decisions, they resort to their professional role and their role morality; and in the second instance, when they want to kill – or torture – based on political decisions, they resort to a special professional role and a special role morality. In both cases, condemning voices abound. But double morality does not deal with whether killing is morally right or wrong, it just shows how it is morally possible. And, thus far, it seems to be quite effective as an explanation.

II) Medicine and Money

One can never be sure of course, but it does not seem probable that money is the main reason why there are so many people eager to study medicine; money does not even seem to be a reason at all. For the god of Medicine money is a triviality, a petty detail. The ideal physician takes it for granted that society will provide the appropriate material compensation for his work, and then he is free to concentrate on the higher purposes of his profession. It would be unethical to think of payment when people suffer; someone else can take care of that. Nevertheless, in an attempt to be a little more realistic, we should consider Aasland's view: 'can we, as we imagine people did in the days of Hippocrates, still be confident that the physician acts primarily in the interest of preserving or restoring the health of the individual patient, without self-interest or other hidden agendas? I am afraid not.'[23]

Modern medicine is an enterprise and physicians sometimes appear to gather the features of an employee rather than the ones of a servant. The modern physician has to be familiar with concepts which the god of Medicine does not understand, such as 'cost-effectiveness' and 'health care management'. Therefore, the adoption of double morality seems to be essential for the medical enterprise's balance, with the difference that it functions reversely as regards to its presentation in

[23] Olaf Gjerlow Aasland, 'The physician role in transition: is Hippocrates sick?' *Social Science and Medicine* **52** (2001), 172.

the previous section (where killing was unethical in general and role morality could make it ethical); now we have to deal with something that common morality considers to be ethical, but which is unethical from the ideal physician's point of view, and that is business. In order to function, double morality is reversed in the sense that common morality has to prevail over role morality. This can happen in two instances: first, when the physician sees himself as a worker, and second, when people in control see the physician as a worker.

Plato's ideal expectations and modern physicians

> The doctor *qua* doctor prescribes with a view not to his own interest but that of his patient.[24]

This is how Plato tried to describe the ideal physician in the ideal state he imagined. But, being a wise man after all, he also knew that 'no one really wants authority and with it the job of righting other people's wrongs, unless he is paid for it.'[25] Moreover, Plato had never listened to a junior doctor describing his normal day, mentioning details like this one:

> 'I don't think we do too badly. I get a good six hours sleep most nights. Except, of course, on Tuesdays and Fridays and the weekends when we're on call. I manage at least one meal a day, and quite often two. I was foolish at first, and didn't eat at all if I was busy. Nobody tells you to go and have supper. So in the first two months I lost nearly a stone. But that didn't do me any harm.'[26]

Or this one:

> 'If I can sneak ten minutes off I get a cup of tea with the nurses in their own little office off the ward. This is strictly forbidden ... I should go to the mess, and the nurses to their dining hall. We should pay for our cuppas. But it's a long trip. Five minutes

[24] Plato, *The Republic* [translated with an introduction by Desmond Lee, 2nd edition] (London: Penguin Books, 1987, 1955) p. 25.
[25] *Ibid.*, p. 30.
[26] Donald Gould, *The Medical Mafia* (London: Sphere Books, 1985) p. 76.

there and five minutes back. And we don't have that much time to waste.'[27]

Bearing these narratives in mind, it is only fair to suppose that the least society can do for these tormented workers is to make sure that they are provided with a satisfactory salary. Not every physician works equally hard of course, just as not every physician cares equally about the salary and is prepared to view medicine as business. However, there is a growing interest in this business from the physicians' part as the numbers of medical graduates with additional business degrees indicate.[28] Medicine has become among the biggest of businesses[29] and physicians are considered to be among the wealthiest members of our society. Does this mean that physicians in our day and age can behave like the butcher and the baker, who are not expected to feed the hungry unless the hungry can pay?[30] Or, worse still, like the dealer, who tries to sell as many products as possible in order to make profit, even if he knows that people do not really need to buy these products?

a) The baker and the possibility of undertreatment

A layperson finds it absolutely normal and ethical to exchange the appropriate product or service for the corresponding amount of money. The product that physicians have to offer is health care and, because of its immense value, a way had to be found in order for it not to be treated like bread. Therefore, in many countries it is the state which pays for the product and everyone has access to it. However, when a poor man needs two loaves in order to satisfy his hunger, but can afford only one, then one loaf is what he will get; or perhaps the baker will give him two bad-quality loaves and save the good ones for a richer customer. The same can happen with the health care system, however crude it may

[27] *Ibid.*, p. 77.
[28] Windsor Westbrook Sherrill, 'Dual-Degree MD – MBA Students: A Look at the Future of Medical Leadership' *Academic Medicine* **75** [10] (2000), S37-S39.
[29] See, for example, David Valone, 'A History of Medical Payments: Continuity or Crisis?' *The Mount Sinai Journal of Medicine* **71** [4] (2004), 219-224.
[30] George Bernard Shaw, *The Doctor's Dilemma – Preface on Doctors* (Harmondsworth: Penguin Books, 1966, first published in 1911) p. 70.

sound. For example, the poor are at a significant disadvantage in gaining access to transplant centres.[31] NHS offers the essential services for free, but special treatment is usually excluded. HMOs (health maintenance organisations) do not provide services which are not in the consumer/patient's coverage plan.[32] And the prospect of reimbursement may well influence the physician's judgment to some degree, resulting in undertreatment.[33]

b) The dealer and the possibility of overtreatment

There is nothing morally wrong with the pursuit of profit in our modern capitalistic society, admittedly governed by Adam Smith's 'invisible hand'.[34] Everybody is trying to sell his product to the customer, before other sellers do, and as much of it as possible. The god of Medicine would not like his servants to be like everybody and this is why, to give an example, the profession traditionally condemns its members' public advertisements.[35] However, there are many physicians who regard their profession as a good way to make a lot of money – serving their patients' interests at the same time, but perhaps not their *best* interests. Therefore, there is the question of whether physicians should dispense drugs for a profit,[36] for example, or the one as to whether they should accept gifts from pharmaceutical companies.[37] But there is also the problem of patients' overtreatment, an unnecessary surgery for example,

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[31] Arthur Caplan, *If I Were a Rich Man Could I Buy a Pancreas? And other essays on the ethics of health care* (Bloomington: Indiana University Press, 1992) p. 172.
[32] Mark Waymack, 'Health Care as Business: The Ethic of Hippocrates Versus the Ethic of Managed Care' *Business & Professional Ethics Journal* **9** [3 & 4] (1990), 69-78.
[33] Lance Stell, 'Two Cheers for Physicians' Conflicts of Interest' *The Mount Sinai Journal of Medicine* **71** [4] (2004), 236-242.
[34] Adam Smith, *An Inquiry Into the Nature and Causes of the Wealth of Nations* [edited by R.H. Campbell and A.S. Skinner] (Oxford: Oxford University Press, 1976, first published in 1776) p. 456.
[35] See, for example, Robert Veatch, *A Theory of Medical Ethics* (New York: Basic Books Inc., 1981) p. 81.
[36] See, for example, Michael Weinstein 'Should Physicians Dispense Drugs for a Profit?' in James Humber and Robert Almeder (eds.), *Biomedical Ethics Reviews 1989* (New Jersey: Humana Press, 1990) p. 96.
[37] See, for example, Dana Katz, Arthur Caplan, Jon Merz, 'All Gifts Large and Small: Toward an Understanding of the Ethics of Pharmaceutical Industry Gift-Giving' *American Journal of Bioethics* **3** [3] (2003), 39-46.

which can come up if the physician is focused too much on either the disease,[38] or the profit.[39]

Leaving aside the question of whether it is appropriate, the fact that physicians can be like bakers and dealers is troubling. It is indeed 'hard to fuse the roles of Hippocrates and Uncle Scrooge'[40] but such a fusion is not demanded. Being a good businessman does not necessarily mean that one lets down the god of Medicine, or that one is a bad physician; but, certainly it can mean a different level of orientation. The orientation towards business rather than complete devotion to the customer is acceptable according to common morality's perspective, but it could create problems when considered in the ideal physician context, where higher values prevail. Therefore, what the physician has to do is to switch over to common morality. His own sense of self can be set aside; this is why Mansfield believes that 'good' doctors do 'bad' things.[41] By acquiring the moral profile of the layperson (the baker or the dealer), the physician is able both to do business and to retain his orientation towards the ideal. This means that this ideal is forgotten for an instant; the physician simply goes to a different level, the one of the common morality, without changing his orientation at the level of his role morality. And when his financial purpose is secured, he can switch back to the role of the physician which was imagined by Plato; the physician who does *not* behave like either a butcher or a dealer.

The physician as an employee of a non-physician employer

This is what a physician recollects from his days as a medical student, regarding a patient who was suffering from a terminal disease:

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[38] Mary Tinetti, Terri Fried, 'The End of the Disease Era' *The American Journal of Medicine* **116** [3] (2004), 179-185.
[39] Ivan Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (Harmondsworth: Penguin Books, 1990, first published in 1976) p. 37.
[40] Gudmund Hernes, 'The medical profession and health care reform – friend or foe?' *Social Science and Medicine* **52** (2001), 176.
[41] Peter Mansfield, 'Bribes for Doctors: A Gift for Bioethicists?' *American Journal of Bioethics* **3** [3] (2003), 47-48.

> Given his findings, I suggested a human albumin transfusion to prevent further intravascular fluid depletion. The attending doctor and the senior resident remarked in shock, 'Do you have any idea how much albumin costs?' After telling me that it cost 'thousands of dollars', they pointed out that infusing [the patient] would not be 'cost-effective' because he would soon die ...[42]

Physicians nowadays are not usually employed directly by the patients, but this does not abolish the duty they have to them. According to his ideals, the physician is always an agent of his patient. However, according to the contract, the physician is also an agent of his employer, and sometimes the patient's and the employer's welfare may not go along with each other. For instance, it is in the nature of the employer to try to reduce the costs, but for the ideal physician the cost is irrelevant when it comes to the aid of a patient. Some writers believe that 'whenever a nurse or a doctor have a conflict between doing something in an economically most efficient method and doing something in the most caring manner, he/she should always adopt the most caring method,'[43] while others regard this as an inherently morally undesirable conflict of interests and, in order to overcome it, try to redefine what it means to be a professional.[44] The former approach is oversimplifying, while the latter seems to agree with what Wolinsky refers to as 'proletarianization': 'the growing corporatization and bureaucratization of medicine has resulted in eliminating the autonomy of physicians.'[45] This appears to be true; the archetypical free professional in medicine is the doctor working independently in solo practice,[46] and an employee cannot be as autonomous as this archetype is.

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[42] Salmaan Keshavjee, 'Medicine and Money: The Ethical Transformation of Medical Practice' *Medical Education* **38** (2004), 271.
[43] Norman E. Bowie, '"Role" as a Moral Concept in Health Care' *The Journal of Medicine and Philosophy* 7 (1982), 61.
[44] Waymack, *Op. cit.*
[45] Fredric D. Wolinsky 'The Professional Dominance, Deprofessionalization, Proletarianization, and Corporatization Perspectives: An Overview and Synthesis' in Frederic W. Hafferty & John B. McKinlay (eds.), *The Changing Medical Profession: An International Perspective* (New York: Oxford University Press, 1993) p. 15.
[46] Michael Moran and Bruce Wood, *States, Regulation and the Medical Profession* (Buckingham: Open University Press, 1993) p. 136.

However, as Wolinsky notes, although the autonomy of individual physicians may have been reduced, the autonomy of the profession as a whole remains intact.[47] One could say that this happens because the employers of the physicians-employees are also physicians, but this is not the case generally. The employer does not belong to the servants of the god of Medicine; otherwise there would be no organised profit in the medical business. Once again, the only explanation has to be related with the concept of double morality. Common morality, which entails the employee's morality, is used instead of role morality and it is in this manner that the physician can avoid moral conflict between his ideals and his way of working as an employee. Minogue describes this situation as 'the dual-stewardship model' and argues that 'physicians who view themselves as having ethical duties only to the patient are at odds with the new world of medicine.'[48] But this dual ethical duty is possible only through a double morality for the physician. When he understands that he cannot do the best for his patient due to his position, which is one of a worker and not of someone in absolute control, the way he regards the therapeutic relationship changes, and he goes over to common morality. He then conceives of the patient as a customer of his employer, and himself as an intermediate who facilitates their relationship by trying to achieve a compromise between them. In other words, he realises that sometimes there are limits which are imposed by man, and not by nature – something that his role morality would not accept. As for the rest, idealism and the pursuit of the ideal physician can carry on.

The same procedure takes place when physicians decide to go on strike. They may be entirely justified in their demands, especially if one considers the case of the above mentioned junior doctor whose workload 'would send most of us screaming to the European Court of Human Rights.'[49] And besides, 'to argue that a particular kind of worker under no circumstances has a right to strike is to make an argument for enslaving

[47] Wolinsky, *Op. cit.*, p. 17.
[48] Brendan Minogue, 'The *Two* Fundamental Duties of the Physician' *Academic Medicine* **75** [5] (2000), 442.
[49] Gould, *Op. cit.*, p. 79.

such a worker.'[50] However, the physician's strike does not cause a mere inconvenience; it may endanger lives, 'identified lives' if we assume that the physician knows his patients,[51] and in any case, a physician's refusal to work means breach of duty and does not seem to agree with his role morality. The only solution is to resort to common morality in order to push his claims. Does this mean that common morality permits the physician to put people's lives in danger so easily? Certainly not. A humane organisation is always required when a strike is planned; otherwise we could as well imagine a pilot who decides to strike during a flight and abandons his airplane and his passengers by parachuting. The difference with the physician is that whenever he decides to strike, and however humanely he organises it, his action's moral significance is the same from the ideal physician's perspective. He chooses not to be a servant and, therefore, he abandons his god for a while.

This concludes my account of the relationship between medicine and money. Physicians do not have to give up their unique values in order to behave like businessmen; after all the priority remains to help people, and perhaps they know that unless they make a profit, they will not be able to help people for long.[52] But even though these values are not given up they certainly need to be forgotten for a while, for the sake of doing business. In order for this to happen, the employment of double morality seems to be essential.

III) Professional Dishonesty

Despite the remarkable progress which has been achieved, the field of medicine remains full of bad news for many patients, and physicians have the difficult task of breaking it to them. However, when this task becomes too difficult and the possibility of inflicting harm by telling the

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[50] Erich Loewy, 'Of Healthcare Professionals, Ethics, and Strikes' *Cambridge Quarterly of Healthcare Ethics* **9** (2000), 516.
[51] *Ibid.*
[52] Merrill Matthews Jr, 'Medicine as a Business' *The Mount Sinai Journal of Medicine* **71** [4] (2004), 225-230.

truth arises, physicians can resort to the doctrine of 'therapeutic privilege' and withhold information,[53] which is a kind of elegant professional dishonesty. It is difficult to know how often this practice takes place, as with respect to truth-telling most of the physician's style seems to be determined by the personality and the philosophy of the individual.[54] Besides, it also depends on cultural backgrounds, as, for example, in traditionally-Catholic countries, it is common-sense ethics which admits that truth can be concealed for another's good, while medical ethics prescribes that diagnosis and prognosis must be communicated out of respect for the patient's autonomy.[55] Nevertheless, medical deception surely takes place, and the question that arises is whether this professionally justified dishonesty could have any implications in the physician's private life, related to his character or his conscience. But first one needs to ponder over the importance of truthfulness, and ask why honesty is a virtue praised so much by common people.

Why truthfulness becomes an ethical issue

Honesty is a basic premise of common morality. Not being honest causes distrust and a society where people as a rule distrust each other cannot be very easily imagined. As Williams remarks, 'a necessary condition of co-operative activity is trust, where this involves the willingness of one party to rely on another to act in certain ways.'[56] And as James adds: 'Truth lives, in fact, for the most part on a credit system. Our thoughts and beliefs 'pass', so long as nothing challenges them, just as banknotes pass so long as nobody refuses them.'[57] To be sure, very often scepticism is better than faith and trust, but never as a rule –

[53] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* [5th edition] (New York: Oxford University Press, 2001) p. 84.
[54] Naoko Miyaji, 'The Power of Compassion: Truth-Telling Among American Doctors in the Care of Dying Patients' *Social Science and Medicine* **36** [3] (1993), 249-264.
[55] Franco Toscani and Calliope Farsides, 'Deception, Catholicism, and Hope: Understanding Problems in the Communication of Unfavorable Prognoses in Traditionally-Catholic Countries' *American Journal of Bioethics* **6** [1] (2006), W15.
[56] Bernard Williams, *Truth & Truthfulness: An Essay in Genealogy* (Princeton: Princeton University Press, 2002) p. 88.
[57] William James 'Pragmatism's Conception of Truth' in Simon Blackburn & Keith Simmons (eds.), *Truth* (New York: Oxford University Press, 1999) p. 57.

otherwise any transaction with banknotes would be immensely complex. When we ask someone to tell us what time it is, we are not allowed under normal circumstances to suspect that his answer may not be honest; this is because we have faith in the general honesty of our society, and we know that common morality demands truthfulness rather than deceit. There can be instances where lies are easily forgivable but they are never easily acceptable, no matter how trivial they are; because 'since we, when lied to, have no way to judge which lies are the trivial ones, and since we have no confidence that liars will restrict themselves to just such trivial lies, the perspective of the deceived leads us to be wary of *all* deception.'[58] Therefore, common morality prescribes honesty in general; deception and lying require a reason.

Reasons abound and people lie, there is no point in trying to deny this. Altruistic motives are the most common reasons presented, as well as self-preservation; for example, St. Athanasius justifiably deceived his unjust prosecutors by not telling them who he really was.[59] But this fact does not render deception's moral value any the better. Kant, who admittedly speaks employing a universal perspective, says that 'whoever tells a lie, however well intentioned he might be, must answer for the consequences, however unforeseeable they were, and pay the penalty for them ...'[60] Therefore, people feel uncomfortable even when they have to participate in a completely innocent lie, like agreeing with their children on Santa Claus's existence. No one would recommend deception in our realistic age, not even for the aesthetic value of it; Wilde's statement that 'lying, the telling of beautiful untrue things, is the proper aim of Art'[61] belongs to another era. In our days 'only where a lie is a *last resort* can one even begin to consider whether or not it is morally justified.'[62]

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[58] Sissela Bok, *Lying: Moral Choice in Private and Public Life* (Hassocks: The Harvester Press, 1978) p. 21.
[59] James Rachels, *The Elements of Moral Philosophy* [3rd edition] (Singapore: McGraw-Hill College, 1999) p. 181.
[60] Immanuel Kant 'On a Supposed Right to Lie From Altruistic Motives' in Lewis White Beck (ed.), *Critique of Practical Reason and Other Writings in Moral Philosophy* (Chicago: The University of Chicago Press, 1949) p. 348.
[61] Oscar Wilde 'Decay of Lying' in Hesketh Pearson (ed.), *Essays by Oscar Wilde* (London: Methuen & Co., 1950) p. 72.
[62] Bok, *Op. cit.*, p. 31.

How physicians are excluded

If lying about Santa Claus causes discomfort, then what are the consequences of lying about an issue far more important than Santa's existence, that is, one's health? They must be serious. Yet this does not seem to impress the physicians and their god very much. Bok notes that:

> Honesty from health professionals matters more to patients than almost everything else they experience when ill. Yet the requirement to be honest with patients has been left out altogether from medical oaths and codes of ethics, and is often ignored, if not actually disparaged, in the teaching of medicine.[63]

This means that if no new directions are given, physicians are influenced by the 'hidden curriculum' and the surviving dictates of other ages. For example, McFadden in 1967 suggests the use of 'mental reservation': this refers to an expression which has two meanings; the patient 'places a hasty interpretation on the words he hears and thus misleads himself'[64] – in other words, it is a clever way for the physician to deceive. And in the 13th century, Arnald of Villanova offers the following advice: 'it helps greatly to use...a term not understood.'[65] These writers, among others who have contributed to the shaping of the god of Medicine throughout the ages, do not suggest clear lying; however, 'the crucial moral issue,' as Gillon remarks, 'concerns the doctor's intentions.'[66] And it is certain that the intentions reflected in the views of McFadden and Arnald are not honest.

These views have been under attack but they have not been abolished; therefore, they can still be influential and physicians may keep practising what was the norm in distant periods, when autonomy was not that important, and when physicians believed that health did not belong

[63] *Ibid.*, p. xvi.
[64] Charles McFadden, *Medical Ethics* (Philadelphia: F. A. Davis Co., 1967) p. 392.
[65] Arnald of Villanova 'On the Precautions That Physicians Must Observe' in Stanley Reiser, Arthur Dyck, and William Curran (eds.), *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Massachusetts: The MIT Press, 1977) p. 13.
[66] Gillon, *op. cit.*, p. 104.

to the individuals concerned, but solely to the god of Medicine. Surveys have been carried out, which suggest that patients in general want to know the truth about their condition however hard it may be,[67] and there is of course extensive debate as to whether a physician is nowadays justified in withholding the truth or telling lies to a patient, with sound arguments employed by both sides.[68] But this debate has not radically changed the physician's role morality yet, which morally justifies deception and even promotes it in some cases. To put it simply: in a professional context, physicians are allowed to be dishonest, and what is more (if we attribute to health its appropriate importance), dishonest about one of the most critical aspects of their patients' lives.

However, physicians do not have the reputation of dishonest people; quite the opposite, they are respectable and deeply esteemed members of every society. Their medical deception is not an issue when they are no longer in their professional role. This is not merely a matter of reputation; it goes further, because the physicians themselves do not appear to be troubled about their professional dishonesty and the ease with which they can tell lies about a fatal disease. But the trick does not work in other instances; like every layperson, they can feel uncomfortable when they have to play their part in their children's imagination and post their letters to Santa Claus. As one can easily assume, this is a case of double morality. What seems immoral in general is moral in the professional domain as the standards for an honest physician and for an honest person are different. As a physician one can deceive whenever he thinks it is appropriate and have the approval of his god for his experienced and careful handling of difficult situations. But as a layperson, the deceiver cannot expect to be encouraged by anyone. The god of Medicine is no longer there when medical reasons for deception do not exist, and the unsophisticated common morality holds lying to be a mistake.

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[67] Robert Sullivan, Lawrence Menapace and Royce White, 'Truth-telling and patient diagnoses' *Journal of Medical Ethics* **27** [3] (2001), 192-197.

[68] See, for example, William Ruddick, 'Hope and Deception' *Bioethics* **13** [3/4] (1999), 343-357.

Let me repeat that things are not usually that simple. For a start, many physicians may find lying to their patients unacceptable. Even if they do, hope based on deception is not something universally condemned. But this issue cannot be fully analysed here. We just note that double morality may help an honest person to tell lies, in the above described way.

Conclusion

So these were three characteristic cases showing how double morality can be used by physicians in order to behave a) not as ordinary people, like when they have to end a life or tell a lie, and b) not as physicians, like when they have to secure payment before treatment. In the first instance it is their role morality which justifies their actions, while in the second case it is their common morality which does it. However, the discussion of the cases presented in this chapter is not sufficient to support double morality as a fully functioning concept. In the next chapters there shall be more cases analysed, and the theory of double morality shall be further tested.

Chapter 5

CASES WHERE DOUBLE MORALITY SEEMS TO MALFUNCTION

In this chapter some more complicated issues shall be considered, where the concept of double morality seems applicable in the beginning, but turns out to be problematic in the end. The first issue to be examined is the one of the physician's possible spiritual beliefs, and how double morality could be used when these beliefs contradict with the dictates of medicine as a science. The second section deals with issues of caring, and how the physician can adopt double morality in order to create a professional way of caring when at work, and retain his natural way of caring in his private life. Finally, the third section is about the abstinence which physicians need to exhibit with regard to their feelings and their desires, and considers double morality as a potentially effective way of preserving and promoting a good, professional image.

I) The Religious Physician Paradox

Despite the constant decrease of religion's importance all over the world, it seems that God is not dead yet. Many people are still influenced by various religions' dictates and divine laws, and their morality can be shaped accordingly. Religious attitudes are indeed a powerful source of morally good and praiseworthy behaviour, leading even to the view that 'in the case of God's non-existence, there are no moral obligations, and morally everything is permitted.'[1] This is a quite extreme interpretation of religion's mission of course, but it functioned for many years with remarkable success and is still valid to a certain extent. Surprisingly, it is not a strictly fundamentalist point of view; some quite modest thinkers

[1] Ton Van Den Beld, 'The morality system with and without God' *Ethical Theory and Moral Practice* 4 (2001), 396.

often share it. In any case, religion is very important when it comes to morality, so the following discussion is of considerable interest.

For the physician who is devoted to any religion a kind of double morality is directly created, based on the two gods; the common God, accessible to everyone, and of course the god of Medicine, exclusively for physicians. However, it shall be shown that the different moralities which come attached to these different gods cannot easily co-exist within the same person. The time when religion could simplify everything has passed; now it can only make things more complicated.

The miracle of theism

In his last book, J. L. Mackie explored whether God's existence can be logically proven. After discussing all the arguments that could support theism, he concluded that no one could rationally defend it[2] – and ironically he died almost immediately after this conclusion, as if he wanted to test it as soon as possible. Hume, whom Mackie had quoted, says that religion cannot be believed by any reasonable person without a miracle – but whoever is moved by faith to assent to religion 'is conscious of a continued miracle in his own person, which subverts all the principles of his understanding'[3] – and this is what Mackie calls 'the miracle of theism'.

But it seems that this miracle takes place very often, the result being a lot of people for whom religion plays a vital role in their lives. And it must indeed be a miracle, for there can be no predicament as to what kind of persons are affected by religion. Physicians, and scientists in general, are no exception; recent relevant surveys, like the one of Larson and Witham,[4] show that roughly 40% of scientists can be very religious, not much less than their colleagues of one hundred years ago (of course this study deals with American scientists only, but religion is equally

[2] J. L. Mackie, *The Miracle of Theism* (New York: Oxford University Press, 1982) p. 199.
[3] David Hume, *Enquiries Concerning Human Understanding and Concerning the Principles of Morals* [3rd edition, edited by L. A. Selby-Bigge] (New York: Oxford University Press, 1988, first published in 1777) p. 131.
[4] Edward Larson & Larry Witham, 'Scientists are still keeping the faith' *Nature* **386** (1997), 435-436.

strong in many parts of the world). It is surprising, and perhaps Leuba (who conducted a similar research in1916) was right when he said that 'the greater loss of belief suffered by the greater men is probably not to be ascribed chiefly to their greater knowledge, but rather to certain temperamental qualities or energies which make it relatively easy for them to rid themselves of much of the social pressure to which others yield.'[5] Whatever the explanation is, it seems that science cannot satisfy all human needs, and that reason does not always function when faith is established in one's personality. Therefore, it is naïve to suppose that believers are naïve.

Historically, medicine and religion were intricately linked[6] but that was before the time when science – and medicine as a science – started to be on the winning side of its incontrovertible conflict with religion. Our era is an evidence-based one and religion was never very good at this, while medicine as a science has to present some of the most well-known scientific evidence and beneficiary outcomes. Despite the fact that many religious writers have tried to deny it,[7] it is impossible for religion and science simply to co-exist or collaborate. Whenever this happens, it is the result of important mutual compromises, because in fact science and religion are enemies, and they have always been so. Science means curiosity and constant doubt, while religion demands faith and trust. The medical religion is a very peculiar one, which can combine scientific doubt with faith in the god of Medicine and his ideals. And this god would not allow for any other religion to exist in his servants' lives. A religious physician would appear to be some kind of a paradoxical creature, especially after the recent medical advancements. To support this, some problematic aspects of religion and medicine's interaction are discussed below.

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[5] James Leuba, *The Belief in God and Immortality* (Boston: Sherman, French & Co, 1916) p. 287 as cited in C. Mackenzie Brown, 'The conflict between religion and science in light of the patterns of religious beliefs among scientists' *Zygon* **38** [3] (2003), 611-612.

[6] Christina Puchalski, 'Reconnecting the Science and Art of Medicine' *Academic Medicine* **76** [12] (2001), 1224-1225.

[7] See, for example, Evrin Laszlo, 'Why I believe in science and believe in God: a credo' *Zygon* **39** [3] (2004), 535-539.

a) Collision of two gods

Health care problems related to religion are numerous, very well-known and discussed at length; Jehovah's witnesses forswear blood transfusion,[8] Catholics consider abortion to be a sin,[9] Orthodox Jews impose a Sabbath ban on Medicine[10] and strongly oppose heart transplants[11] – to say nothing of Christian Scientists who reject traditional medicine altogether.[12] The religion of Islam is also very interesting: 'Devout and pious Muslims believe that death is part of Allah's plan and that to struggle against it is wrong. Such fatalism is very disturbing for many doctors reared in the Western tradition.'[13] Other religions, where spirituality has traditionally greater links with the art of healing, can impose a greater variety of problems for modern medicine – for example, the witch doctor of some African and Indian tribes who also has the role of their healer; they do not abound nowadays, but one can certainly come across them: 'One evening a nurse entered the room of a cardiac surgical patient and noticed blood and feathers on the furniture, walls, floor, and patient. When asked what had occurred, the visitors explained that their religion required the sacrifice of a chicken at the bedside of the sick.'[14]

The underlying concept is the same in every case: some religious patients often do not want to do what the physician advises, if it is against what their religion dictates. But what is the case when the physician, and not the patient, happens to be religious? It is certain of

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[8] See, for example, Osamu Muramoto, 'Bioethical aspects of the recent changes in the policy of refusal of blood by Jehovah's Witnesses' *British Medical Journal* **322** (2001), 37-39.
[9] Pope John Paul II 'The Unspeakable Crime of Abortion' in Thomas Mappes & Jane Zembaty (eds.), *Social Ethics: Morality and Social Policy* [6th edition] (New York: McGraw-Hill, 2002) p. 11.
[10] Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch Publishing Company, 1975) p. 74.
[11] *Ibid.*, p. 288.
[12] G. Steven Neeley 'Legal and Ethical Dilemmas Surrounding Prayer as a Method of Alternative Healing for Children' in James Humber & Robert Almeder (eds.), *Alternative Medicine and Ethics* (New Jersey: Humana Press, 1998) p. 173.
[13] Julia Neuberger 'Cultural Issues in Palliative Care' in Derek Doyle, Geoffrey Hanks, Neil MacDonald (eds), *Oxford Textbook of Palliative Medicine* [2nd edition] (New York: Oxford University Press, 1998) p. 778.
[14] L. A Burton & M. S. DeWolf Bosek 'When Religion May Be an Ethical Issue' *Journal of Religion and Health* **39** [2] (2000), 101.

course that no Christian Scientist would ever become a physician, as well as that no sound physician would want to sacrifice a chicken at the bedside of the sick. But is it possible that, for example, no Jehovah's Witness will ever consider medicine as a career because one of its aspects contradicts its faith? One could easily answer that he may choose to follow medicine in everything else apart from the transfusion technique, and never practice it; the same with a Catholic physician, who would choose never to perform an abortion, or even never to give instruction on contraception,[15] and so on. But it is not so simple, for two main reasons.

First, when a physician faces a particular medical problem, he may be afforded no choice. When a patient has lost a lot of blood, transfusion is the only solution. And what happens if the Catholic physician can only save the life of a mother-to-be by performing an abortion? He could leave these tasks to non-religious colleagues – but what if he is the only physician available when the particular forbidden act has to be done? And what if he refuses and the family of the deceased sued him? But apart from that, there is something deeper here than the question of who is going to perform the forbidden act, or what the risk of getting sued is, which brings us to the second reason why a physician cannot escape so easily. Medicine is not the physician's super-market, where he can choose the product he likes. Of course this happens as well quite often, but every physician should be prepared to deal with any aspect of medicine when a particular need arises. One is a servant of the god of Medicine all the time, and not only when there are no transfusions involved; there are no aspects which can be entirely rejected due to another authority. In England the legal right of conscientious objection exists, but this concept is certainly unclear and problematic when it comes to defining the boundaries between tolerance and objection.[16] The profession tries to keep any personal beliefs away

[15] Charles McFadden, *Medical Ethics* (Philadelphia: F. A. Davis Co., 1967) p. 118.
[16] See, for example, B. Farsides, C. Williams, P. Alderson, 'Aiming towards "moral equilibrium": health care professionals' views on working within the morally contested field of antenatal screening' *Journal of Medical Ethics* **30** (2004), 506.

from the area of medical practice.[17] So it seems that when at work, the highest authority for the physician is the god of Medicine.

b) Collision of underlying values

A more universal, yet less controversial version of the problem of religion and medicine is reflected in an article by Veatch and Mason, where they compare Hippocratic to Judeo-Christian medical ethics and explore the conflict between them.[18] If we assume that the Hippocratic principles correspond to what the god of Medicine dictates (which must be true for the most part), then these principles can be found in the physician's role morality while the Judeo-Christian principles are part of a religious morality, and their conflict exists within any religious physician – but in a much wider and indefinite sense, compared to the concrete problems mentioned earlier. For example, Christian religion considers all people to be equal and promotes humility as a basic religious element; however, when it comes to physicians, there are certain tasks that are considered unfit for members of the cult, and acceptable only for other health care professionals. Therefore, this is a sign that physicians may be going back to their Hippocratic heritage. The arrogance which prevails among physicians is widely acknowledged[19] and certainly conflicts with Christian values. In addition, the Hippocratic tradition asks from the physician to give top priority to his patients individually, while 'in one way or another Christian ethics insists on moving beyond the mere commitment of a physician to benefiting his patient ... he or she should be concerned about the entire community as well as the isolated patient ...'[20] Once again, the difficulties are apparent when religion and medicine are combined, even in mild cases like the one Veatch and Mason explore, where Christian ethics is represented by the most commonly recognized principles, like equality or caring for the others.

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[17] *Ibid.*
[18] R. Veatch & C. Mason, 'Hippocratic versus Judeo-Christian Medical Ethics: Principles in Conflict' *Journal of Religious Ethics* **15** [1] (1987), 86-105.
[19] See, for example, Allan Berger, 'Arrogance Among Physicians' *Academic Medicine* **77** [2] (2002), 145-147.
[20] Veatch & Mason, *op. cit.*, at 92.

Finally, there are two more problems worth mentioning. The first one is clearly practical and it has to do with patients' preferences; religious patients try to select their physician on the basis of a mutually held religious background, but 'this freedom of choice is declining rapidly as managed-care programs dominate the market.'[21] Given the religious and cultural diversity which has much increased in some societies, it is highly probable that when a religious patient and a religious physician meet, they do not have the same religious beliefs. And since some beliefs may be quite opposite and create tension in the therapeutic relationship, the problem could be skipped simply by having neutral, non-religious physicians. The final problem is clearly theoretical; religions in general offer ready solutions, dogmas, and in general they oppose what medicine dictates, which is constant scientific doubt, consciousness and awareness.

Double morality as a – failed – explanation

Despite all the above mentioned difficulties, the religious physician exists, and it must be clear enough by now that his existence creates a paradox. Perhaps double morality can explain it; if we separate the physician from the layperson, the issue seems to become relatively simple. Two different personalities exist within the same person in such a way that they do not interfere with each other – and therefore, two separate moralities exist in the same way. When the personality of the physician is active, he is able to forget the religious constraints that could be imposed on his work, and be totally moral in his view at the same time. Similarly, when the layperson's personality is used – obviously not in any health care professional area – religiosity can be recovered, since it is so important for the particular person. So according to this approach, morality is just a matter of context; a religious physician is moral in the physician's way when at work, and in the religious man's way when not. The god of Medicine is satisfied as long as the other god does not

[21] Larry VandeCreek, 'Should Physicians Discuss Spiritual Concerns with Patients?' *Journal of Religion and Health* **38** [3] (1999), 199.

interfere with his medical business. And as Hanson notes for religious groups who do not cause trouble, 'they have learned to bracket their religious commitments from at least any professional settings.'[22]

After some more serious consideration however, something does not seem right. A person for whom religion is so important will not be willing to simply forget its dictates now and then when it looks convenient. One is reminded of the Jews who worshiped golden cows when Moses left them on their own and went to climb the mountain and get the Ten Commandments;[23] a fact which caused the destruction of the original text, but also taught us that either one is faithful or one is not. The physician cannot be unfaithful while at work, and faithful during the rest of his day. Besides, there is evidence to prove that religious physicians act in a different way than their non-religious colleagues in the hospital – which means that, within them, religion and medicine co-exist in the same personality. For example, some physicians have put prayer to scientific test trying to understand, not its psychological influence on the patient, but its supposed actual elimination of diseases.[24] Another example is Wenger and Carmel's recent survey regarding to end-of-life care, which shows clearly that a physician's religiosity influences use of analgesics, withholding and withdrawing behaviours, and views toward euthanasia.[25] The same survey also indicates that religious physicians have fewer dilemmas since they are guided by clear religious guidelines, while secular physicians face more internal conflict and perhaps more stress when treating terminally ill patients; this shows that role morality is influenced by religious morality when the physician is religious, and therefore, it is not anymore the clear role morality coming directly from the god of Medicine.

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[22] Mark Hanson, 'The Religious Difference in Clinical Healthcare' *Cambridge Quarterly of Healthcare Ethics* 7 (1998), 57.
[23] *The Holy Bible* [New Revised Standard Version, Anglicized Edition] (Oxford: Oxford University Press, 1995) *Exodus* 32.32, p. 81.
[24] Cynthia Cohen, Sondra Wheeler, David Scott, Barbara Springer Edwards, Patricia Lusk, and the Anglican Working Group in Bioethics, 'Prayer as Therapy: A Challenge to Both Religious Belief and Professional Ethics' *Hastings Center Report* **30** [3] (2000), 40-47.
[25] Neil Wenger & Sara Carmel, 'Physicians' religiosity and end-of-life care attitudes and behaviors' *The Mount Sinai Journal of Medicine* **71** [5] (2004), 335-343.

It seems that the examination of the religious physician paradox under the perspective of double morality leads to a dead-end. A physician cannot pursuit the ideal set by medical religion when another religion plays an important role in his life. With regards to religious matters, one does not seem able to function at the two separate levels of common and role morality. Therefore moral conflict in this area seems inevitable unless some compromises take place in order to avoid it. Naturally the arrogant god of Medicine would not agree; this requires further discussion, which has to be postponed until the issue of double morality in general is further clarified.

II) Caring, Cynicism, and the Physician's Sense of Humour

I turn now to discuss the physician's approach to the concept of caring. This has to be done together with the study of the development of cynicism among physicians, since there seems to be a link between the two; it is either improper caring which triggers cynical attitudes or a cynical disposition which results in lack of empathy. Cynicism serves as a bridge between the issue of caring and another issue which shall be discussed in this section, namely the physician's sense of humour – an issue which is not as irrelevant to caring as it may at first seem. Caring, cynicism, and humour are going to be examined in a double morality framework, which shall leave great uncertainty as to its usefulness.

Caring, and caring about caring

Without wanting to undervalue the theory of the ethics of care, it is not my intention to refer to caring in the way feminists do. A feminist 'moves beyond the impartiality of an ethics of justice to the partiality of an ethics of care'[26] and this is not what happens in the field of health care, as far as I am concerned. To be sure, health care professionals are constantly asked to be more caring, empathetic, and sympathetic – humane to put it

[26] Rosemarie Tong 'Feminist Approaches to Bioethics' in Susan Wolf (ed.), *Feminism & Bioethics: Beyond Reproduction* (New York: Oxford University Press, 1996) p. 81.

differently – but an ethic of care focuses on small-scale, personal relationships[27] which can take place very rarely between carer and patient, for mainly practical reasons which shall later be explained. Caring in general is traditionally linked to women mostly, and in the health care arena to nurses rather than to physicians. But this is not an obstacle to our physician-orientated discussion, for two main reasons: first, there have been numerous attempts by a range of professional groups to develop a theory or concept of care in a health context,[28] which clearly indicate that this concept is important in every aspect of health care, for physicians as well as for nurses; and second, many physicians happen to be women nowadays. I am not prepared to assume that women have an entirely different nature with regards to caring. But even if this is true, double morality still has to be used; otherwise, how could female physicians move from their natural instincts to the professional detachment which is the norm in the – traditionally male-dominated – area of Medicine? This issue needs separate examination, by somebody more expert probably, and it would be best therefore if I left gender-related speculations aside. Having clarified the feminist issues, I may proceed.

a) Natural and ethical (professional) caring

I do not think that common morality has anything to dictate with regards to the issue of caring. Perhaps it simply provides a recommendation that empathy is preferable to indifference, or that an affectionate person is more attractive than a cold-hearted one; but apart from that there is no reason to suppose that anyone who is indifferent or disinterested has also to be immoral. Role morality on the other hand does not leave this issue subject to the professional's choice or nature. It commands caring – which is impossible without empathy – but not any kind of caring; it has to be a professional one, and be constantly provided regardless of the

[27] James Rachels, *The Elements of Moral Philosophy* [3rd edition] (Singapore: McGraw-Hill College, 1999) p. 171.
[28] See, for example, Adrian Barnes, 'Am I a Carer and Do I Care?' *Medicine, Health Care and Philosophy* 7 (2004), 153-161.

receivers' attitude.[29] As Noddings notes, there is 'ethical caring' which requires an effort, and 'natural caring' upon which the former is dependent.[30] Therefore, it seems that ethical caring refers to the kind of empathy that health care professionals have to develop, while natural caring is about how each layperson feels about others. Depending on the level of natural caring each one has, the result can be compassion, indifference, or something in between – nothing immoral though. But the health care professional has to adjust his natural caring to meet the requirements of the professional, 'ethical' caring. Too much natural caring needs curtailment while too little needs elevation. 'Good medical practice can better be characterized as a tension between engagement and detachment.'[31]

So this is where double morality enters the discussion; the physician uses role morality in order to be able to care in a professional way; this means that he cares enough but without letting himself reach the phase of compassion, which would mean going beyond the limit of reasonable caring. Compassion is too much empathy, which should only be found in natural caring and not in the professional ethical caring. The god of Medicine demands professional detachment and avoidance of emotional implications like compassion, as they lead to bias, burnout, injustice and inefficiency,[32] obstructing in this way the physician's work. But he also demands caring, as 'in many cases empathy may be the only way that a health care professional can understand patient needs.'[33] In other words, the physician has to care and care about his caring at the same time; a kind of 'emotional labour' is required, a process of regulating experienced and displayed emotions to present a

[29] Ove Hellzen, Kenneth Asplund, Per-Olof Sandman and Astrid Norberg, 'The meaning of caring as described by nurses caring for a person who acts provokingly: an interview study' *Scandinavian Journal of Caring Sciences* **18** (2004), 3-11.
[30] Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley and Los Angeles: University of California Press, 1984) p. 80.
[31] Jack Coulehan and Peter Williams, 'Vanquishing Virtue: The Impact of Medical Education' *Academic Medicine* **76** [6] (2001), 600.
[32] Howard Curzer, 'Is Care a Virtue for Health Care Professionals?' *Journal of Medicine and Philosophy* **18** (1993), 54-60.
[33] Patrick Boleyn-Fitzgerald, 'Care and the Problem of Pity' *Bioethics* **17** [1] (2003), 4.

professionally desired image during interpersonal transactions at work.[34] The layperson does not know how to achieve this if he has not happened to deal with suffering in a special way and learn how to cope with it. 'One grows out of pity when it is useless,' says the doctor of *The Plague* and finds in his detachment his only solace.[35] A plague is not necessary for a physician to learn that; his everyday routine and his professional environment should be enough to teach him how to care up to a certain limit without letting pity and compassion show up.

When this attitude is no longer necessary he can turn back to common morality and his own natural caring, which can be pity and compassion for some people who happen to suffer outside any therapeutic relationship where the particular physician is involved, or which can even be complete lack of empathy in some extreme cases. One can follow Nietzsche for instance:

> Pity is the most agreeable feeling among those who have little pride and no prospects of great conquests; for them easy prey – and that is what all who suffer are – is enchanting. Pity is praised as the virtue of prostitutes.[36]

The layperson who uses common morality could adopt this extreme view, provided that his natural caring is very limited. Or maybe he could be like a 'prostitute' and pity everyone, if his natural caring is too much. The physician who is not at work can also be like that, because there is no need any more to adjust his caring to the professional level. The organised professional caring 'stands in sharp contrast with the characteristic freedom that marks the possibilities of caring in friendship relations.'[37] The god of Medicine does not tell him how, or how much to care for his friends and relatives. There is freedom in the physician's relationships when he is not in his role. It would seem that double

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[34] Eric Larson, Xin Yao, 'Clinical Empathy as Emotional Labor in the Patient-Physician Relationship' *JAMA* **293** [9] (2005), 1100-1106.
[35] Albert Camus, *The Plague* [trans. By Stuart Gilbert] (Harmondsworth: Penguin Books, 1960, first published in 1947) p. 76.
[36] Friedrich Nietzsche, *The Gay Science* [trans. by Walter Kaufmann] (New York: Vintage Books, 1974, first published in 1887) pp. 87-88.
[37] Peta Bowden, *Caring: Gender-sensitive Ethics* (London: Routledge, 1997) p. 101.

morality – and double personality – can be used here successfully. However, there are implications, which I immediately turn to discuss.

b) Troublesome friends and relatives

Based on what has already been said, it is reasonable to assume that problems may arise when the physician is the healer of a friend or a relative. In this case, a strong emotional attachment already exists before the therapeutic relationship. And as this attachment can create problems, when the physician is a friend or a relative of the person who is sick, and provided that the sickness is not a common cold, it is preferable to leave the treatment to another physician, emotionally detached.[38] To give an example, an American physician who treated his friend explained that he made a mistake by cutting the antibiotic course short, and he realised that the cause of this mistake was the fact that he liked the patient – his friend – and that he did not want to inflict more pain.[39] Also, a nurse who treated her ill mother reported that there were some questions she should not ask as a nurse, but she had to, because she could not always 'think in a rational way.'[40] These behaviours are understandable, and it is normal that double morality cannot function properly in such a case. This is why dual relationships have to be avoided.

However, even when the physician is not involved in the therapeutic relationship, it seems that he cannot be clearly a caring friend or relative. Perhaps it is the effect of other people's expectations, as this story of another doctor with regards to his uncle shows:

> As I take a seat and slip into character, the love and warmth of a nephew gives way to a physician's clinical detachment. They want to know everything and I attempt to explain to father,

[38] W. Clay Jackson, 'When Patients Are Normal People: Strategies for Managing Dual Relationships' *Primary Care Companion Journal of Clinical Psychiatry* **4** [3] (2002), 100-103.
[39] Kent Sepkowitz, 'Why Good Friends Don't Always Make Good Doctors' *New York Times, November 30, 2004*, World Wide Web (http://www.nytimes.com/2004/11/30/health/30essa.html?pagewanted=all), accessed December 5, 2004.
[40] David Edvardsson, Birgit Holritz Rasmussen & Catherine Kohler Riessman, 'Ward atmospheres of horror and healing: a comparative analysis of narrative' *Health* **7** [4] (2003), 385.

> mother, brother, sister, cousin, and uncle the meaning of gauges and squiggles.[41]

This is certainly not a wrong approach when an uncle is ill; but perhaps it shows that double morality cannot be used so easily when it comes to caring. It is possible that the physician retains the 'necessary degree' of his professional inhumanity[42] even when he is outside the therapeutic relationship. The physician's role, its morality, and the way it seeks to confine emotions are maybe too strong to get rid of when a friend or relative happens to be a patient. It seems to be difficult for the physician to deal with his loved one's suffering in a layperson's way. His professional, 'ethical' caring may prevail, either because it is more convenient, or because every other – non-professional, that is – way to handle emotions may have been forgotten after spending a considerable time as a physician, and dealing with illness, suffering, and death based on clinical detachment.

c) Prevalence of natural caring

Apart from the above mentioned difficulty, where double morality is presented to be weak on the grounds of failure to return from professional to natural caring, there is also the possibility of a more original failure, namely the inability to turn from natural caring to the expected professional one in the first place. This can happen in two ways; first, natural caring can be of a very high level. There are persons who are naturally too affectionate, full of empathy, and inclined to emotional attachment. In the event of becoming physicians, their professional role may not be enough to stop them from being so compassionate in a therapeutic relationship. It is perhaps difficult to imagine this when everyone notices decline in empathy and tries to

[41] Ted Listokin 'He's Still Alive!' in Michael LaCombe (ed.), *On Being a Doctor* (Philadelphia: American College of Physicians, 1995) p. 55.
[42] Ruth Richardson, 'A Necessary Inhumanity?' *Medical Humanities* **26** [2] (2000), 104.

teach the empathic response[43] but it is a fact that in some cases physicians let patients move them very naturally, without any effort. The second way in which professional caring fails takes place when physicians cannot care at all, either because their natural caring is very low in general and they fail to elevate it, or because their natural caring is very low for some particular patients. A good example is the one of the Jewish physician to whom a patient had expressed her Nazi-influenced convictions about Jews, without of course knowing that her physician was Jewish. After much thought, the physician found that she could treat the patient but not care about her.[44] This is reasonable and in any case, not unethical. But it shows the inefficiency of double morality, and it brings down the image of the ideal physician who should care about all his patients equally.

Perhaps the concept of double morality is not applicable to caring matters. It was supposed to create for the physician two distinct ways of caring, one for the professional within him, and one for the layperson; but it seems that these two roles get mixed up, and so do the ways of caring. Furthermore, the approach which the god of Medicine would require often seems to be unattainable. This shall be further supported by a short discussion of cynicism, which is a very troubling issue in health care, and which demonstrates a failure to acquire the 'ethical' professional caring, the development of which we were too ready to accept in the beginning of this section.

Cynicism and further problems of caring

Even though a lot of descriptions could be provided, I am going to refer to cynicism simply as indifference. Cynical individuals cannot deliver

[43] See, for example, John Spencer, 'Decline in empathy in medical education: How can we stop the rot?' *Medical Education* **38** (2004), 916-920.
[44] Renate Justin, 'Can a physician always be compassionate?' *The Hastings Center Report* **30** [4] (2000), 26-27.

sympathetic support to others[45] and in the field of health care this can be either an exaggerated way to cope with distress which interaction with patients can provoke, or a natural result in the disappointment which the physician feels when he realises the impossibility of high-minded ideals and standards.[46] This last point is the one which interests us most. The importance of professional caring is evident; empathy ameliorates health outcomes and according to the experts it can be taught.[47] Do the cynical attitudes which occur nevertheless imply that ideals can never be met, that physicians know that, and that medical students eventually find it out? If this is true, then there must be something wrong with the concepts of the ideal physician and the god of Medicine; for where is their authority if their servants stay indifferent? To be sure, as Kopelman notes, 'reasonable beings expect lofty goals to be only imperfectly realised by imperfect beings in an imperfect world.'[48] But physicians become cynical when they perceive that goals are not honoured where they might be; when they know that things could be better and they are disappointed that they are not.[49] And ethical caring is one of the things that could be better and is not.

To be sure, there must be many proponents of cynicism, who do not consider it as a negative aspect of the physician's personality which has to be eliminated. Indeed, professional cynicism has to offer at least two very important things to the physician. First, we have seen that it helps him overcome the disappointment which medicine in practice possibly causes; and second, it possibly provides a more disinterested and clear perception of the whole situation, not only regarding the medical profession, but life in general. For example, Agger admits that:

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[45] Seth Kaplan, Jill Bradley, Janet Ruscher, 'The inhibitory role of cynical disposition in the provision and receipt of social support: the case of the September 11th terrorist attacks' *Personality and Identity Differences* **37** (2004), 1221-1232.
[46] Loretta Kopelman, 'Cynicism Among Medical Students' *The Journal of the American Medical Association* **250** [15] (1983), 2006-2010.
[47] See, for example, Stewart Mercer & William Reynolds, 'Empathy and Quality of Care' *British Journal of General Practice* **52** (2002), S9-S13.
[48] Kopelman, *Op. cit.*, at 2006.
[49] *Ibid.*

> In 15 years of practice, of treating, of caring, of comforting, there is one thing I have never done. I have never saved a life. I have only delayed deaths.[50]

This statement abounds in cynicism; yet its truth cannot be doubted very easily. And it shows that cynicism is perhaps a way for physicians to understand more clearly what their profession's goals should be, instead of asking for impossibilities. Cynicism is against idealism, and this gives much importance to it – as I shall further explain in Chapter 7 of this thesis. Of course our focus here is on cynicism's negative side, the one of indifference and lack of caring. But this does not mean that its – potentially – good aspects refer to a different kind of cynicism.

Therefore, it all comes back to the issue of ideals, the ideal physician and the god of Medicine. Cynicism may show that these concepts cannot function when care is the issue to be considered, but it also implies that these concepts are not useful in general. Perhaps the feminists know better after all, and care is not a system of principles, but a mode of personal responses,[51] which by no means can be described by one ideal which everyone should try to reach. Perhaps it cannot be taught, or it has been traditionally taught in the wrong way,[52] and thus the system has been turning out cynical physicians for quite a long time, or perhaps creating an artificial, professional mode of caring is wrong. In any case, cynicism is not (often) a product of evil intentions, but one of frustrated compassion.[53] And this can be regarded as a failure of double morality, which has been regarded from the start as a means to avoid any kind of frustration. It advanced the idea of a fixed ideal professional caring, but the above discussion on cynicism further supports the view that this idea is problematic; because, even if we could separate sufficiently natural from professional caring, as double morality suggests,

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[50] William Agger 'Predator and Prey' in Michael LaCombe (ed.), *On Being a Doctor* (Philadelphia: American College of Physicians, 1995) p. 14.
[51] John Lincourt, 'A place for empathy: ethics involving architectural designs in healthcare' *Healthcare Ethics Committee Forum* **14** [2] (2002), 87.
[52] William Stempsey, 'The quarantine of philosophy in medical education: Why teaching the humanities may not produce humane physicians' *Medicine, Health Care and Philosophy* **2** (1999), 3-9.
[53] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* [5th edition] (New York: Oxford University Press, 2001) p. 48.

and thus abolish professional cynicism, there could not be any certainty as to the beneficial outcomes of this separation. To sum up: the existence of cynical attitudes among physicians shows that double morality malfunctions; and furthermore, the potentially good aspects of cynicism imply that even if there was no malfunctioning, the rejection of cynicism which double morality proposes could be wrong.

Medicine's amusing side

The discussion of cynicism as the physician's attitude of indifference opposing the professional caring which the god of Medicine would like is perhaps insufficient. After all, it is very difficult to evaluate indifference morally. Therefore, in order to further explore the possibilities or impossibilities of double morality, I shall move beyond cynicism and briefly deal with the issue of humour in medicine; that is, beyond indifference and to a potentially more dangerous element, which can even have some disintegrating effects when applied to the field of health care.

a) What is not and what is of interest

Because humour is a very complicated concept I have to explain first what aspects of medical humour are irrelevant to the present discussion. The first irrelevant aspect is the one of therapeutic humour; according to some writers, the use of humour can result in better health outcomes,[54] a view which has received much criticism. A second point of no interest is the beneficial influence of humour on patient-physician communication,[55] as well as the more effective holistic care of the patient – the use of 'prepared' humour by oncologists, for example, designed to make patients see the lighter side of aspects of cancer care.[56] Finally, a very

[54] See, for example, William Fry Jr, 'The Physiologic Effects of Humor, Mirth, and Laughter' *JAMA* **267** [13] (1992), 1857-1858.
[55] Howard Bennett, 'Humor in Medicine' *Southern Medical Journal* **96** [12] (2003), 1257-1261.
[56] Anthony M. Joshua, Angela Cotroneo, & Stephen Clarke, 'Humor and Oncology' *Journal of Clinical Oncology* **23** [3] (2005), 645-648.

important point which needs to be made is that medical humour shall be morally evaluated intrinsically, and not as an expression which the patient or any one else perceives – otherwise, I should have discussed this issue in the section of medical etiquette. The humorous disposition of the physician, his playful mood as some would say, shall be examined under the perspective of double morality and in contrast with the seriousness of the medical science. There will be no external considerations, like how the physician's humour is perceived by the patient; it is the moral attitude that humour implies within the physician which is of interest to us. Hopefully this is going to become clearer in what follows.

b) Dark humour described as lack of empathy

'Trying to define humour is one of the definitions of humour'[57] but the element of morality is inherent in the concept of humour, even though there are not any universally accepted rules. 'Radically opposed views about when it is morally permissible to find something funny are easy to motivate and render plausible.'[58] And in order for something to be funny, it has to please in itself 'appropriate people through being grasped, where the pleasure is of the sort that leads, though not inevitably, to laughter.'[59] But what does the term 'appropriate people' refer to, when it comes to moral considerations? Some would say that it is just a matter of taste, and that 'appropriate people' are the ones who can laugh at what is generally considered to be a serious matter with no place for fun. Others would say that humour is not an aesthetic issue, and that finding something serious to be funny does not imply bad taste, but bad moral character. And others would say that situations are intrinsically funny and that therefore people's reactions, either triggered by taste or restrained by morality, are not important. 'Life does not cease to be funny when

[57] Joseph Boskin, *Humor and Social Change in Twentieth-Century America* (Boston: Trustees of the Public Library of the City of Boston, 1979) p. 1.
[58] Berys Gaut, 'Just Joking: The Ethics and Aesthetics of Humor' *Philosophy and Literature* **22** [1] (1998), 51.
[59] Jerrold Levinson 'Humour' in Edward Craig (ed.), *Concise Routledge Encyclopedia of Philosophy* (London & New York: Routledge, 2000) p. 368.

people die any more than it ceases to be serious when people laugh.'[60] In the end it seems that humour can be better described as an emotion,[61] and this is how it can be treated more easily. For the purposes of this discussion, this emotion shall be antithetical to any emotions related to empathy and caring – 'an economy of pity is one of the most frequent sources of humorous place' as Freud remarks[62] – even though, quite reversely, humour can also be seen as a measure of empathy and compassion, by Edwin Kilbourne for example;[63] but here I just have to quote Cicero words, that 'there is nothing so absurd that some philosopher has not already said it,' and move on.

c) How common and role morality treat dark humour

As noted earlier, common morality does not consider lack of empathy to be necessarily wrong or bad, hence the existence of various levels of natural caring. At the lowest levels of natural caring one can find a very peculiar sense of humour, to which I simply refer as 'dark'. People possessed by dark humour can find amusement in some aspects of life where others find discomfort and depression. Some of these aspects entail diseases, disabilities, and death – and this is where one could object that common morality does not allow making fun of people who are affected by any health malfunctioning; but it seems pretty clear to me that this objection can be easily disregarded if we think that what we consider to be funny is not the victim of a disfigurement, but the disfigurement itself. If one laughs at a squint-eyed person for example, what he finds funny is the squinting and not the squint-eyed person. In other words, a disfigurement or a disease is not funny by itself; it can be funny if it is applied to a victim. But this does not mean that one who

[60] George Bernard Shaw, *The Doctor's Dilemma* (Harmondsworth: Penguin Books, 1966, first published in 1911) p. 182.
[61] Glenn Hartz & Ralph Hunt, 'Humor: The Beauty and the Beast' *American Philosophical Quarterly* **28** [4] (1991), 299-309.
[62] Sigmund Freud 'Jokes and their Relation to the Unconscious' in *The Standard Edition of the Complete Psychological Works (Vol. VIII)* translated and edited by James Strachey (London: The Hogarth Press and the Institute of Psycho-Analysis, 1960, first published in 1905) p. 230.
[63] Edwin Kilbourne, 'Humor in Science' *Proceedings of the American Philosophical Society* **140** [3] (1996), 348.

wants to consider it funny laughs at the victim; one laughs at the disfigurement, but it just happens that this laughter turns against a specific victim, because the victim is the subject of the disfigurement. Therefore, as soon as we understand that the disposition is not to laugh at the victim for what he is, but only for what has happened to him – death, disfigurement, or disease – we can confirm that common morality does not forbid dark humour. An 'appropriate' layperson does not feel bad if he finds someone's misfortune funny.

When it comes to physicians there is no such tolerance. Medicine is a serious science,[64] and it has to deal seriously with dark humour's objects of ridicule such as disease and disability. In order to remain sublime and immaculate, the god of Medicine has to show that there cannot be any jokes about the matters for which he is responsible. Without a solemn image there could not be the immense respect which this god and his servants enjoy – most of the times, that is. The physician's role morality dictates that he should be serious about his work, which happens to be disease, disability, and death. This is not to suggest that he has to be as severe and rigid as the Victorian doctors in Vienna, who expected nurses and patients to kiss their hands when they entered the ward,[65] but it certainly means that he has to exclude dark humour from his professional life. As Sully notes, 'for one thing, though seriousness *may* combine with a taste for the laughable, it is and remains fundamentally opposed to the playfulness of mirth.'[66] The ideal physician would never find the serious matters with which he has to deal funny, even if he could keep this playful approach exclusively for himself. It would be morally wrong for him, for his patient, and for his profession. Therefore, the layperson is allowed to have a dark sense of humour and the physician is not. This is why Goodman suggests that his fellow physicians should 'pursue goals and career roles seriously, while taking

[64] Mel Borins, 'Are you suffering from a laugh deficiency disorder?' *Canadian Family Physician* **49** (2003), 723-724.
[65] T. G. Wilson, *Victorian Doctor* (Yorkshire, Wakefield: EP Publishing Limited, 1974, first published in 1942) p. 98.
[66] James Sully, *An Essay on Laughter* (London: Longmans, Green, and Co., 1902) p. 395.

themselves lightly, to be serious without being solemn.'[67] Double morality can be used in order to keep a physician's mirth out of his professional role if he happens to enjoy dark amusement in other instances. One has to know when it is time to be serious.

d) A danger to medical religion

However, using double morality in cases where humour is involved can sometimes seem to be impossible. Bergler notes that laughter is incorruptible, and that man 'cannot prevent his *involuntary* laughter from coming to the surface; he has no control over that ...'[68] Humour cannot be so easily confined; amusement can replace professionalism in instances where it can be less expected.[69] It is not probable that a clear distinction can exist between layperson and physician when it comes to humour. There can be an external, professional-looking behaviour to hide the dark humour away but this does not stop it from existing; and morality has to go much deeper than external appearances. If dark humour is the layperson's attitude towards suffering then this remains his attitude when he puts on the white coat, no matter what his behaviour implies. How can one follow Goodman's suggestion and take oneself lightly and one's role seriously? This would mean that one's role is completely foreign to one's self.

Besides, double morality is not supported by the facts of this case. Notwithstanding the god's demands and his most faithful servants' warnings about medical wit's crudeness[70] it seems that many physicians resort to dark humour as a (good?) way to communicate difficult messages, express frustration and anger, and cope with anxiety.[71]

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[67] Joel Goodman, 'Laughing Matters: Taking Your Job Seriously and Yourself Lightly' *JAMA* **267** [13] (1992), 1858.
[68] Edmund Bergler, *Laughter and the Sense of Humor* (New York: Intercontinental Medical Book Corporation, 1956) p. 242.
[69] Kamran Abbasi, 'All doctors have a personal horror story' *British Medical Journal* **329** (2004), 0.
[70] Anon. 'Which humour for doctors?' (editorial) *The Lancet* **351** [9095] (1998), 1.
[71] M. Granek-Catarivas, S. Goldstein-Ferber, Y. Azuri, S. Vinker & E. Kahan, 'Use of humour in primary care: different perceptions among patients and physicians' *Postgraduate Medical Journal* **81** (2005), 126-130.

According to Freud, humour can be regarded as a higher defensive process: 'humour is a means of obtaining pleasure in spite of the distressing affects that interfere with it; it acts as a substitute for the generation of these affects, it puts itself in their place.'[72] Physicians use dark humour (Freud has referred to this as 'gallows humour' – the crudest case of humour[73]) in the face of tragedy or death, because they often need this 'trivializing effect'[74] of humorous material. And when the subject-matter of the physician's profession becomes trivialised, that is, when suffering becomes funny, then the god of Medicine himself feels trivialised to a certain extent and his power is diminished. As humour had always been an enemy to Christian religion,[75] so is dark humour an enemy to medical religion.

Humanism against double morality

The issues of caring, cynicism, and dark humour, all belong to the human side of medicine. Coller describes science and humanism as the twin pillars of medicine and wonders how we can ever hope to keep building the pillar of humanism taller and stronger so that it continues to match the progress of the pillar of medical science.[76] There can be hope for sure, but it seems that the pillar of humanism cannot be built based on a plan. The inadequacy of double morality in issues of caring and the spreading of this inadequacy to physicians' modes of cynicism and dark humour suggest that the god of Medicine is not all powerful and that his wishes are not always granted by his servants. However, like caring, cynicism and dark humour are aspects of humanism, in the sense that they show that the physician is a human being who naturally fails his god. A more personal response to these issues and the dismissal of role morality constitute perhaps a better approach to caring. This is

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[72] Freud, *Op. cit.*, p. 228.
[73] *Ibid.*, p. 229.
[74] Hartz & Hunt, *Op. cit.*, at 303.
[75] Ingvild Saelid Gilhus, *Laughing Gods, Weeping Virgins: Laughter in the History of Religion* (London and New York: Routledge, 1997) p. 110.
[76] Barry Coller, 'Science and Humanism: The Twin Pillars of Medicine' *The Mount Sinai Journal of Medicine* **69** [5] (2002), 279.

necessarily a blow to the god of Medicine and to the image of the ideal physician. But it is not yet a critical one.

III) Abstaining from unprofessional habits

Two separate issues shall be considered in the following section, even though there was a time – before the days of sophisticated medical ethics – when there could not be a clear distinction between them. Both of them appear to entail an inherent double morality which shall be explored in detail. The first issue is the one of medical etiquette, whatever this may include, and the second issue is the possibility of sexual attraction between a physician and a patient. To be sure, there can be an objection to the relevance of etiquette to ethics, as the former refers to aesthetic components and external appearances, while the latter goes much further and seeks to explore human nature in depth. However, Giovanni Maio, who has pondered over this objection and has explored the pioneer John Gregory's writings, concludes that 'in lending pleasant forms to the medical activity, etiquette contributes to an improvement of medical outcome.'[77] This should be enough for a start; in what follows, the relationship between etiquette and ethics shall be more fully demonstrated.

The importance of looking professional

In Part I of this thesis I explored the essence of the concepts of 'profession', 'professionalism' and 'professional ethics', focused on the professional's point of view. Here I shall deal with a different perception of these concepts, the layperson's point of view, which related mostly to appearances – etiquette – rather than essence. It certainly makes sense that the layperson has a different opinion as to what constitutes professionalism, since he can only be an observer, without actually experiencing the professional values himself. The fact that there are two

[77] Giovanni Maio, 'Is Etiquette Relevant to Medical Ethics? Ethics and Aesthetics in the works of John Gregory (1724-1773)' *Medicine, Health Care and Philosophy* **2** (1999), 186.

distinct perceptions about the medical profession, namely, the professional and the lay one, is obvious in a number of instances. For example:

> 'The layman is full of fads, and he doesn't like his doctor to have anything the matter with him.'[78]

This is one aspect of the physician's deification which takes place in the layman's mind;[79] people do not see the physician as one of them, and they usually consider him to be superior in some way. They attribute special characteristics to him, they construct stereotypes, and they demand of the physician nothing less than what they expect. The physician's image has been crafted throughout years of medical legends and medical worship, and the final result must be something good and useful, as the profession is willing to hold on to this image. The shaping of medical etiquette is based on it and this seems to be good for the patient, as it is easier to confront an appearance which is expectable, a fixed and stable view of his doctor. But it is also good for the physician, as he also comes to have a personal view of himself in accordance with medical etiquette; this facilitates his assimilation into the medical profession, and it makes his role easier for him. The way this medical etiquette is taught remains unclear; lessons in attitude and external appearance are part of the implicit – the hidden – curriculum and governed by unwritten rules. This means that the newcomer gradually internalises the values and beliefs of members of the profession and service users at a largely unconscious level.[80] Therefore, a complete understanding of medical etiquette cannot be achieved, I believe either by me or by physicians. I shall mention only some very apparent aspects of this etiquette, for the existence of which we can be sure.

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[78] W. Somerset Maugham, *Of Human Bondage* (London: Vintage, 2000, first published in 1915) p. 529.

[79] Another (clearly negative) aspect, which was discussed in chapter 2, is the physician's alienation.

[80] Lynn Clouder, 'Becoming Professional: Exploring the Complexities of Professional Socialization in Health and Social Care' *Learning in Health and Social Care* **2** [4] (2003), 213-222.

Double morality enters the discussion of etiquette in a negative sense. There are behaviours and appearances that are subject to every individual's choice. In the physician's case, without being forbidden, these appearances and behaviours are strongly non-advisable since they do not seem to go well with medical etiquette. To give just one simple example, some researchers have explored the question of whether physicians should have facial piercings.[81] But why is this question important? It is because, apart from spoiling his own professional profile, the physician can also harm the image of the god of Medicine if his behaviour is not appropriate, that is, appropriate in accordance to medical etiquette's standards. Therefore, where certain freedoms – of action and expression – exist for the layman without any serious worries, the physician is justifiably reluctant and considers these freedoms to be unethical taking his position into account. Outside his professional environment, where there are no obligations, can he forget about his role and his role morality and be like any other liberated layperson who finds ethical what the god of Medicine finds unethical? If he adopts a double morality perspective then perhaps he can.

a) The mask

In the 19th century, one of the prerequisites in order for doctors to achieve public respect and professional success was a smooth manner.[82] But this does not mean that manners 'suggest concerns of an age past.'[83] The physician's appearance is still important; his manners, the way he talks and the words he selects, the way he moves, and the way he looks have to represent more or less the image formed in the average layperson's mind. He is the professional to whom one entrusts one's well-being; I suspect that there would not be many people prepared to entrust it to a debonair hippie with a bohemian-looking

[81] Alison Newman, Seth Wright, Keith Wrenn, Aline Bernard, 'Should Physicians Have Facial Piercings?' *Journal of General Internal Medicine* **20** (2005), 213-218.
[82] Rebecca Tannenbaum, 'Earnestness, Temperance, Industry: The Definition and Uses of Professional Character Among Nineteenth-Century American Physicians' *Journal of the History of Medicine and Allied Sciences* **49** [2] (1994), 251-283.
[83] Christopher Morris, 'Morals, Manners, and Law' *The Journal of Value Inquiry* **34** (2000), 45.

attitude. The physician has to look like the person who knows exactly what needs to be done and is going to take care of everything. Even if he is not like that at all, he has to wear this mask for the sake of his career and his profession, and behave accordingly. I shall just mention an example: a child refuses to open his mouth. The doctor expresses his thoughts about this incident in the following manner: 'I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her.'[84] This of course, however justifiable it could seem from the point of view of one who knows how annoying some kids can get, would be clearly unethical for everybody; but the physician does not even swear or become aggressive in any other way which would be acceptable in general. With extreme patience he continues his efforts, because he knows that he is a physician, and therefore, as he says, 'one goes to the end.'[85]

'That is his punishment. Those who want a mask have to wear it,'[86] notes Oscar Wilde. 'But now and then when you are alone, and have no audience, you have, I suppose, to take the mask off for breathing purposes,' as he adds. 'Else, indeed, you would be stifled.'[87] Taking the mask off corresponds to a retreat from the physician's role back to the layperson. When the physician drives home and role morality – which forbids loss of temper – is no longer useful, he can express his thoughts about the careless driver in front of him ethically by using common morality and saying as many bad words as he feels like. Use of double morality is necessary sometimes in order for a balance to be achieved in his private life. Another example is the one of arrogance, a trait which some people see as desirable to be possessed by a physician.[88] Can the physician remain arrogant when at home with his wife? In an attempt to avoid bad consequences, it would be best if he

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[84] William Carlos Williams, *The Doctor Stories* (New York: New Directions Books, 1984) p. 59.
[85] *Ibid.*
[86] Oscar Wilde, *De Profundis (and other writings)* (Harmondsworth: Penguin Books, 1984, first published in 1954) p. 180.
[87] *Ibid.*, p. 193.
[88] See, for example, Franz J. Ingelfinger, 'Arrogance' *New England Journal of Medicine* **303** 1980, 1507-1511.

tried not to be. This is why the mask of professionalism should be removable.

b) How double morality results in unhealthy lifestyles

It is time to examine a more complicated issue, namely the physicians' attitude towards unhealthy lifestyles; it remains a matter of etiquette in essence, but it goes beyond mere appearance as it deals with health directly. The patient could do with a physician who does not meet his ideally imagined criteria of appearance, but it is more difficult to accept a physician who does not seem to value his own health. A lot of activities fall within the category of unhealthy lifestyles, but I shall discuss two of the most common: alcohol and drug abuse. These habits look repulsive to the god of Medicine who demands first of all sober servants in order to remain respectful, to do their job properly (otherwise there may be dangers for the patients), but also to promote health by exemplifying themselves. From this respect, perhaps smoking should also be treated as if it were equally despised in the traditional medical etiquette. Times have changed, and the dangers that smoking entails are well known by *everyone* in a modern society – especially by the physicians, whose colleagues have discovered these dangers, and who have the duty to warn the public in the context of preventive medicine first of all; and of course this cannot happen very easily when the physician's persuasiveness is damaged by his own habits. However, since there appears to be no acute problem with physicians and smoking lately,[89] the issue of cigarettes shall be left aside.

Substance abuse is never advisable, but it is not prohibited from the common morality's point of view. Certainly drugs are illegal for everyone, but their use can be ethically justified,[90] and in any case, their legitimacy is of no interest in the present discussion. What matters here is that a layman can state that health is indeed important, but other

[89] Paul Wallace, 'Medical students, drug and alcohol: time for medical schools to take the issue seriously' *Medical Education* **34** (2000), 86-87.
[90] Thomas Szasz 'The Ethics of Addiction' in Thomas Mappes & Jane Zembaty (eds.), *Social Ethics* [6th edition] (New York: McGraw-Hill, 2002) p. 278.

things come first, such as pleasure; therefore, the choice of substance abuse lies in him and is of no moral consequence. The case of the physician differs, for the above mentioned reasons related to etiquette, to good practice, and to duties to health and its promotion. Role morality should intervene and stop the physician who is about to have a few more drinks than he can take, to say nothing of drugs. But when the physician is away from his professional area, behind his god's back, the reasons presented seem unimportant; common morality can be used instead which means that he may not be abstemious for a while. The results caused by this kind of double morality suggest that perhaps it should be best if the mask of professionalism stayed on all the time.

A 1992 American study presented some findings which 'substantiate what was previously suspected: physicians have a distinctive pattern of substance use.'[91] In trying to have an idea about how many of them can have substance abuse or dependence problems, the same study estimated the number at about 8%.[92] It does not seem too bad considering the corresponding 16% for the general population, but one must keep in mind that the estimate of 8% was based on self-admitted abuse and cannot control the tendency of some respondents to deny a substance abuse problem, which happens quite often among health care professionals.[93] A 1997 U.K. similar study showed that 'most of the house officers surveyed drink excessive amounts of alcohol; many use cannabis and take other illicit drugs.'[94] Finally, a recent study in medical students also provided some worrying statistics.[95] It seems that double morality works too well in these cases. The reason why physicians need to use substances so extensively may be related to

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[91] Patrick Hughes, Nancy Brandenburg, Baldwin DeWitt, Carla Storr, Kristine Williams, James Anthony, David Sheehan, 'Prevalence of substance abuse among US physicians' *JAMA* **267** [17] (1992), 2336.
[92] *Ibid.*
[93] Susan McCall, 'Chemically Dependent Health Professionals' *Western Journal of Medicine* **174** (2001), 50-54.
[94] D. Birch, H. Ashton, F. Kamali, 'Alcohol, drinking, illicit drug use, and stress in junior house officers in north-east England' *The Lancet* **352** [9130] (1998), 785.
[95] Mark Pickard, Lucy Bates, Matt Dorian, Helen Greig & Dustyn Saint, 'Alcohol and drug use in second-year medical students at the University of Leeds' *Medical Education* **34** (2000), 148-150.

stress caused at work,[96] or it could be attributed to observations such as the one of an addiction psychiatrist: 'If you think about how often these people prescribe or talk about medications, such as opiates or tranquilizers, how often [they] hear their patients tell them about enjoying them, this situation inspires a curiosity and makes substance abuse more likely.'[97] In any case, even if they do it 'for the best reasons in the world,'[98] it remains a worrying fact for which double morality should also be blamed, as its use facilitates the satisfaction of the need which these reasons cause. Double standards and the resulting double morality can be very useful in other areas, but their consequences are really disappointing when it comes to substance abuse. 'Alcoholism is almost an occupational disease of the profession'[99] because double morality works a little too well perhaps. What role morality prohibits, common morality allows; so the physician is able to be both a physician and an alcoholic.

How to avoid fatal attraction

Specialists in mental health have always been particularly interested in the issue of emotional and sexual attraction to their patients, as the therapeutic relationship between the physicians and the mentally ill is of a very peculiar nature, where various emotions and desires can openly arise. A quite recent bestseller was based on a hypothetical sexual relationship between Joseph Breuer, co-founder of psychoanalysis, and Anna O., one of his most famous and interesting patients.[100] It is remarkable that Freud, Breuer's friend and early associate, had asserted that a mutual sexual attraction indeed existed between these two and that this was the reason why the publication of Anna O.'s case history

[96] Birch et al., *Op. cit.*
[97] Howard Markel, 'When Health Professionals abuse drugs and alcohol: personal problems and Public Health consequences' *Medscape Public Health & Prevention* **2** [1] (2004), World Wide Web, (http://www.medscape.com/viewarticle/481520), accessed April 1, 2005.
[98] George Vaillant, 'Physician, Cherish Thyself: The Hazards of Self-prescribing' *JAMA* **267** [17] (1992), 2373.
[99] Donald Gould, *The Medical Mafia* (London: Sphere Books, 1985) p. 109.
[100] Irvin Yalom, *When Nietzsche Wept: A Novel of Obsession* (New York: Harper-Collins, 1993)

had been hold back for many years.[101] Apart from this entertaining detail, psychiatric literature is rich in relevant reports, which suggest the mental health professionals' continuous preoccupation with the particular issue. This does not mean of course that other health professionals have gone beyond it; the possibility of sexual attraction is inherent in many therapeutic relationships and, for many undoubtedly good reasons which are of no interest to us for the time being, therapists are strongly discouraged from yielding into any temptation of sexual content which might involve any patients of theirs.[102] Clearly for reasons related to tradition, the discussion here shall be focused on psychiatrists, with the case of Dr Breuer providing a context. Nevertheless, most of what is said applies to every physician, irrespective of specialty.

a) When suspicious feelings appear

Since time immemorial, stories and fairytales and movies have been trying to persuade people that love can be found anywhere, and that it is never impossible for an affair to arise and bloom against all odds. In order for this to take place, a certain amount of emotional activity is required, and there is also the prerequisite that the persons in question are open to this emotional activity. Common morality does not restrict people from having strong feelings for others and being open to these feelings, or from being open to other people's feelings; if nobody gets hurt, one can be looking for love in any place and at any time. Usually the instinct of survival and self-preservation works against such an approach, as it can be really self-damaging in the real world. But in some special cases, like the one of Dr Breuer, it is role morality first of all that has to work against feelings.

Dr Breuer was a married man when he treated Anna O., but he could also have been a single man open to the possibility of love, just like many ordinary single men are. If Anna O. belonged to the type of

[101] Josef Breuer and Sigmund Freud, *Studies on Hysteria* [translated by James Strachey] (London: Vintage, 2001, first published in 1895) p. 40-41, note 1.
[102] Wolfgang Spiegel, Tanja Collela & Philip Lupton, 'Sexual Feelings in the Physician-Patient Relationship: Recommendations for Teachers' *Medical Education* **37** (2003), 840-841.

woman which Dr Breuer preferred, what could have stopped him from contemplating the possibility of an affair between them, just like if he had met her in a pub? In other words, how could Dr Breuer be closed to the possibility of emotions inspired by Anna's presence, and at the same time be open to emotions inspired by other similar-looking women? The answer has to lie in the physician's double morality. Where common morality refers to feelings between a man and a woman and does not see a problem (until they get to know each other better), the god of Medicine points out that these feelings have to do with a physician and a patient, and he asserts incompatibility from the very beginning. The physician's role has to prevail, leaving the dictates of common morality for a different instance. But emotions can never be perfectly controlled, especially when physical and social barriers are crossed;[103] what if Dr Breuer happened to retreat from his role morality back to his common morality at an inappropriate time?

b) When feelings turn to desire

Every emotion expresses a desire, but our civilisation puts satisfaction of some desires out of court and restrains us to do the watered-down 'what is appropriate'.[104] But the civilised world does not always impose a ban on our desires. In Dr Breuer's case the desire can be of sexual nature. Sexual interaction is usually considered to be acceptable by contemporary common morality, with certain reservations which refer mainly to other people's interests, including the issue of common decency and the one of adultery. If such implications are out of the question and the interested parties are willing to proceed, then modern civilisation does not pose any more difficulties; a sexual intercourse can be viewed as normal and ethical as a game of tennis.[105] Let us suppose both Dr Breuer and Anna O. have the same desire – otherwise the

[103] Wolfgang Spiegel, Tanja Collela & Philip Lupton, 'Private or Intimate Relations between Doctor and Patient: Is Zero Tolerance Warranted?' *Journal of Medical Ethics* **31** (2005), 27-28.
[104] Peter Goldie, 'Explaining Expressions of Emotion' *Mind* **109** [433] (2000), 33.
[105] Vincent Punzo 'Morality and Human Sexuality' in Hugh LaFollette (ed.), *Ethics in Practice: An Anthology* [2nd edition] (Oxford: Blackwell Publishers, 2002) p. 220.

situation would change to sexual abuse and criminal law procedures would apply.[106] Since mutual affection is expressed, there can be no problems related to common morality. However, the god of Medicine, who could not prevent the arousal of the emotion, must now try to restrain his servant from satisfying the corresponding desire. The easy solution for the physician would be to terminate the treatment and abandon the patient, but this would not satisfy his ideals; from the ideal physician's point of view, abandoning and walking away is an easy and contemptible solution. 'Sexual desires must be handled,'[107] so one should stay and handle them.

'Sexualising the doctor-patient relationship is an extreme violation for which the practitioner has to take responsibility, even if the patient has initiated it.'[108] Role morality works by reminding Dr Breuer the special duties and commitments that go along with his role, and the power that he has over his patient which enables him to exploit their relationship for his own purposes.[109] The layperson within him is the one who desires Anna O. (his, inadequate for these refined situations, 'behavioural genetics' as Genova notes)[110]; this side has to be suppressed by the rational and professional side that role morality promotes. Perhaps there is the possibility of a sexual intercourse to be beneficial or therapeutic for the patient, as some therapists argue,[111] but even then role morality should prevail; and role morality dictates that this kind of sexual intercourse should never take place, and not that it may occur depending on its therapeutic value. First, because one can never be sure, and second, because, apart from the patient, a boundary

[106] Jonathan Montgomery, *Health Care Law* [2nd edition] (New York: Oxford University Press, 2003) p. 328.
[107] Donna Norris, Thomas Gutheil, Larry Strasburger, 'This Couldn't Happen to Me: Boundary Problems and Sexual Misconduct in the Psychotherapy Relationship' *Psychiatric Services* **54** [4] (2003), 519.
[108] Gillian White, 'Setting and Maintaining Professional Role Boundaries: An Educational Strategy' *Medical Education* **38** (2004), 903.
[109] Paul Chodoff 'The responsibility of the psychiatrist to his society' in Sidney Bloch and Paul Chodoff (eds.), *Psychiatric Ethics* [2nd edition] (New York: Oxford University Press, 1991) p. 452.
[110] Paul Genova, 'Boundary Violations and the Fall from Eden' *Psychiatric Times* **XVIII** [6] (2001), World Wide Web, (http://www.psychiatrictimes.com/p010664.html), accessed March 30, 2005.
[111] Frank Margison, 'Boundary Violations and Psychotherapy' *Current Opinion in Psychiatry* **9** (1996), 204-208.

violation can seriously harm the profession by showing that it is not meeting its obligations.[112] Dr Breuer cannot justify himself to the god of Medicine by making claims to Anna O.'s benefit. He has to be a professional, that is, to confront his desires with abstinence, or redirect them effectively to another person, outside any professional relationship, where common morality can once again be used. So the practical necessity of double morality becomes manifest for Dr Breuer.

c) Development of dual relationships

However, let us suppose that, despite the efforts of the physician to be professional, a dual relationship is developed. As Kaplan notes, 'dual relationships occur when a professional and a client take on additional roles with one another outside of the primary professional relationship.'[113] In our case this means that patients can view the physician as 'parent, spouse, lover, adversary, or friend.'[114] If the physician accepts any of these imaginary roles, this has to mean that different sub-moralities will develop alongside his professional role morality and be at his disposal to use alternatively. Therefore, it will be a kind of double morality which allows Dr Breuer to think about Anna O. from a different point of view when he finds it convenient to do so and ultimately to proceed to sexual intercourse with her. But this approach does not entail the concept of double morality as it has been discussed, because when the patient is present the god of Medicine must also be; the physician cannot act like in the case of substance abuse, behind his god's back. If the same person, Anna O., can be viewed both as patient and as lover, then the professional is clearly lost and there is no pure role morality.

As our discussion has shown thus far, there are cases where role morality has to be used and others where common morality has to be

[112] Cherrie Galletly, 'Crossing Professional Boundaries in Medicine: The Slippery Slope to Patient Sexual Exploitation' *Medical Journal of Australia* **181** [7] (2004), 380-383.
[113] Laura Kaplan, 'Dual Relationships: A Call for Open Discourse' *Professional Ethics* **9** [1] (2001), 3.
[114] Glen Gabbard & Carol Nadelson, 'Professional Boundaries in the Physician-Patient Relationship' *JAMA* **273** [18] (1995), 1447.

used; but if both of them are used in the same case, role morality is contaminated by common morality. The physician cannot act according to any ideals and his job is not done properly.[115] As for the roles of parent, spouse, lover, etc., they are common, and they come together with instances of common morality; so there is no role morality corresponding to these roles. Therefore, when only common morality remains, it is only natural that double morality cannot exist. But is this a misunderstanding of how double morality is to be used, or does it demonstrate another double morality's malfunctioning? Is this contamination of role morality by common morality in the case of dual relationships just an exception, or can it express a more general attitude? A complete answer cannot be provided at this point, but I will certainly come back to it, after examining some more practical applications of double morality.

The discussion of medical etiquette's issues leaves great uncertainty with regards to double morality's value. Its excessive application can result to the worrying facts related to alcohol and drugs abuse, while its misunderstanding causes the physician's fall. In the end, does the adoption of double morality serve physicians by helping them to be abstemious, or by helping them to be non-abstemious? Some gaps need to be filled in the following chapters as the answer provided is not satisfactory.

Conclusion

In this chapter it became apparent that the concept of double morality does not always work too well, especially when it is applied to the complicated cases which were discussed. Issues of religiosity, caring, and abstinence are perhaps too difficult to be examined by using solely the perspective of double morality. But is this the only reason as to why double morality seemed to malfunction, or maybe the concept is wrong

[115] *Ibid.*

per se? In the next chapter I shall discuss some even more complicated cases and examine more seriously the possibility that the theory of double morality is not correct, or that it has a very limited usefulness at the very least.

Chapter 6

CASES SHOWING THE FAILURE OF DOUBLE MORALITY

In this chapter, the concept of double morality is under serious contestation. The cases which I shall discuss reveal that double morality as a moral tool is insufficient to explain, or secure, the physician's response to specific problems. In the following section, I shall deal with two issues of confidentiality; firstly the duty of confidentiality which is inherent in a therapeutic relationship, and secondly the reluctance of physicians to 'blow the whistle' when they discover any inappropriate performance by their colleagues. The next section shall be devoted to the extremely complicated issue of defensive medicine with continuing reference to the legal aspects of it. And in the last section I shall discuss the case of the sick physician; this does not directly create any moral problems, but it shows nevertheless that one of double morality's prerequisites, namely the separation of the layperson from the physician, is not as easy as it was assumed to be. All these examples imply that the approach of double morality is probably wrong, and this shall be further supported in the next chapter.

I) The Secrets of Medicine

Whether we like it or not, we live in the age of information. Most people want to have information on past, present, or future matters, even if they do not aim at using it in any foreseeable way. But the demand for information is not created out of nothing; there is a big supply which justifies the demand. In our age, it is relatively easy to get hold of information on almost anything. The means by which people acquire it vary from media reports to internet surfing and simple gossiping. With all these facilities at hand, there is the feeling that every piece of information has to be shared, just because it is so easy to do so. Therefore,

whenever there are suspicions that a fact has been concealed, for whatever reason, the public demands complete revelation in order to satisfy its hunger for information. To be sure, there are some people who prefer not to care about issues not directly related to them; but I think that the general image of our age is what I have just described. So this means that common morality is not opposed to the provision of information in general. The secrecy which characterised societies of the past is no longer deemed desirable.

When silence is preferred

However, there are some issues which normally require a certain level of confidentiality. Freedom of speech has to have some limitations, otherwise everyone would know, for example, the secrets of the British Secret Intelligence Service,[1] and they would not be secrets anymore. Medical issues are also subject to confidentiality, but only insofar as health care professionals are concerned. As Edward Richards III notes with regards to HIV:

> Keeping medical information confidentiality is a difficult problem. People the world over, and through history, like to talk about their ailments. Unauthorized disclosures by health care providers are not the source of most unwanted disclosures of HIV status, the infected individuals are.[2]

Common people, whether they are infected or not, can discuss their, or other people's ailments freely, and it seems that they like it. For them, there is no moral difference whether they gossip about suffering and diseases or a famous person's taste in clothes. Probably health care providers would also like to be able to do that, but their role morality, backed by the courts' approach clearly in favour of the obligation to keep

[1] Often referred to as 'MI6'. See: http://www.sis.gov.uk/output/Page50.html
[2] Edward Richards III 'HIV Testing, Screening, and Confidentiality: An American Perspective' in Rebecca Bennett and Charles A. Erin (eds.), *HIV and AIDS: Testing, Screening and Confidentiality* (New York: Oxford University Press, 1999) p. 79.

patients' details secret,[3] prevent them from considering these two cases of gossiping as morally equal. The god of Medicine would seem to clearly dictate that whatever they learn about their patients has to be kept confidential. As Tur notes, 'there is a well established and well-understood presumption in favour of confidentiality. Compelling reasons are therefore necessary in order to justify disclosure by a health care professional of information acquired in practice.'[4] And this is where the issue of medical confidentiality becomes complicated; when compelling reasons exist, its violation seems morally preferable.

A Hollywood movie plot could be something like this: two friends, the hero and the walk-on, accidentally witness a gangster killing an innocent man. In fact, the gangster is their childhood friend, whom they love very much. He notices them, and makes them take an oath not to say a word to the police. The walk-on does not really love his friend the gangster, but he is frightened and tries to forget about the issue – this is why he is the walk-on – while the hero feels that something is wrong and is determined to reveal the truth. Then the gangster says that he is going to get the hero's family if he opens his mouth. After much thought, and having explained to his wife and son how much he loves them, the hero decides to be brave, ignore both the oath and the threat, and divulge what he saw to the police. The police immediately kill the gangster in a shoot-out, and arrest anyone who could harm the hero's family. In the best-case Hollywood scenario, the policemen are not very effective, and it is the hero who has to kill his friend the gangster after all. So everything turns out fine in the end, and everyone feels that the hero did the right thing when he informed against the gangster, while his friend the walk-on appears to be cowardly and contemptible.

This plot is addressed to a wider public, and it therefore reflects the common morality's attitude towards special issues of confidentiality. If there is a more important issue at stake, like social justice or a duty to the state, then the situation does not resemble simple gossiping, where it

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[3] Jonathan Montgomery, *Health Care Law* [2nd edition] (New York: Oxford University Press, 2003) p. 257.

[4] Richard H. S. Tur, 'Medical Confidentiality and Disclosure: Moral Conscience and Legal Constraints' *Journal of Applied Philosophy* **15** [1] (1998), 16.

matters the same morally whether one decides to be silent or talkative; it becomes clearly morally preferable to forget about confidentiality and speak. Moreover, the information provided must be as detailed as possible. Nothing relevant has to remain hidden. And of course, the information has to be targeted correctly. The hero is not asked to reveal the truth to his neighbour; he has to tell it to the police. The murderer cannot stay unpunished even if he happens to be a friend and there is an oath protecting him. To be sure, there can be an internal conflict and the decision may be difficult, but common morality is pretty clear as to what the right thing to do is.

There are many instances in the health care area where the physician can be seen in the place of the hero. Within the therapeutic relationship, he has a duty of confidentiality to his patient, which is a role duty derived from his role morality. But sometimes there is also the duty to protect innocent people, whether they are in such a relationship with him or not; this is a common duty, part of the general duties one has as a citizen.[5] This consideration weakens the authority of the god of Medicine who commands silence, through the Hippocratic Oath, for example. 'The patient lives in society. What he or she does, or does not do, affects others. The professional cannot view the patient as an isolated entity.'[6] Therefore, there is the question whether the physician should warn the sexual partners of an HIV positive patient that they risk infection;[7] whether he should report gunshot injuries to the police if he has reasons to believe that the patient is a danger to the public;[8] the relevant issue of reporting domestic violence;[9] and the influential *Tarasoff* case, which shall be the point of reference for the present discussion. Slightly

[5] Adarsh Kaul 'Confidentiality in Dual Responsibility Settings' in Christopher Cordess (ed.), *Confidentiality and Mental Health* (London: Jessica Kingsley Publishers, 2001) p. 95.
[6] Margaret Brazier and Mary Lobjoit 'Fiduciary Relationship: An Ethical Approach and a Legal Concept?' in Rebecca Bennett and Charles A. Erin (eds.), *HIV and AIDS: Testing, Screening and Confidentiality* (New York: Oxford University Press, 1999) p. 186.
[7] See, for example, Donald Ainslie ,'AIDS, Sexual Ethics, and the Duty to Warn' *Hastings Center Report* **29** [5] (1999), 26-35.
[8] See, for example, A. Frampton, 'Reporting of gunshot wounds by doctors in emergency departments: A duty or a right? Some legal and ethical issues surrounding breaking patient confidentiality' *Emergency Medicine Journal* **22** (2005), 84-86.
[9] See, for example, Michael Rodriguez, Elizabeth McLoughlin, Gregory Nah, Jacquelyn Campbell, 'Mandatory Reporting of Domestic Violence Injuries to the Police: What do Emergency Department Patients Think?' *JAMA* **286** [5] (2001), 580-583.

different is the issue of whistleblowing, which shall be discussed separately. Both issues deal with secrecy; *Tarasoff* refers to secrets of patients, while whistleblowing is about secrets of the profession.

a) *Tarasoff*, or how not to be a hero

When Prosenjit Poddar, a student at Berkeley, told his psychiatrist that he wanted to kill Tatiana Tarasoff, a girl who had rejected him, Dr Moore was worried. Evaluating risk is part of everyday practice in psychiatry,[10] and his professional experience and judgment indicated to him that it was possible for Poddar to carry out his threat. As a citizen, and a fellow human being, he felt that Tatiana had to be protected; but as a physician he was confined by his role morality, which prescribed that there was a duty of confidentiality to Poddar. The physician had to choose what his course of action would be. If his choice was in accordance with common morality, and the Hollywood scenario, he would immediately go to Tatiana's house to warn her, persuade her to move out and hide from Poddar, or, backed with his professional expertise, explain everything to the police and make them protect her; he would be the hero (of course I assume that this is what common people would do, but certainly there are others who could not care less about whether Tatiana was in danger or not). On the other hand, and in accordance with the god of Medicine, the physician could remain silent and that would be all; he would be the walk-on. Either of these two options would refer to a double morality, which actually is the choice, depending on the circumstances, between common and role morality. However, *Tarasoff* has not been adapted to a movie yet, and it is a case which clearly shows that double morality is not real, and does not work in the real world.

Real life situations avoid extremities. Dr Moore did not become the hero who saved the day, but he did not act as a complete walk-on and remain indifferent either. His decision was to simply write a letter to the campus police, express some concerns, and propose Poddar's

[10] Navneet Kapur, 'Evaluating risks' *Advances in Psychiatric Treatment* **6** (2000), 399-406.

detention for psychiatric evaluation, which did take place, and after which he was released.[11] If double morality was possible, he could let aside his professional identity and behave like a layperson that happens to be aware of a danger, by becoming more active (in the above mentioned ways of letting Tatiana know or being more persuasive with the police). Or he could do nothing whatsoever, either by managing to forget everything that he learned by virtue of his role when the working day was done, or by forbidding himself to think about the situation from any point of view other than the one of the physician – the role he played, that is; the point of view of the good citizen would not be an option under the authority of the god of Medicine. However, he chose to do something in between. He violated the duty of confidentiality but not sufficiently, and he tried to protect Tatiana but not very actively. In the end nobody was satisfied; neither the god of Medicine, nor the public, and certainly nor Tatiana, who remained in ignorance and was killed two months later, when she returned from a trip to Brazil.

I am not arguing that double morality could have made things better – even though it seems that it could indeed, if Dr Moore had chosen to employ common rather than role morality and become the common hero. My consideration is that it is not possible for double morality to be used like it might be used in a different age perhaps. The god of Medicine still says that there is a duty of confidentiality, but now there are other clearly acknowledged duties which conflict with it and which cannot be overlooked. *Tarasoff* created a 'duty to warn' which then became a 'duty to protect'[12] and this duty still remains, even though its importance and applications may have decreased recently.[13] Legally, 'the therapist is excused from any liability if he or she carries out certain acts, such as warning the victim and/or the police, or hospitalizing the

[11] Robert Veatch, *A Theory of Medical Ethics* (New York: Basic Books Inc., 1981) p. 109.
[12] Randy Borum & Marisa Reddy, 'Assessing Violence Risks in *Tarasoff* Situations: A Fact-Based Model of Inquiry' *Behavioral Sciences and the Law* **19** (2001), 376.
[13] Damon Muir Walcott, Pat Cerundolo, & James Beck, 'Current Analysis of the *Tarasoff* Duty: an Evolution towards the Limitation of the Duty to Protect' *Behavioral Sciences and the Law* **19** (2001), 325-343.

patient.'[14] And apart from the special case of *Tarasoff*, the difficulty in preserving the confidentiality of patient information in today's information age had been identified very early.[15] However, these decisions are based not on Medicine's, but on society's demands; and as Mason notes, this trend 'is likely to amplify the doctor's role of gaoler – and, hence, his public responsibility – at the expense of his private duty as a therapist.'[16] Role morality presupposes a certain level of 'pure' medical practice; when there are too many social considerations involved, role morality, and consequently double morality, is impossible. The god of Medicine notices it, he feels uncomfortable about it, but there is not much he can do.

b) Whistleblowers: enemies of the people

Another aspect of confidentiality refers not to medical findings, but to knowledge about poor moments of practice of one's colleagues – or intentional malpractice (abuse) in some extreme cases. This is not something unique to the health care arena; such incidents, whether intentional or not, can occur in various social settings. The action of reporting these incidents is called 'whistleblowing'.

> 'Whistleblowing' is a new label generated by our increased awareness of the ethical conflicts encountered at work. Whistleblowers sound an alarm from within the very organization in which they work, aiming to spotlight neglect or abuses that threaten the public interest.[17]

For most areas of professional practice, there does not seem to be a tradition regarding the issue of whistleblowing. Medical practice,

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[14] James Beck, 'Current Status of the Duty to Protect' in James Beck (ed.), *Confidentiality Versus the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry* (Washington, DC: American Psychiatric Press, 1990) p. 19.

[15] See, for example, Robert Gellman, 'Divided Loyalties: A Physician's Responsibilities in an Information Age' *Social Science and Medicine* **23** [8] (1986), 817-826.

[16] J. K. Mason, 'The Legal Aspects and Implications of Risk Assessment' *Medical Law Review* **8** (2000), 84.

[17] Sissela Bok 'Whistleblowing and Professional Responsibility' in Tom Beauchamp & Norman Bowie (eds.), *Ethical Theory and Business* [5th edition] (New Jersey: Prentice-Hall, 1997) p. 328.

however, differentiates itself as usual. Physicians are acculturated to be loyal to their colleagues and not to blow the whistle on a fellow physician. As Percival notes, putting an unwritten code into writing for the first time in 1849:

> The Medical gentlemen of every charitable institution are in some degree responsible for, and the guardians of, the honour of each other. No Physician, or Surgeon, therefore, should reveal occurrences in the hospital, which may injure the reputation of anyone of his colleagues ...[18]

Before Percival, this was part of the medical culture which the physicians were accustomed to without being able to fully explain how they knew about it; Percival just wrote down this one, along with some other previously unwritten rules. As an aspect of their role morality then, peer support is to be expected between physicians, especially when there has been an unfortunate mistake in practice.

The ideal physician does not make mistakes in his practice of course, but his colleagues do. Brazier identifies the leaving of swabs and equipment inside the patient as a good example.[19] Suppose then that a certain non-ideal surgeon forgets a pair of surgical scissors in a patient's stomach, but without grave consequences; someone notices it, they open the patient again, and they take their property back. The ideal physician who sees or learns what happened shall never speak about this incident. 'A white wall of silence protects the secrets of these professions from public scrutiny and keeps the dirty linen from being aired.'[20] He wants to cover up his colleague's mistake and keep it safe from the relatives, the media, and the lawyers. And this is not only because he wants to help his colleague or because he thinks that his colleague would have done the same for him; it is mainly because he wants to protect his profession and his god. Percival is a loyal servant of

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[18] Thomas Percival 'Of Professional Conduct' in Stanley Reiser, Arthur Dyck and William Curran (eds.), *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Massachusetts: The MIT Press, 1977) p. 19.

[19] Margaret Brazier, *Medicine, Patients and the Law* [2nd edition] (Harmondsworth: Penguin Books, 1992) p. 130.

[20] R. Rhodes, J. J. Strain, 'Whistleblowing in Academic Medicine' *Journal of Medical Ethics* **30** (2004), 37.

his god when he calls on physicians to defend the honour of the profession by withholding criticism, either of individual practitioners or the profession as a whole.[21] Every neglectful medical practice has an impact on all medical practice; the less negligence comes to light the better it is for Medicine. And even if the ideal physician is tempted to go to the pub like every layperson and say 'Guess what happened today at work' without identifying (and therefore causing harm to) any patient, surgeon, or hospital, he will still not do it, because it would inflict a harm on his profession in general. His role morality prevents him from doing so.

It seems then that double morality can work in this case; the god of Medicine tells his servant to forget about the incident and support his colleague. But this imagined case is far too simple, as it does not go beyond the issue of simple gossiping. What is the situation like when that surgeon keeps forgetting his equipment inside his patients, almost everyday, but keeps on practicing debonairly, like nothing has happened? This certainly puts people at serious risks, and one would expect that the physician should switch from his role to his common morality, act not as a colleague but as a good citizen, and bring the matter to other people's attention; blow the whistle in other words. However, this does not happen very often. Julia Burrows provides many examples – there is no need to mention all of them – which demonstrate well the prevailing culture in the health service, where doctors can perform poorly for years unchallenged.[22] The above mentioned acculturation is the most compelling reason; but there is also the stigma attached to whistleblowing.[23]

As noted in the *Tarasoff* discussion, real life does not resemble a Hollywood movie where the obvious choice is clear and the ending dictated to be happy; in this case it rather becomes like a depressing

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[21] Jeffrey L. Berlant 'Medical Ethics and Monopolization' in Stanley Reiser, Arthur Dyck and William Curran (eds.), *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Massachusetts: The MIT Press, 1977) p. 54.

[22] Julia Burrows, 'Telling Tales and Saving Lives: Whistleblowing – The Role of Professional Colleagues in Protecting Patients from Dangerous Doctors' *Medical Law Review* **9** (2001), 110-129.

[23] Ruth McGuire, 'Blowing the whistle – safely' *British Medical Journal Career Focus* **328** [7430] (2004), s7.

Norwegian play: In *An Enemy of the People* Dr Stockmann thinks that it is his job as a citizen to warn the public about the health hazards of the business on which the economy of his city depends;[24] the Mayor thinks that this matter should be kept a professional secret;[25] and when Dr Stockmann insists in telling the truth he becomes an enemy of the people, and is despised by everyone. In the same way that the Mayor values the city's prosperity above all else, the god of Medicine values Medicine's prosperity; and they both oppose any good citizen who tries to warn the public about something which could harm what they value so highly. 'Whistleblowers have been likened to bees: a whistleblowing employee has only one sting to use, and using it may well lead to career suicide.'[26] Dr Stephen Bolsin, who blew the whistle on unacceptably high infant morality rates following cardiac surgery at the Bristol Royal Infirmary and had to leave the country afterwards, assures us that this happens: 'Many whistle blowers never regain the level of employment they had previously achieved and are discriminated against by their former colleagues and employers ...'[27] The god of Medicine is not a forgiving god.

Therefore, one would say that physicians are reluctant to be good citizens and to use common morality. It looks as if they had to stick to their role morality at all costs. But like in the *Tarasoff* discussion, this is not possible. It certainly was in another age, but not in the present one, where social considerations constantly 'pollute' medical practice and unsettle the physician's role morality. This is clearly reflected in the GMC guidelines on good medical practice which state that every physician should try to expose fellow physicians who practice poorly.[28] In addition, medical journals tend to support whistleblowers like for example Dr Olivieri and her case against Apotex pharmaceutical company.[29] And in

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[24] Henrik Ibsen, *An Enemy of the People* [translated by Michael Meyer] (London: Rupert Hart-Davis, 1963, first published in 1882) p. 73.
[25] *Ibid.*, p. 54.
[26] Gavin Yamey, 'Protecting whistleblowers' *British Medical Journal* **320** (2000), 70.
[27] Stephen Bolsin, 'Whistle blowing' *Medical Education* **37** (2003), 294.
[28] Guidance from the General Medical Council: *Good Medical Practice* (London, 1995) p. 6 (para 18).
[29] Clare Dyer, 'Whistleblower vows to fight on' *British Medical Journal* **328** (2004), 187.

general it is evident that the expectation of the public and the profession is that accepting and facilitating whistleblowing in mainstream medical education and practice is desirable.[30] This trend does not mean that physicians from now on shall always report any malpractice when it occurs (even though some surveys have shown impressive results, such as that 90% of NHS workers blew the whistle when they had concerns about patient safety,)[31] but it means that more brainstorming and internal conflict is to be expected, regardless of the decision to blow the whistle or not. Double morality means clever avoidance of conflict by instant trust in the rightness of medical culture, and this is not possible when more thinking is encouraged, as it constantly brings to the test the medical culture's authority. So every case of whistleblowing is a dual blow to the god of Medicine. First, because it reveals growing weaknesses of his servants, and, second, because it reveals his own growing weakness to control the revelations.

To conclude, confidentiality is obviously a very important aspect of medical practice, related both to patients' information and to details regarding colleagues' practice. The god of Medicine would like his servants to respect his traditional demand for confidentiality, but society's demands are forbidding. *Tarasoff* created a duty to protect, and there also seems to emerge a duty to wash Medicine's dirty linen in public, as a special aspect of the duty to protect. But these duties are not part of the physician's role morality, nor do they seem to be part of common morality completely. Without offering clear and indisputable guidance as to the correct kind of action, they belong perhaps to another physician's role, 'polluted' by other considerations which are sometimes inescapable. Even though the physicians face unfamiliar challenges, this is an age where they need to accept responsibilities outside regular practice

[30] T. Faunce, S. Bolsin, W-P. Chan, 'Supporting whistleblowers in academic medicine : training and respecting the courage of professional conscience' *Journal of Medical Ethics* **30** (2004), 40-43.
[31] Survey Report 2003: 'Is Whistleblowing Working in the NHS?' *Public Concern at Work*, World Wide Web, (http://www.pcaw.co.uk/policy_pub/nhs.html), accessed May 1, 2005.

settings,[32] and consequently trouble themselves more. Internal conflict, spending time to ponder over alternatives, and active thinking distress the god of Medicine and render the concept of role morality utopian. This can be further supported in what follows.

II) A Study of Complexity: Defensive Medicine

Double morality is the ability to alternate between common and role morality according to the needs, and being able to keep them separate and intact. One of the aspects of modern medical practice which clearly demonstrates that this is impossible is the one of defensive medicine. It is an issue far too complex to be regarded in such a simple context as the one of double morality.

Endangered physicians

In 1871, a medical journal praised a physician who knocked down a patient, anaesthetised him without his consent, and operated successfully on his limb, for 'the courage that many physicians lack, to take responsibility and act, and look up the law afterwards.'[33] This was the solution that this particular physician found when the patient informed him that he intended to sue for the results of a poorly healed fracture, refusing the physician's offer to correct the defect. The god of Medicine must have been very pleased; medicine was clearly above the law in that case, as it represented the supreme authority when a patient's benefit was at stake. According to the ideal physician, legal consequences seem unimportant at the point where a medical decision has to be taken and a medical act to be performed. The physician's role is so powerful that its morality makes all other considerations fade from view when it comes to the practice of medicine – including dictates of the law. Therefore, role

[32] Russell Gruen, Steven Pearson, Troyen Brennan, 'Physician-Citizens – Public Roles and Professional Obligations' *JAMA* **291** [1] (2004), 94-98.
[33] W. C. Appley, 'How Rip Van Winkle, jr. M.D. disposed of a case of medical malpractice' *Medical and Surgical Reporter* **25** (1871), 381-382 *as cited in* Kenneth De Ville, 'Act First and Look up the Law Afterward?: Medical Malpractice and the Ethics of Defensive Medicine' *Theoretical Medicine and Bioethics* **19** (1998), 569.

morality in that case allowed knocking someone down for his own benefit, while it is clear that common morality considers knocks to be associated with inflicting harm, and triggering fights and legal implications. A layperson would think of the law first and he would never knock down someone to benefit him, but only to do him harm.

Things have changed since 1871. The physician's role has undergone so many changes that it is impossible to say that it has retained a morality so pure and powerful as to render every non-medical consideration unimportant. Self-interest, whatever form it assumes, seems most of the time to prevail over good medical practice. This is why, for example, when the HIV epidemic came along, there were a lot of doctors who wanted to debate whether it was an ethical obligation to take care of patients with HIV infection, forgetting that danger in the past was a well-known and well-accepted part of what it meant to be a doctor.[34] In this case, the danger is not an epidemic but the law, and self-interest means compliance with the law and avoidance of any practice or non-practice which could bring on any legal claims. The tendency to think legally before thinking medically is called 'defensive medicine', and it makes apparent the inefficiency of double morality, as it creates extreme confusion about the boundaries of role and common morality and their characteristics. The following discussion elaborates, and gives support to this view.

The physician's disturbed role

Lawsuits against physicians do not constitute a recent development. In the United States, already by the mid-nineteenth century the frequency of malpractice suits had filled doctors with a mixture of anger, panic, and confusion and 'many men abandoned the practice of surgery, leaving it to those who, with less skill and experience, had less reputation and

[34] Anon. 'Ethics during epidemics: old lessons get new look: balancing personal protection with professional duty' *Medical Ethics Advisor* **20** [5] (2004), 49-51.

property to lose.'[35] In the following century, malpractice suits kept on rising in number and making physicians worry, not only in the States but everywhere in the world. Even in Britain where, according to some writers, people dislike making a fuss and the tendency is to avoid the courts,[36] there has been a 'malpractice crisis': this is supported by statistics demonstrating a stable rise in medical accident claims and in the cost of malpractice litigation,[37] by reports showing practitioners dropping out of high risk specialties such as obstetrics,[38] and by the growing number of lawyers specialising in medical negligence.[39] This continuous crisis results in worried physicians, who are reluctant to practice medicine without considering first what the consequences of their acts may be. And in order to be as safe as possible, they resort to defensive medicine. This can be categorised as positive defensive medicine, where many unnecessary diagnostic and therapeutic procedures are demanded just to be sure, and as negative defensive medicine, where difficult operations and high-risk patients are avoided, while other physicians narrow the scope of their practice by refusing to treat individuals who they perceive as litigation-prone.[40] In other words, they put their interests above their patients'.

But when a physician considers whom to treat and in what way to practice medicine from a non-medical point of view, his role is 'disturbed' to a certain extent. Physicians create expectations of themselves about how to use medicine and how to handle patients in accordance with the ideal physician and his pure medical role. Defensive medicine can be regarded as a failure and a compromise of this role; therefore, physicians who fail to live up to the ideal physician's expectations and feel that their

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[35] Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America* (New York: New York University Press, 1990) p. 25.
[36] Linda Lamont, 'Why patients don't sue doctors' *Journal of the Medical Defence Union* **28** (1993), 39-41.
[37] Jonathan Montgomery, *Health Care Law* [2nd edition] (New York: Oxford University Press, 2003) pp. 204-205.
[38] Patrick Hoyte, 'Unsound Practice: The Epidemiology of Medical Negligence' *Medical Law Review* **3** (1995), 53-73.
[39] Jean McHale, Marie Fox, and John Murphy, *Health Care Law: Text, Cases and Materials* (London: Sweet & Maxwell, 1997) p. 147.
[40] Kenneth De Ville, 'Act First and Look up the Law Afterward?: Medical Malpractice and the Ethics of Defensive Medicine' *Theoretical Medicine and Bioethics* **19** (1998), 581.

medical autonomy has been compromised by non-medical factors may become disappointed with themselves.[41] Surveys have indicated that 'the consequence of constantly being unable to comply with their ideals was reported to be *burn-out* in the form of lack of morality, lack of energy to resist pressure and lack of satisfaction with work.'[42] It is obvious then how badly defensive medicine can influence the physician's role.

To be sure, there must be many physicians who just try to avoid being sued by being more cautious without neglecting any medical considerations, and simply practice what Panting describes as 'defensible medicine'.[43] However, there is no point in denying that many others practice defensive medicine; and, as Jones and Morris note, 'even if liability for negligence were to be abolished ... there would, presumably, still have to be some complaints mechanism ...' and defensive medicine '... would continue to be practised under such a regime.'[44] Given that complaints against doctors can rise even 50% in one year,[45] there can be no doubt that defensive medicine can be, and probably is already, established as a normal aspect of medical practice. And this is where the confusion begins, where the role of the physician becomes blurred, and the demands of the god of Medicine uncertain; because, when a practice has become so common and indeed necessary, there is great difficulty to distinguish whether it falls outside the physician's role or has been embodied within it. However, for the sake of the argument, let us assume that the role remains as it used to be, back in the days when medicine did not need to be defended. Can a double morality approach be adopted?

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[41] Kristin Henriksen, Ebba Holme Hansen, 'The threatened self: general practitioners' self-perception in relation to prescribing medicine' *Social Science & Medicine* **59** (2004), 49.
[42] *Ibid.*, at 51.
[43] G. Panting, 'How to avoid being sued in clinical practice' *Postgraduate Medical Journal* **80** (2004), 165.
[44] Michael Jones and Anne Morris, 'Defensive Medicine: Myths and Facts' *Journal of the Medical Defence Union* **14** (1989), 41.
[45] Sir Christopher Paine, 'Il Dissoluto Punito: Medicine in the Age of Blame' *Medico-Legal Journal* **70** [4] (2003), 161-175.

a) Defensive double morality

One could say that, when the physician practices defensive medicine, he just forgets his role and resorts to common morality. To be an ideal physician is sometimes to obey to an instant madness; forget about the rest of the world, and concentrate on the task of Medicine, free from any constraints, like a hero who goes to the battlefield. A layperson is not generally required to be a hero and put someone else's interest above his own; nor does he have only one point of view – like the medical point of view – which should be cardinal in some appropriate circumstances. Where the ideal physician employs solely a medical point of view, and thinks of nothing else but how to save the patient's life, the layperson has the ability to consider possibilities of failure and success, the impact that could have on him and others, and, in general, have a wide spectrum of thoughts instead of strictly medical ones. Therefore, the practice of defensive medicine could still be seen as a case of double morality, where common morality prevails over role morality, and common sense prevails over medical madness.

However, it is not safe to presume that a layperson functions in this way, or that common morality is more sensible than role morality. The situation is far more complex, and no generalisations can be made. First, one needs to keep in mind that the practice of defensive medicine is still medicine; it is not like the case of the physician's fees where it was supposed that the physician can slip off his role morality and use common morality to get paid, because money is just a side-effect, independent of medical practice. To be sure, it can delay medical practice or cancel it, but when the physician starts working, money is no longer an issue. However, this is not the case with defensive medicine; legal considerations exist along medical ones all the time, influencing the medical outcome. It cannot be common morality therefore; it has to be a special kind of role morality, a 'disturbed' kind as noted previously.

b) Good Samaritans and physicians

Evidence that the situation is far too complex is also to be found in what is widely known as 'Bad Samaritan Laws'. A Good Samaritan is one who, against one's interests, helps a person in need. To put it crudely, this means that if one sees, for example, a traffic accident and no one else is around, one goes to help the victims of the accident. In almost every continental European country there is a Bad Samaritan law, where the failure to be a Good Samaritan has been declared a criminal offence. The glaring exceptions to this trend have been those countries within the Anglo-American legal tradition.[46] According to people from those countries who oppose Bad Samaritan laws, it should be left to one's conscience whether he shall be the Good Samaritan or not, and the creation of a legal duty to aid others would interfere with their liberty.[47] They obviously have a good point, but this does not matter in this discussion. What matters is that common morality seems to encourage helping people in need without too much consideration. In the Anglo-American world it is left to one's conscience, but in such a way as implying that everyone knows that the right course of action is to offer help; it is up to them, though, to decide whether to act in accordance with it. Besides, even if they do not have Bad Samaritan laws, they can still have Good Samaritan laws which protect against liability for persons who may cause harm in the course of providing aid, and in that way, they encourage people to help by removing the fear of getting sued.[48] On the other hand, in continental Europe this moral detail is expressed as a duty in criminal law; and a law which is the same in almost every country certainly reflects an aspect of common morality. Surely the physician who practices defensive medicine is not in a highway witnessing an accident, but in his work area, and probably in a hospital; but, having considered the sort of common morality which underlies Samaritan laws,

[46] John Kleinig, 'Good Samaritanism' *Philosophy & Public Affairs* **5** [4] (1976), 382.
[47] H. M. Malm, 'Bad Samaritan Laws: Harm, Help, or Hype?' *Law and Philosophy* **19** (2000), 707-750.
[48] Peter Agulnick, Heidi Rivkin, 'Criminal Liability for Failure to Rescue: A Brief Survey of French and American Law' *Touro International Law Review* **8** (1998), 93-116.

can we still say that, when he decides to put other considerations above offering help to one in need, he uses common morality?

To make matters even more complex, we should also consider what the physician would do when he happens to witness an accident, that is, when he is not officially at work. Having France in mind as an example, we note that the general opinion is that there is no necessity to establish special rules to deal with the physician's responsibility in this matter; nevertheless, the duty to aid a person in danger may occasionally require more from a physician. Kleinig notes that, even though such obligations are less than clear-cut, doctors, nurses, policemen, firemen, and lifeguards are committed by their *vocational* skills to render aid.[49] And this is why Cadoppi believes that high penalties are provided for violation of the Bad Samaritan law in France: to enable judges 'to punish people who have special duties to rescue – especially doctors – and who cause harm through their omission.'[50] So, apparently, in France, they believe that, for the physician, the duty to rescue people in danger is stronger than it is for the layperson. They also have the Bad Samaritan law which applies to everyone and reflects common morality. Therefore, in France, the physician's common morality and his role morality demand the same thing from him in this instance; to help a stranger in need.

Nevertheless, one may remark that in that country there are a proportionally large number of members of the medical profession among the violators of the Bad Samaritan law.[51] This is subject to various explanations, but it certainly signifies that, unless it is a coincidence that most of the people who fail to rescue a stranger are physicians, there is something wrong with boundaries between the roles of the physician and the layperson. The French physician possibly practices defensive medicine when he decides not to help; he knows that

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[49] Kleinig, *op. cit.*, at 383.
[50] Alberto Cadoppi 'Failure to Rescue and the Continental Criminal Law' in Michael Menlowe & Alexander McCall Smith (eds.), *The Duty to Rescue: The Jurisprudence of Aid* (Hants: Dartmouth Publishing Company, 1993) p. 109.
[51] F. J. M. Feldbrugge, 'Good and Bad Samaritans: A Comparative Survey of Criminal Law Provisions Concerning Failure to Rescue' *The American Journal of Comparative Law* **14** [4] (1965), 643.

if something goes wrong, he could be in trouble. In this way he manages to go against both his common and his role morality. And the same is true for the English physician as well, even if he comes from a culture of 'mind your own business' jurisprudence,[52] as common morality must be the same in England and in France, with the exception that in France they just try to impose it on people sometimes. But this is absurd; one cannot go against everything. There must be something to go with. We have to accept that the role of the physician is indeed disturbed, and that it leaves the physician confused. There are no clear orders coming either from the god of Medicine, who probably is as confused with recent developments in his area as his servants are, or from common morality, which in the age of lawsuits seems to say: 'Do the right thing if you want to, but you have been warned.' As stated previously, the situation is far too complex. Bad Samaritan laws just offer a demonstration of this complexity.

It is not my purpose to further analyse this complex situation; and even if I could propose any solutions or advice on the issue of defensive medicine – which I could not do – this would not be the place. However, this brief discussion was necessary in order to show that the theory of double morality is far too simple to be applied to cases like the one of defensive medicine. Role morality is not clear because the god of Medicine does not seem anymore to have the authority to enforce it. Common morality is not clear either, and the law makes the situation worse; statutes such as Bad Samaritan laws do not have any real deterrent effect: 'cowards go on being cowards, brave men keep on being brave, and heroes go on being heroes.'[53] We cannot separate role morality from common morality; and if we insist on doing this, we end up with a disturbed role morality of no practical use. To conclude, there are indeed dangers for the physician which he tries to confront in various ways. His defences are complex and their underlying rationale cannot be

[52] Eric Mack, 'Bad Samaritanism and the Causation of Harm' *Philosophy & Public Affairs* **9** [3] (1980), 231.
[53] Cadoppi, *op. cit.*, p. 122.

fully analysed. Double morality can be regarded as a hasty explanation of what triggers defensive medicine; when one considers the problems which have to be encountered when trying to adjust the role of the physician to meet recent developments, or the frailty of any presumptions about the layperson, the concept of double morality becomes superficial. In fact, its superficiality is so evident that it creates doubts about its functionality even in the simplest cases, let alone complexities like defensive medicine.

III) The Importance of Being a Patient

The final example which I shall be presenting to support the impossibility of double morality does not raise any ethical issues. Its purpose lies in demonstrating the difficulty which one encounters when trying to separate the physician from the layperson within the same individual; the separation of these roles leads to the development of different moralities, of course, but this is a consequence which shall not be considered in this section. The following discussion deals with the impossibility of double role exclusively; but if this can be supported, then indirectly it also supports the impossibility of double morality, even if no moral issues are discussed. Having said this, it is time to see what this example is about.

The healthy and the sick

During his lifetime, Nietzsche had many ideas. One of these was to separate the healthy from the sick, so as to prevent the latter from being jealous of the former; therefore, doctors and nurses who care for the sick should also be sick.[54] Nobody believes that all of Nietzsche's ideas were brilliant; however, the image of a sick health care professional who continues to be the health care professional for other sick people instead of joining them as a sick person has something very authentic in it, especially when it comes to physicians. The physicians cannot get sick

[54] Friedrich Nietzsche, *On the Genealogy of Morality* [trans. by Carol Diethe] (Cambridge University Press, 1994, first published in 1887) p. 97.

like ordinary people. They confront sickness as physicians, and not as patients, not as laypersons, in other words. As it shall be shown, this attitude creates many hazards for their health; but it also proves that it is very difficult to abandon the role of the physician and assume the role of the layperson. As part of his medical culture, the physician has his own very special way of dealing with personal illness – and personal health; and the latter seems to be endangered first of all when one takes the first steps in the area of Medicine.

a) Medical studentitis

When Jerome K. Jerome went to the British Museum to consult a medical book, he found out that he suffered from every known disease apart from housemaid's knee. 'Students would have no need to "walk the hospitals" if they had me,' he writes. 'I was a hospital in myself. All they need do would be to walk round me, and, after that, take their diploma.'[55] However, medical students, who consult medical books all the time, are in a more difficult position than Jerome's. While studying about symptoms and diseases, they tend to make diagnoses about themselves and think that they are sick. Their imaginary sickness has come to be known as 'medical studentitis' and it surely has some amusing aspects as this medical student's remarks show:

> I discovered a public health horror story: my university was home to some of the most vicious, lethal, and rare diseases in the world. My friends had every disease known to humanity including leprosy, tuberculosis, mesothelioma, and Waldenstrom's macroglobulinemia.[56]

Recent surveys have questioned the widely held view that medical students are more likely than others to have excessive anxiety about

[55] Jerome K. Jerome, *Three Men in a Boat (To say nothing of the Dog)* (Bristol: Arrowsmith, 1927, first published in 1889) p. 9.
[56] Enrique Soto Perez de Celis, 'Studying with the enemy (effects of medical students self-diagnoses)' *Student British Medical Journal* **11** (2003), 347.

their health,[57] and some writers suggest that the whole concept of medical studentitis has been based on insufficient evidence.[58] Nevertheless, it cannot be denied that medical knowledge has a certain impact on students' perceptions of their own health; knowledge always creates disquiet, and students' inexperienced minds can easily allow this disquiet to result in hypochondria. Therefore, medical students frequently think that they are sick when they are not; and to strike a balance, when they become physicians, they frequently think that they are not sick when they are.

b) Invulnerable physicians

Within medical culture, illness is perceived as being 'inappropriate' for doctors; an ethos of invulnerability prevails.[59] Young doctors, perhaps modelling themselves on their senior teachers and colleagues, learn not to complain or to seek help because to do so is to admit weakness.[60] They deny their symptoms or their meaning, hold the delusion of being indispensable, feel reluctant to place personal needs above the desire to satisfy demands from patients and colleagues, and many physicians rarely take sick leave and often work when they feel significantly unwell.[61] This is particularly worrying if one considers that usually the job that physicians are required to do entails many threats to physical, and, especially, to mental health, what Ellard refers to as 'the disease of being a doctor.'[62] According to relevant and relatively recent studies, physicians indicate that objective, personal medical attention is not needed, despite the effect of the situation on their personal relationships

[57] Oliver Howes, Paul Salkovskis, 'Health anxiety in medical students' *The Lancet* **351** (1998), 1332.
[58] Gurminder Singh, Matthew Hankins & John Weinman, 'Does medical school cause health anxiety and worry in medical students?' *Medical Education* **38** (2004), 479-481.
[59] Chrystal Jaye & Hamish Wilson, 'When general practitioners become patients' *Health* **7** [2] (2003), 202.
[60] *Ibid.*
[61] Stuart Schneck, '"Doctoring" Doctors and Their Families' *JAMA* **280** [23] (1998), 2039.
[62] John Ellard, 'The Disease of Being a Doctor' *Medical Journal of Australia* **2** [9] (1974), 318-322.

and ability to work,[63] while almost half of them do not identify a primary care physician other than themselves.[64] As a general practitioner remarks: 'It is as if we, as docs, can accept other people's humanity ... but we don't seem to be able to accept it in ourselves.'[65]

To be sure, physicians are humans, even if they tend to forget it often. There are times, like in the case of personal illness for instance, when it is crucial not to forget it and to behave like humans. If the role of the invulnerable physician to which they are accustomed does not tolerate personal illness, they need to get out of it, and deal with the reality of their human vulnerability. It is the most reasonable thing to do, and yet it seems that they cannot do it. They cannot see themselves as weak humans when they stand next to the god of Medicine all the time. They resemble generals who command a mighty army from the top of a hill; they fight the enemy forces from a distance and it is as if it has never occurred to them that some of those forces may be close enough to pose a threat to the general. Eventually, the enemy comes so close to the physician that it is impossible not to perceive it, however much he has tried to deny what has been happening. Then he bravely decides to fight alone, supposing that if he is able to protect other people, he surely can protect himself. But illness is often so very strong an enemy that the physician is forced to admit that he is not invulnerable and needs help.

c) The physician/patient

The situation does not get much better when the physician accepts his illness and employs other physicians to assist him. He never becomes a complete patient, as the physician's role 'sticks to him like a burr.'[66] The physician/patient is a very peculiar case, and the same applies to the therapeutic relationship which is established with the treating physician.

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[63] Suzanne Campbell, Diane Delva, 'Physician do not heal thyself: Survey of personal health practices among medical residents' *Canadian Family Physician* **49** (2003), 1121-1127.
[64] Ilene Rosen, Jason Christie, Lisa Bellini, David Asch, 'Health and Health Care Among Housestaff in Four U.S. Internal Medicine Residency Programs' *Journal of General Internal Medicine* **15** [2] (2000), 116-121.
[65] Jaye & Wilson, *op. cit.*, at 221.
[66] Humphry Osmond, Miriam Siegler, 'Doctors as Patients' *The Practitioner* **218** (1977), 835.

'Both parties enter into a corrupt bargain to be nice to each other even at the risk of overlooking important (and perhaps fatal) medical problems.'[67] Some writers have tried to shift the blame entirely to the treating physicians, suggesting that they feel happy to 'unload some of the diagnostic responsibility back onto the patient and ask him, in a sense, to treat himself ...'[68] It has also been said that some physicians 'have even gone to distant towns, where their medical identity was unknown, in the hope of being treated like an ordinary patient ...'[69] But treating physicians are not to take all the blame if the physician/patient receives a different – and lower – quality of care than other patients; if the physician/patient is able to abandon his medical authority and acquire the role of the patient, then the treating physician shall be treating a patient instead of consulting with a colleague and the corresponding care shall be pretty normal. However, judging from all the above mentioned reports, it is obvious that sometimes this is simply impossible.

Inseparable roles

The role of the physician is so powerful that the physician *becomes* the role. It is very difficult afterwards to turn over a new leaf and become a patient. In a physician-physician/patient relationship it is difficult to remember which one is the doctor.[70] But this difficulty goes deeper once we consider that a patient is just a type of layperson. The physician cannot be any type of layperson; this does not mean that he cannot be anything else apart from physician, but that he cannot be left without any traits of his medical personality. Perhaps it is possible for double, or even multiple roles to be acquired by the same person; but they can never be as distinct from each other as it was thus far supposed. The physician's personality cannot be suppressed to such a degree as to leave the field entirely clear for the layperson. The physician and the layperson coexist

[67] Don Lipsitt, 'Doctoring Doctors' *JAMA* **281** [12] (1999), 1084.
[68] Joseph Philips III, 'Caring for Other Physicians' *New England Journal of Medicine* **308** [25] (1983), 1543.
[69] Osmond & Siegler, *op. cit.*, at 834.
[70] Alex Freeman, Kate Adams, 'Looking after doctor patients' *British Medical Journal Career Focus* **326** (2003), S105.

within the same individual but they are not separated. The fact that the physician cannot be a normal patient is an example demonstrating this situation. When sick, he is neither a physician nor a patient; as it was noted, he is a physician/patient.

I have emphasized the negative aspects of the physician's response to illness, so it is fair to mention that sometimes he can also be an excellent patient, even if he cannot be an authentic patient. His practice can also be greatly benefited by the process of a disease, as 'for the physician, the greatest lessons may be found in personal illness.'[71] Perhaps a great lesson is that the physician remains a physician all the time; it is impossible to give up this role in favour of another one and then simply take it back. Being a physician is a full-time profession in every possible way. The physician cannot alternate between his professional role and any other role, and keep them separate from each other. There are no double roles; only mixed ones. And this view shall be discussed at length in Chapter 9.

Conclusion

In this chapter, I discussed some cases where the effort to use double morality as an explanation utterly failed. In the first section, we have seen the duty of confidentiality to the patient clashes with the duty to protect the public without any signs being clearly visible as to which duty prevails. The reluctance which physicians show to 'blow the whistle' confirmed this view. In the second section there was more confusion for the physician as the complexities of defensive medicine, with an emphasis on 'Bad Samaritan' laws, were discussed. And, finally, the third section, which presented the example of the sick physician, further supported the view that roles cannot be always as clear as the theory of double morality assumes. Thus, it became apparent that the concept of double morality encounters many difficulties which cannot be surmounted. These difficulties shall be analysed separately in the next

[71] David Freeman 'Heal Thyself' in Michael LaCombe (ed.) *On Being a Doctor* (Philadelphia: American College of Physicians, 1995) p. 64.

chapter, where I shall argue that the theory of double morality as described is wrong, and try to find a new direction for it.

Chapter 7

DOUBLE MORALITY AS A FAILED CONCEPT

Having discussed practical applications – and practical problems – of the theory of double morality, and having identified important difficulties in practice which put the whole concept under serious doubt, it is time to go back to the theoretical context and reconsider the discussion which took place in Chapter 3. When I explained the theory of double morality many possible objections arose, but I preferred to postpone extensive discussion until the presentation of practical examples, which would provide a more complete picture of the theory. Now that this has been done, and revealed many weaknesses, a number of theoretical problems can be analysed, and perhaps used to explain those weaknesses.

I) The problems with double morality

The concept of role morality and all that comes with it – the god of Medicine, the ideal physician, and the physician's submission – and the concept of double morality are interdependent. This means that every problematic aspect of double morality shall have an impact on the concept of role morality as well; and if there are no satisfactory answers to the objections which shall be raised, double morality shall be rejected. Whether everything which was part of that theory has also to be rejected will be discussed later on. For the time being, I shall start identifying problems.

Divided Self

It was said that there were two personalities within every individual physician; the physician and the layperson, with their corresponding moralities. It was also implied that these two personalities do not meet

with each other, thus avoiding the conflict of their moral values. Finally, it was assumed that the god of Medicine chooses, on behalf of the individual physician, the personality which shows up depending on the circumstances, as an extra course which medicine's hidden curriculum offers to the physician, probably without his being aware of it. The discussion of practical cases clearly demonstrated that it does not work this way. The cases of defensive medicine, professional caring, medical confidentiality, the religious physician, and the sick physician all show that the role of the physician is by no means entirely separated from the layperson; there is confusion about what the right conduct is, and the professional boundaries are far from clear. It is not possible to ensure that a 'clean' role morality or common morality shall be used without any interference coming from the adversary. This is why I stated earlier that the physician's role should be seen perhaps as 'disturbed'.

All these remarks should be expected to a certain extent because it does not seem normal for two distinct personalities to exist within the same individual. In describing someone suffering from schizophrenia, Laing notes that 'someone else's personality seems to "possess" him and to be finding expression through his words and actions, whereas the individual's own personality is temporarily "lost" or "gone".'[1] This sounds like what happens in the case of the physician according to the theory of double morality; the layperson is the true personality, but there are instances where the individual becomes possessed by the personality that the god of Medicine sends to him, that of the physician, temporarily suspending that of the layperson. Of course Laing admits that 'a man without a mask is indeed very rare,'[2] but he also distinguishes the normal person who wears a mask from the schizophrenic: in the former, a good number of his actions may be virtually mechanical, while the latter characteristically dissociates himself from much that he does.[3] As was remarked, the physician under the double morality perspective justifies his immoral (for the layperson) actions, and is able to make some difficult

[1] R. D. Laing, *The Divided Self: an existential study in sanity and madness* (Harmondsworth: Penguin Books, 1969) p. 58.
[2] *Ibid.*, p. 95
[3] *Ibid.*.

decisions by shifting the responsibility to the mighty god of Medicine, and relying on his power. For example, Dr Arthur killed an infant in the name of medicine just like another physician allocates scarce resources – and therefore decides who lives and who dies – based on his medical authority. The theory of double morality explains these actions by suggesting that they are in a sense dictated by the god of Medicine, and that the individual, suspending the layperson's personality and his common morality, obeys. Therefore, it is not about a normal person who wears a mask, but about one suffering from dissociative identity disorder. Then the theory of double morality actually suggests that every physician suffers from that disorder, and this is not easily defended.

Furthermore, I have to argue that even if the element of schizophrenia cannot be established in double morality's suggestions, wearing a mask is still the wrong approach. Earlier, in Chapter 5, I referred to the physician's mask with the remark that it should be removable for the physician to be able to switch between his two personalities and their moralities. But, when I said that, I did not consider a very important objection, coming from Jean-Paul Sartre; for him, wearing a mask or playing a role constitutes 'bad faith', and by doing so one deceives first of all oneself.[4] Individuals are free and fully autonomous, but 'the reality of our freedom is so unbearable that we refuse to face it ... refusing to freely make ourselves what we are, we masquerade as fixed essences by the adoption of hypocritical social roles and inert value systems.'[5] Bad faith is an evasion of responsibility, and the physician who acts by adopting the pre-made physician's profile is denying his own self, and becomes a representation.[6] Personal and professional selves have to be experienced as an integral part of the whole.[7]

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[4] Jean-Paul Sartre, *Being and Nothingness: An Essay on Phenomenological Ontology* [translated by Hazel Barnes] (London: Routledge, 2000, first published in 1943) p. 48.
[5] Stephen Priest (ed.) 'Bad faith' in *Jean-Paul Sartre: Basic Writings* (New York: Routledge, 2001) p. 204.
[6] Sartre, *op. cit.*, p. 60.
[7] Kristin Henriksen, Ebba Holme Hansen, 'The threatened self: general practitioners' self-perception in relation to prescribing medicine' *Social Science & Medicine* **59** (2004), 50.

I do not want to further analyse these views, which would lead the discussion to the theory of French existentialism, and all the problems that come with it. I just want to mention an example which illustrates the concept of bad faith, and shows that it leads to moral stagnation. Imagine that when the country's Prime Minister returns home after a hard day's work he is able to slip off his role along with his suit, and become a layperson who sits on his sofa to watch the news on the television and read his newspaper. Then he starts criticising the government's actions and decisions as these are presented in the press, just like every layperson is allowed to do. But after complaining for some time, he does not do anything else about the bad situation of his country and he goes to bed. This is exactly how non-politicians deal with politics: they criticise the government, they express their opinions to themselves and to their spouses, and then they occupy themselves with other, more personal affairs. Besides, they can never get the whole picture from what the media tells them. This is totally acceptable. But the Prime Minister cannot simply criticise the government if any improvement is to take place; he must criticise himself, because, after all, he is the government. The same is true with physicians. Medicine has made so much progress because, throughout the years, physicians were open to self-criticism and they learned from their mistakes. To be sure, laypersons have been criticising them as well, but there are many aspects of medicine which laypersons do not understand and cannot criticise. If the physician acts in bad faith, and evades his responsibility, then this beneficial self-criticism cannot take place and progress cannot be made.

Serving medicine's interests

I supported the view that by devoting himself to the medical profession the physician becomes a servant of the god of Medicine, and also that in this way it is not the patients' interests that the individual physician promotes over his own, but rather the profession's interests. This is why, for example, whistleblowing is discouraged in medical culture, even though it is officially promoted by regulating bodies such as the General

Medical Council (as noted, role morality streams from a lengthy medical tradition which is beyond recently approved guidelines). In this case then, double morality has to be used to switch from role to common morality, and for the physician to report a colleague's poor practice to serve the public's interest. It was noted that it does not always work, as another proof of double morality's inefficiency; and that when it does work it constitutes an assault on the god of Medicine.

This is the wrong approach, for it implies that the physician has to stop being a physician to promote patients' interests, denying in this way one of the main aspects of the medical profession. Of course, there are cases where it is perhaps justifiable for physicians to behave in inappropriate ways when this is necessary in order to fulfil their profession's obligations to society (undertake actions outside the role's prescribed means to achieve the role's ends),[8] or re-define these obligations. For example, when a physician goes on strike, he switches to common morality and stops being a proper physician, but he does not violate the profession's contract with society in this way; he simply negotiates the terms, or makes a demand. Role morality does not find this behaviour appropriate, even though it can be justifiable. However, this is not the case when there is a breach of the contract. And this is what happens when physicians are devoted to medicine as a profession and not to what this profession represents – in other words, when they are the profession's servants. Kennedy asks physicians to take back the power to control their lives, and to become masters of medicine, not its servants.[9] This seems to be the correct approach, instead of trying to escape only temporarily from the dominance of the god of Medicine and the dictates of role morality. Double morality does not seek to correct a wrong approach, but rather to move to another level where an alternative approach can be found. And in this way one may become a fugitive, but not a master.

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[8] Mortimer Kadish & Sanford Kadish, *Discretion to Disobey: A Study of Lawful Departures from Legal Rules* (Stanford: Stanford University Press, 1973) p. 31.
[9] Ian Kennedy, *The Unmasking of Medicine* (London: George Allen & Unwin, 1981) p. 25.

Kadish and Kadish believe that the solution lies in imposing a 'finite surcharge' on one's obligation to one's role.[10] This means that, when a decision has to be taken, the role morality should always be present, but without prevailing unqualifiedly over common morality, as would happen if an 'infinite surcharge' were imposed on role obligations; this would mean that a person puts his obligation to a role unqualifiedly first, and, in the case of the physician, that he becomes a servant of the god of Medicine. On the contrary, the physician should be at liberty to act on his own judgment in certain circumstances, and be able to expect his decision to be supported by others in related roles; 'this is the finesse that introduces flexibility into role behaviour and reduces the instances in which people simply step out of their roles in order to do what must be done.'[11] In other words, the physician should never think of himself as a mere role-holder, but rather as an individual with various commitments, on which he has to impose the proper surcharge and make the appropriate, personal decisions. Common and role morality should both be present at the same time, as opposed to what the double morality scheme claims. The physician has to keep his individuality, and not to become a servant; and this individuality is another problem which I have to discuss.

Individuals under threat

Medicine is, to a certain extent, autonomous, but the autonomy of its members is quite peculiar. It is a kind of 'group autonomy', a situation where the group, rather than the individuals within the group, has dominion over the affairs of the group; and Wellman, who examines this issue, finds no way out of this paradox.[12] We can assume that when physicians resort to their role morality their course of action streams from their group autonomy, and this makes their behaviour quite predictable. The same happens with every homogeneous group which is influenced

[10] Kadish & Kadish, *op. cit.*, p. 28.
[11] *Ibid.*, p. 29.
[12] Christopher Heath Wellman, 'The Paradox of Group Autonomy' *Social Philosophy & Policy* **20** (2003), 265-285.

too much by a certain culture. We have been provided with stereotyped pictures of persons engaged in various occupations, and these types are expected to react to the situations of life in characteristic manner.[13] But, as Warnock argues, nobody wants to be predictable:

> We want to be, not random in our conduct, but to a certain extent *unpredictable*. We want to be able to claim to have made, for example, a difficult choice ... to have decided on our own to take a course, even if that course turned out in the end to be disastrous.[14]

There is no doubt that individuals value their freedom of choice and action; but they also want other people to acknowledge that a particular choice is individual, and not guided by one's social role – and therefore, predictable. In a way, individuality lies in unpredictability. Lack of it causes stereotyping.

> Stereotyping is the process through which we come to judge other people and respond to them in terms of their social category memberships ... Stereotyping can be contrasted with the process of individuation, whereby one considers the unique constellation of attributes that a particular individual possesses.[15]

Bodenhausen notes that people are more likely to use stereotypes when they are busy or distracted, because individuation is more work than stereotyping; and he argues that physicians, who are usually very busy, use stereotypes when treating their patients.[16] For the same reasons, one can say that physicians use stereotypes when referring to themselves. Due to his lack of time and energy, the physician's individuality is under threat; one prefers to acquire a standard personality which characterises physicians, and the already made moral recipe which the god of Medicine offers, instead of trying to become a *unique*

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[13] Everett Cherrington Hughes, *Men and Their Work* (London: The Free Press of Glencoe, 1958) p. 24.
[14] Mary Warnock, *An Intelligent Person's Guide to Ethics* (London: Duckworth, 1998) p. 93.
[15] Galen Bodenhausen, 'The Role of Stereotypes in Decision-Making Processes' *Medical Decision Making* **25** [1] (2005), 112.
[16] *Ibid.*, at 116.

physician. Thomas Hobbes would describe the individual who resorts to this predictable behaviour as an 'Artificial Person,' that is, representing the words and actions of another, and opposed to the 'Natural Person.'[17] These people tend to be predictable, not only from the point of view of the external observer, but also from their own. This is why a decline in personal moral awareness is noted among medical students;[18] as they become physicians, they tend to stereotype themselves.

Perhaps individualism is indeed far more difficult to achieve, as there is always a large and complex support system which stands behind the physician, never leaving him entirely on his own,[19] to say nothing of the threats to the individual coming from external forces such as strategies of cost containment and rising consumerism.[20] In addition, individualism surely is more complex as a procedure than the simplified process of choosing among the moral recipes which double morality offers. However, when the individual becomes a 'complete moral chameleon,'[21] personal values disintegrate, and one's identity is under serious threat. As we have seen, double morality looks convenient because it evades moral conflict by offering two separated alternatives. But, as Chambliss notes, the great ethical danger is not that, when faced with an important decision, one makes the wrong choice, but, rather, that one never realises that one is facing a decision at all.[22] Conflict is always troublesome and it sometimes leads to 'moral distress'[23] but it is in the negotiation of it that an individual can construct a real professional

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[17] Thomas Hobbes, *Leviathan* [edited by Richard Tuck] (Cambridge: Cambridge University Press, 1996, first published in 1651) p. 111.
[18] Johane Patenaude, Theophile Niyonsenga, Diane Fafard, 'Changes in students' moral development during medical school: a cohort study' *Canadian Medical Association Journal* **168** [7] (2003), 840-4.
[19] Harmon Smith, 'Threats to the Individual' *Social Science & Medicine* **11** (1977), 451.
[20] David Armstrong, 'Clinical autonomy, individual and collective: the problem of changing doctors' behaviour' *Social Science & Medicine* **55** (2002), 1776.
[21] Kevin Gibson, 'Contrasting Role Morality and Professional Morality: Implications for Practice' *Journal of Applied Philosophy* **20** [1] (2003), 20.
[22] Daniel Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics* (Chicago: The University of Chicago Press, 1996) p. 59.
[23] Sofia Kalvemark, Anna Hoglund, Mats Hansson, Peter Westerholm, Bengt Arnetz, 'Living with conflicts-ethical dilemmas and moral distress in the health care system' *Social Science & Medicine* **58** (2004), 1076.

character.[24] If we want to reinforce the moral primacy of individual choice, and stress moral awareness, then double morality, which avoids moral conflict, has to be rejected.

Against idealism

The concept of the ideal physician which the theory of double morality promotes refers to *Medicine's* idealism. It says that when the individual is in his role and acts as a physician, then he should strive to be as good as possible by trying to follow the actions of an ideal role-model; and that, even if this role-model represents an impossible morality, the individual's effort to reach it should never stop. This point looked good when I discussed what the ideal physician was. It exhibits a kind of idealism which can be very useful, both for physicians and for their patients. It is probable that medicine managed to make so much progress because of its inherent idealism. Bertrand Russell notes that scepticism is wicked because myths help to win wars, and so a rational nation would be killed rather than kill.[25] The same is true for physicians; if they were rational and sceptical enough to realise that the ideal physician is a myth and that they can never be like him, they would not have tried so much for medicine's progress throughout history. So why do I turn against idealism and believe that the concept of the ideal physician should be rejected?

It is true that medicine would not be where it is now if idealism had never constituted a part of it, and I do not refer only to scientific progress but also, and mainly to the respect which the profession enjoys. But times change, and it does not seem right to let ideals guide one's course of action anymore. Not that it would be definitely bad; but it is definitely not possible, for our age is a very sophisticated one. For example, ideally, mental health professionals should avoid boundary violations, but it is acknowledged that this rule is 'aspirational in nature' and can never

[24] David Stern, 'The Development of Professional Character in Medical Students' *The Hastings Center Report* **30** [4] (1999), S26-S29.
[25] Bertrand Russell, *Sceptical Essays* (London: George Allen & Unwin, 1928) p. 16.

be fully observed.[26] Ideally physicians should be caring and compassionate in a professional way; but it is acknowledged that most physicians have become cynical, developing an 'us versus them' mentality.[27] Academic leaders and health care professionals have been trying for years to change the situation, prevent the shift towards cynicism, and reinforce medical idealism, without any profound success.[28] Perhaps it would be better if they could change their approach and discredit this idealism as a leftover of a different era.

Indeed, idealism presupposes an ideology, and ideologies can be defined as prescriptions for unreflective ways of behaving.[29] The ideal physician refers to the ideology of orthodox medicine, the one which was illustrated as a god of Medicine who knows what the right thing to do is. But, as Jones remarks, there are parallels between medical orthodoxy and religious orthodoxy which cannot be ignored.[30] The notion that there is only one right belief or course of action seems outdated. The suggestion that there is an ideal physician as a point of reference for every individual physician is disturbing. Susan Wolf argues that even if one could attain the moral perfection which an ideology demands, and become a 'moral saint', then that would require either the lack, or the denial of the existence of an identifiable, personal self.[31] So we are coming back to the point that stresses the importance of the physician's individuality and warns against his becoming a servant of medicine. Idealism as reflected in the image of the ideal physician is against the individual and his personal moral awareness. Therefore, the idealism that double morality presupposes is certainly problematic; another weakness of the theory has been identified.

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[26] Michael Gottlieb, 'Avoiding Exploitive Dual Relationships: A Decision-Making Model' *Psychotherapy* **30** [1] (1993), 41-48.
[27] Jack Coulehan and Peter Williams, 'Vanquishing Virtue: The Impact of Medical Education' *Academic Medicine* **76** [6] (2001), 600.
[28] John Goldie, 'The detrimental ethical shift towards cynicism: can medical educators help prevent it?' *Medical Education* **38** (2004), 232-238.
[29] R. Kenneth Jones, 'Schism and heresy in the development of orthodox medicine: The threat to medical hegemony' *Social Science & Medicine* **58** (2004), 711.
[30] *Ibid.*
[31] Susan Wolf 'Moral Saints' in Roger Crisp and Michael Slote (eds.), *Virtue Ethics* (New York: Oxford University Press, 2000) p. 84.

Furthermore, double morality probably disregards the necessary social influences on the medical profession, as the ideal physician and his role morality represent 'pure medicine', independent of, but also isolated from any other social institutions. The right conduct which the ideal physician exemplifies is right, not from the public's or an individual physician's point of view, but from the medical profession's point of view. In other words, it is a clearly professional perception of what is right and wrong, without society's consent. The god of Medicine represents a separate culture which is supposedly untouched by the world outside medical contexts. But this is not possible, because the medical profession constantly interacts with its social setting, and is directly influenced by any social changes which take place. The challenge for physicians is to be accountable to society and its changing values while at the same time protecting core health care values.[32] Besides, as Merton notes, attacks upon the integrity of any science (and medicine has received far too many) have led scientists to recognise their dependence on particular types of social structure.[33] These social influences are clear in a formal sense; codes of ethics are re-evaluated, guidelines change, and formal lessons follow society's demands. Informally, however, the god of Medicine and his hidden curriculum are not affected, or they do not seem to be affected, as they continue to respect the old medical tradition. This hidden attitude creates confusion.

We have seen that in a number of cases physicians do not know exactly what to do. They may have no guidance, or their guidance may come into conflict with what they have learned. Supposedly, the god of Medicine could give the solution, as he represents the highest medical authority. But when the situation is complex, it seems that he remains silent. In the *Tarasoff* case, for example, one would expect that the god should persuade the physician to remain silent and respect medical

[32] M. K. Wynia, S. R. Latham, A. C. Kao, J. W. Berg, L. L. Emanuel, 'Medical professionalism in society' *New England Journal of Medicine* **341** [21] (1999), 1614.
[33] Robert K. Merton, *Social Theory and Social Justice* (New York: The Free Press, 1942) p. 604.

confidentiality. However, it seemed that he did not know what to say, and the physician eventually acted in a way which lay between confidentiality and revelation, making a mixture of his role and his common morality. The cases of whistleblowing and of defensive medicine are similarly confusing for the god of Medicine, and against the notion of a 'clean' role morality. There are too many medical situations which cause uncertainty for the god of Medicine, especially in the modern age; and when the god of Medicine is uncertain, so is the individual physician. After all, it is because of this confusion and uncertainty that the teaching of medical ethics has become a necessity in medical schools.

In other words, it looks as if the god of Medicine, based on the medical tradition, knows what the right course of action would be in an ideal world, but also acknowledges that this knowledge cannot always be applied, when all things are considered, in the real world. There are some simple cases where a distinction between role and common morality is easy to make, and the correct choice between them seems to be obvious. But there are also complex situations, where it is clear that a notion of separate role or common moralities does not function, and a god of Medicine who guides the physician's actions based on some old and tested rules is a somewhat naïve idea, or even comic when the god's confusion becomes too apparent. The physician cannot trust a god with uncertain power who commands when the situation is easy, but merely offers an opinion, or remains silent, when the situation is hard; and, most of the time, situations are hard. As Hølm notes, 'because the real structure is so complex decision-making is also complicated.'[34] Therefore, it is normal that one cannot rely on double morality and the 'pure medicine' which it demands.

II) Rejection of double morality

Thus I have explained why the theory of double morality is not a sound theory. Many weaknesses, inefficiencies, and practical and theoretical

[34] Søren Hølm, *Ethical Problems in Clinical Practice* (Manchester & New York: Manchester University Press, 1997) p. 171.

problems have been identified, and they inevitably lead to the conclusion that it should be rejected – despite the trouble I have been going through in previous chapters in trying to support it. To be sure, there can be exceptions. A physician may find it easy and convenient to separate his professional from his lay side. Even if double morality malfunctions in certain cases, it cannot be denied that there are instances where it can be very useful and effective – and some of them have been discussed in detail. So what happens with the cases where double morality seems to function? Could these cases save the theory and preserve it as an alternative approach which would be used in the form of exceptions?

Probably not, as the weaknesses I considered were not only of a functioning kind; one of the conclusions was that the physician's individuality is under threat and that this results in reduced moral awareness; in other words, double morality is *amoral.* The physician does not choose to have double morality. It is not like one becoming a deontologist or a utilitarian because one thinks that one theory is better than the other. No physician states that he is a double-moralist, and ignorance of the concept of double morality, or of the name that I have given to it, is not the only excuse. When the physician uses double morality, he actually does it without being conscious of what he does, and can therefore be considered as amoral. It is like a person who has no morality of his own, and whose roles and identities simply lend him theirs. Now, of course, many philosophers do not follow a particular moral theory; they either choose one according to the situation or their philosophical evolution, or they combine elements of many theories, in the sense that many philosophers are not, for example, clear utilitarians or deontologists. But it is certain that they do this consciously, and after serious examinations, while the theory of double morality does not provide this reassurance in the case of physicians.

As I have explained, the theory of double morality is not much of a moral theory, as it basically deals with how it is possible for the physician to function in certain ways, rather than with the question of which are the best ways in which to function. Nevertheless, it proposes an explanation of the physician's behaviour which excludes basic moral considerations

from his personality. It does not say that the physician does something immoral; but it presents the physician as a 'moral chameleon' without an established moral awareness. And even if physicians do not use double morality exactly in the way I have described, they still can use patterns of it. This is the point where one stops considering double morality as a failure of an explanatory theory of physicians' behaviour and starts thinking that it is actually an enemy of morality.

I do not think that there is a need to continue the attack against double morality. It must be clear by now that it fails as a conceptual framework, and that it should be rejected; furthermore, it fails as a moral tool, as its relationship with morality is surely problematic. It fails in theory and in practice, and it constitutes a wrong approach to the understanding of the physician's thoughts and actions. Therefore, I am quite sure I have to reject it. But, if we were to leave it at that, all this thesis would have to offer is a rejection. That would be too simple. In my view, there is something more important and useful to be gained from the analysis.

PART III

A new concept of 'double morality'

Chapter 8

SALVATION OF DOUBLE MORALITY: THE THEORY OF VIRTUE

After ascertaining that the theory of double morality as it has been presented thus far fails, and after rejecting it in the previous Part, one might say that this thesis has been driven to a dead-end. However, it is my belief that the concept of double morality can be reconstructed in a more functional form. Based on certain elements of it which can still be used, avoiding past mistakes, and drawing inspiration from a moral theory which is compatible with double morality in many ways, that is, virtue ethics, I shall try a different approach which is much more promising. This refinement of double morality shall take place gradually until the end of the thesis. In this chapter, I shall first point out the elements of the old theory that can still be used; then I shall discuss separately the theory of virtue and explain why I believe that it is suitable for the reconstruction I am attempting.

I) How to save double morality

In order for the concept of double morality to become more challenging, from this point onwards the spirit of the thesis has to change. A simple explanation of a theory, and of its weaknesses might be a useful achievement, but not a particularly satisfying one. In addition, a simple conclusion that this theory and its applications have to be avoided would be a negativist approach, showing no signs of real interest in the problem. But an effort to provide a new insight by using the remains of the failed theory seems to be worthwhile. Since we have seen that a theory which explains morality without being a moral theory is in fact amoral, I shall also concentrate on exposing its credentials as a moral theory; this means that, from now on, I shall be clearly talking about how the physician should be, instead of simply assuming that there is a standard common morality, a certain role morality, and a mysterious god

of Medicine. Therefore, the rest of my thesis shall be an effort to refine and reconstruct the concept of double morality by using the experience which has been gained in the previous chapters.

What can still be used?

Many previous ideas proved to be problematic, but there are some which, in my view, deserve further attention. The complete separation between the physician and the layperson within the same individual is clearly utopian, for example, but this does not mean that there cannot be two different sub-cultures interacting with each other. The fact that the physician is a different entity from the layperson cannot be disregarded because of double morality's failure; in Chapter 2, I have extensively discussed, and, I think, adequately supported the physician's peculiarity, irrespective of any theory of double morality. And the fact that behind the physician there is also a layperson culture is also indisputable; no one is born a physician, and an individual who would manage to forfeit permanently his lay characteristics and acquire a pure medical personality would not resemble a human being and he would become the 'weird medical creature' which I mentioned earlier. Common morality exists, even if it is only a groundwork on which one's personal morality is developed. Therefore, despite double morality's rejection, the idea that there are two different sub-cultures, and consequently two different moral orientations within the physician seems to be correct. Role morality is not a complex instance of common morality, as Judith Andre suggests;[1] it is distinct. But the assumption that one can keep these two moralities entirely separated is incorrect.

Also, the assumption that what is good varies according to the circumstances cannot be so easily rejected; and the role one holds is a very important factor which influences the circumstances, but it is not the only one. It would be wrong in this case to accept that, simply by virtue of his medical role, a physician could know what the correct course of

[1] Judith Andre, 'Role Morality as a Complex Instance of Ordinary Morality' *American Philosophical Quarterly* **28** [1] (1991), 73-80.

action is. There are far too many moral elements in any given situation which have to be kept in mind, and relying on role morality is clearly to oversimplify the matter. The same would be the case, of course, if one relied simply on common morality and disregarded the physician's medical culture. The important point to note here is that one cannot know before-hand what the correct course of action is, because what is moral is different for different persons in different situations. This is why common morality and role morality are different. But if they are used independently of each other they establish their own rules and ignore other circumstances apart from the role one holds. This shall be further analysed later on, with particular emphasis on one's self.

Accordingly, 'the ideal physician' is a weak idea as it assumes that the good – reflected in an ideal physician's actions – is well known, but cannot be reached for various reasons. There is not a universal ideal which is the same for every physician. A personal ideal may exist, but it is certainly not preset. This is what Nietzsche means when he proposes to overthrow idols (his word for 'ideals,' as he explains),[2] and this is why I turned against idealism earlier. But even if *the ideal physician* does not exist, there can be an *ideal self* that one is capable of positing as the goal which is itself the ethical task,[3] and I shall turn to discuss this point in detail in the next chapters. Therefore, I conclude that idealism is weak, but also that it cannot be rejected completely; especially if this rejection results directly in cynicism because, as Warnock states, 'to be a cynic is, simply, depressing.'[4]

And what about the god of Medicine who put forward the ideal physician as a role model for everyone to follow? I think that this divine concept has also to be rejected, but it is not as simple as it seems, and some important explanations have to be provided.

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[2] Friedrich Nietzsche, *Ecce Homo: How One Becomes What One Is* [translated by R. J. Hollingdale] (Harmondsworth: Penguin Books, 1992) pp. 3-4.
[3] George Stack, *Kierkegaard's Existential Ethics* (Alabama: The University of Alabama Press, 1977) p. 70.
[4] Warnock, *op. cit.*, p. 118.

Fall of the god of Medicine

The god of Medicine was the central concept of the theory of double morality. It symbolised the medical culture which every physician internalises to some degree, and, because this culture is so powerful and so peculiar and different from lay culture, it was viewed as the supreme medical authority. The god of Medicine could dictate what is good and what is bad for a physician based on a purely medical view. From the concept of the god of Medicine comes the ideal physician and his role morality, and from these notions follows the theory of double morality. Now that I want to leave this failed account of the theory behind and refine the concept of double morality, this god has to fall before I begin.

It is not wrong to accept that there is a certain medical culture which influences the physician's actions. This culture is immense and elaborate, and its existence is beyond dispute.[5] What is wrong is to perceive it as a god, and let the medical profession become a medical religion. This is not only a conceptual problem. The god of Medicine did not come into existence because I described him; he constantly comes into existence when physicians adopt certain attitudes of extreme devotion to their work and absolute respect to its rich tradition, or when they unreflectively attribute importance to it. When they do that, they allow medicine to take them over as individuals, and that is the point where the god of Medicine exists, even if I am the only one referring to this as a god. It is easy for a physician to be caught in this trap, as the god of Medicine is mainly expressed through unofficial methods such as the hidden curriculum. And, as we have seen, when the god of Medicine comes forth, all the other considerations lose much of their force. To be sure, this is not always the case, for I have also mentioned the god's confusion, and his recent inability to provide clear guidance in many instances. But this does not matter; if anything, it facilitates the fall of the god of Medicine.

[5] Hughes, *op. cit.*, p. 118.

So the medical culture exists, and it has to be respected and used wisely; but it does not have to be deified. The individual physician does not have as his purpose to serve the medical tradition; quite the opposite, it is the medical tradition which has to serve the individual physician. There cannot be a god of Medicine who dictates what should be done based on traditional knowledge. Proust says that medicine is a compendium of the physicians' successive errors,[6] and Southey confirms it when he speaks of Louis XIV's physician: when the king was ill, they called people with similar symptoms to a minister's house where the royal surgeon could practice on them. Many of these patients died, but, in the end, the surgeon gained valuable experience, and he was able to operate on the king with great success.[7] Could this surgeon forget the deaths he caused, and keep only the knowledge that he gained to save the king? This would be the first step towards the past's unjustified deification. Similarly, modern physicians should be able to see the whole picture, past and present. It is only then that one can understand that any deification is the result of misdirection; and, after that, and quite naturally, the god of Medicine has to fall.

Everything is now ready for double morality's reconstruction. I think that the most important problem was the concept of the god of Medicine which was inherent in the old theory of double morality. But after the god's fall, perhaps this thesis can start contributing something more essential to the field of medical ethics.

Virtue ethics as the next required step

After picking up the pieces of the failed double morality theory, the next required step is to bind them together in a new beginning, and construct another theory. In order to do that, some new ideas are needed to provide a different framework for double morality and offer some new directions. It may not be very obvious, but I believe that the good ideas of

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[6] Robert Soupault, *Marcel Proust du cote de la medecine* (Paris : Plon, 1967) p. 243 [in French].
[7] Robert Southey, *The Doctor &c* (London: G. Bell & Sons, 1930, first published in 1848) p. 291.

double morality – the ones that can still be used – shall be most efficiently expressed if put in a context of virtue ethics. I cannot fully explain this belief, probably because it is largely based on intuition rather than on logic. However, having explored the medical profession consistently in previous chapters, I think that I am entitled to this intuition. In what follows, I shall discuss the main features of the theory of virtue, without linking them directly to double morality. This general discussion is necessary in order to establish virtue theory's usefulness, and to point out the ideas which shall be of assistance in double morality's reconstruction.

II) The concept of virtue

We saw in Chapter 7 that one of double morality's deficiencies was the physician's submission to the god of Medicine that role morality required. The physician should try to approach a certain ideal imposed by the god of Medicine, and individual traits should be sacrificed whenever there is a need for the physician's, rather than the layperson's personality to come forth. From this perspective, the physician in his role was a mere servant of his profession – or, at least, that was what he was supposed to strive to become: an impersonal representative of medicine, demonstrating the profession's established moral values as expressed in his conduct and his actions. Role morality was trying to erase the individual physician's personal characteristics and make him like all the other physicians, by having a god of Medicine to dictate how the ideal physician should behave. This was the main problem; it focused on the physician's actions, not on the physician himself. The ideal physician thus described was the physician whose actions were ideal from the profession's point of view, and there was no worrying about whether the ideal physician's character was ideal, as long as his actions were. In this way, the individuality of each physician was unimportant; they were only servants, whose actions had to accord with the profession's requirements. It was not asked of them to follow a particular role model, but rather the actions of the role model.

I would like now to consider what the difference would have been if this were not the case; that is, if the ideal physician had been presented as someone like whom every physician should try to become, instead of one whose actions should be imitated by other physicians. To become like someone constitutes moral development, but to behave like someone looks more like plagiarism and can easily result in moral unawareness, as noted previously. These remarks clearly point to a theory of virtues, as they move from an act-centred morality to an agent-centred morality. But then three separate questions need to be answered. First of all, can virtue ethics in general be effective? Second, is it useful to apply virtue ethics in the field of medicine? And third, how exactly can virtues be related to the attempt I am making to refine the theory of double morality?

A brief account of Virtue Ethics

If we locate the beginning of ethics (philosophically of course, not practically) in ancient Greece, then we immediately notice that the first theories were virtue-based. In Plato's and Aristotle's writings, the central concern about morality has to do with what kind of person one should be. The traits of character which are desirable are called virtues, as opposed to the traits which are not desirable and which are called vices. Virtues and vices guide one's actions, and the ideal moral character is the one who gathers all the virtues and none of the vices. So, for the ancient Greeks, moral value is to be found in one's character rather than one's conduct; the latter depends on the former.

Many years have passed, and it would be unnecessary to describe in detail what has happened to moral theory since then. But it is obvious that virtue ethics is no longer a dominant theory, as the modern focus tends to be on acts as opposed to qualities of agents. Modern moral philosophers approach their subject by asking a fundamentally different question than the one that had been asked by the ancients. Instead of asking 'what traits of character make one a good person?,' they begin by asking 'what is the right thing to do?,' and this leads them

in different directions.[8] In *After Virtue*, MacIntyre notes that 'on the modern view the justification of virtues depends upon some prior justification of rules and principles; and if the latter become radically problematic, as they have, so also must the former.'[9] This explains why the theory of virtue ethics has continuingly been disregarded in such an open way. The main interest lies in *actions*, not in the *actor*; in rules and principles which guide actions, not in virtues and the shaping of actors. Recently, however, a number of philosophers (with Anscombe being the first) have suggested that modern moral philosophy is bankrupt, and that a study of ethics must begin by considering the concept of a virtue.[10] It sounds like an interesting idea, but in general can such an approach be effective?

Many writers are sceptical. Louden notes that '... people have always expected ethical theory to tell them something about what they ought to do'[11] and virtue ethics seems unable to say much of anything about this issue; therefore, it will be particularly weak in the area of applied ethics.[12] Also, 'in emphasizing Being over Doing ... virtue theorists lay themselves open to the charge that they are more concerned with style than with substance.'[13] Then there is always the problem of which traits are to be counted as virtues, and whether agreement on this can ever be possible; for a commonly accepted virtue, such as courage, can be used for both good and bad ends,[14] and this might lead some to think that the trait of courage is sometimes a virtue and sometimes a vice. And this leads us to the main problem of virtue theory, namely that a virtue-centred ethic cannot be significantly different from an act-centred ethic, unless it shows that the virtues which are most

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[8] James Rachels, *The Elements of Moral Philosophy* [3rd edition] (Singapore: McGraw-Hill International Editions, 1999) p. 176.
[9] Alasdair MacIntyre, *After Virtue: a study in moral theory* [2nd edition] (London: Duckworth, 1985) p. 119.
[10] G. E. M. Anscombe 'Modern Moral Philosophy' in Roger Crisp and Michael Slote (eds.), *Virtue Ethics* (New York: Oxford University Press, 2000) p. 40.
[11] Robert Louden 'On Some Vices of Virtue Ethics' in Roger Crisp and Michael Slote (eds.), *Virtue Ethics* (New York: Oxford University Press, 2000) p. 205.
[12] *Ibid.*
[13] *Ibid.*, p. 213.
[14] Greg Pence 'Virtue Theory' in Peter Singer (ed.), *A Companion to Ethics* (Oxford: Blackwell Publishers, 1993) p. 255.

important to morality have a life of their own, independent of rules and laws;[15] an agent should be committed to virtues for these virtues' sake, otherwise, as Becker notes, virtue may plausibly be treated as derivative, and matters of moral character may be exhaustively definable in the language of act morality.[16] In other words, an autonomous virtue theory should be able to present some natural virtues, that is, some traits of character which automatically and self-evidently qualify as virtues. There are obvious difficulties here.

It is not my intention to support virtue ethics as an independent moral theory, and perhaps not even virtue ethicists would want to do that. It seems highly improbable that one can overcome the above mentioned problems which the attempt to construct a complete virtue theory creates. Nevertheless, a theory of virtue can always be present as part of a larger ethical system – this must be what virtue ethicists aim at. 'Moral virtue seems best construed as a kind of internalization of moral values or perhaps moral principles or other standards of moral conduct'[17] – and internalization of moral elements means elevation of moral awareness, independently of right or wrong rules, actions, or predispositions. Therefore, virtue ethics can be useful as a theoretical tool, and a virtue-based approach can be, in a sense, effective, even without constituting a complete moral theory. Having said that, I turn now to discuss what the place of virtues is in the field of medicine.

Is virtue a useful concept in medicine?

First, one needs to discuss how the theory of virtue fits medicine in general – a relatively easy task. And second, it is necessary to find a link between virtue ethics and the concept of professionalism which I have advanced in the beginning of this thesis. If this can be done, virtue ethics can be more thoroughly explored, and contribute substantively to the new theory of double morality.

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[15] Jerome Schneewind 'The Misfortunes of Virtue' in Roger Crisp and Michael Slote (eds.), *Virtue Ethics* (New York: Oxford University Press, 2000) p. 180.
[16] Lawrence Becker, 'The Neglect of Virtue' *Ethics* **85** [2] (1975), 111.
[17] Robert Audi, 'Acting From Virtue' *Mind* **104** [415] (1995), 469.

a) Virtue ethics in medicine

Academic writers tend to refer to 'medical virtues' quite often; they proudly state that 'virtue in health care refers to the kinds of physicians we ought to strive to become.'[18] They assume that the way physicians use their ideals in their moral deliberation resembles virtue theory in style;[19] but then they acknowledge that today this basically means technical competence rather than traditional medical virtues.[20] Beauchamp and Childress, who take a closer look at the issue, seem to think that virtues support well their principle-based approach. In particular, and noting that there are many more, they identify five focal virtues in the role of the physician; compassion, discernment, trustworthiness, integrity, and conscientiousness.[21] Then they link principles and rules to corresponding virtues – for example, the principle of beneficence corresponds to the virtue of benevolence.[22] Finally they conclude that 'virtues dispose persons to act in accordance with principles and rules'[23] showing that they do not adopt a complete virtue theory but rather that they use virtue theory as complementary to their approach, in accordance with what we concluded that the place of virtue ethics is in general. Pellegrino holds a more radical view, arguing that 'the good physician will be one who exhibits those character traits which most effectively achieve and indeed are indispensable for attainment of the ends of medicine.'[24] But, in order to understand the proper ends of

[18] Daniel Sulmasy, 'Should Medical Schools Be Schools for Virtue?' *Journal of General Internal Medicine* **15** (2000), 514.
[19] A. Braunack-Mayer, 'What makes a good GP? An empirical perspective on virtue in general practice' *Journal of Medical Ethics* **31** (2005), 87.
[20] Jack Coulehan & Peter Williams, 'Vanquishing Virtue: The Impact of Medical Education' *Academic Medicine* **76** [6] (2001), 601.

[21] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* [5th edition] (New York: Oxford University Press, 2001) p. 32.
[22] *Ibid.*, p. 39.
[23] *Ibid.*, p. 51.
[24] Edmund Pellegrino, 'Professionalism, Profession and the Virtues of the Good Physician' *The Mount Sinai Journal of Medicine* **69** [6] (2002), 381.

medicine, one needs first of all the central virtue of practical wisdom;[25] and this is where we should go back to the *Nicomachean Ethics*.

According to Aristotle, 'excellence of character results from habituation ... we acquire the excellences through having first engaged in the activities'[26] (the term 'ethics' is derived from the Greek verb 'εθίζω' which means 'habituate'). This supports the view that virtues do not function without practical wisdom. For the physician who wants to be good this means that there is not a god of Medicine who can immediately tell him what the right conduct is, but rather one has to find out oneself by continuingly educating oneself. 'Moral events, or dilemmas, are not seen as unrelated, isolated episodes but instead are seen as parts of a continuous story in which one tests and cultivates one's character.'[27] On this view, character is not a permanent fixture, but rather plastic; therefore, virtues should not be treated (as by Beauchamp and Childress for example) as well-known traits which are admittedly useful, but rather as moral elements to be discovered, internalized, and constantly evaluated. This is why a virtue-based approach was incompatible with double morality, where the god of Medicine was supporting an ideal physician with established character and foreseeable courses of action; practical wisdom was lacking in double morality's approach. To sum up, the concept of virtue can be useful in the field of medicine, but practical wisdom, what Aristotle calls 'habituation', is an absolutely necessary element for this to happen.

b) Virtue ethics in the medical profession

In today's society, where 'it is an understatement to say that there are fundamental challenges to what it means to be a medical professional,'[28] there is extensive debate as to how medical professionalism should be

[25] *Ibid.*, at 382.
[26] Aristotle, *Nicomachean Ethics* [translated by Christopher Rowe] (New York: Oxford University Press, 2002) 1103a, p. 111.
[27] Michael Cawley III, James Martin, John Johnson, 'A virtues approach to personality' *Personality and Individual Differences* **28** (2000), 999.
[28] Nuala Kenny and Wayne Shelton 'Introduction: Lost Virtue: Professional Character Development and Medical Education' *Advances in Bioethics* **10** (2006), xi.

regarded. In the beginning of this thesis, I offered a personal opinion, stating that, provided that a universal role morality applies to every physician, medical professionalism is, in essence, the physician's role morality. But is this enough? If so, then why has double morality failed as a concept? This is certainly an assumption which needs to be tested, and I believe that virtue ethics can act as a catalyst for the effective linking of medical professionalism to role morality.

We have already seen that some writers, with Edmund Pellegrino being the most prominent, tend to talk about professionalism in terms of virtues. In one of his most recent articles, Pellegrino mentions that nowadays there is a trend towards the 'deprofessionalization' of medicine, that there is a view that reducing medicine to an occupation like any other would be salubrious, and that a significant number of physicians have embraced this view.[29] This presupposes that any medical virtues are ruled out as important elements in a clearly medical setting. Pellegrino is definitely against this view, as he believes that it drastically alters the nature of medicine and the physician's commitment to the sick.[30] He then admits the problem of virtues' subjectivity, but declares that it can be solved by stressing the importance of the *virtues of individuals*.[31] This is very important; it could mean a more personalised account of professionalism, an individualistic role morality in other words.

Other writers seem to agree on this point. Elliott thinks that a renewed emphasis on virtue and professionalism is almost certain to fail if it does not take account of the realities of contemporary medicine[32] (which demand an adaptation of virtues to a more personal level); Robert Veatch argues that it might be better for a virtue to be intrinsically important (with a personal value for the one who possesses it) as opposed to what he describes as 'naked virtue', that is, a 'virtue out there

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[29] Edmund Pellegrino 'Character Formation and the Making of Good Physicians' *Advances in Bioethics* **10** (2006), 2.
[30] *Ibid.*, p. 3.
[31] *Ibid.*, p. 14.
[32] Carl Elliott 'Disillusioned Doctors' *Advances in Bioethics* **10** (2006), 96.

on its own.'[33] This is why he also believes that virtues cannot be taught by professional educators, providing a short analysis of 'The Chaos of Lists of Virtues.'[34] But it needs to be noted that, nevertheless, he does not reject the notion of virtue in professional settings; he simply points out that there cannot be a common core of virtues.

Therefore, it seems that it is only if we take virtues as more personal elements instead of universal traits of character that we can find a correct use for them in medical professionalism. But then the notion of professionalism has to be modified, and has to become more personalised as well; and if this happens, then role morality cannot be the same for all physicians. But can this be right? I have already explained the way medicine attributes some special and unique moral characteristics to every physician which constitute their shared role morality. There has to be a different conclusion, and I am inclined to say that this 'personalised professionalism', granted that it is a viable concept, is the same thing as the new double morality which I am trying to create. I shall fully explore this argument in the last Chapter of this thesis.

Thus, keeping all this in mind, having noticed that practical wisdom was incompatible with the kind of double morality which was rejected, and making the hypothesis that virtues have to be more personalised in order to be of any assistance in professional ethics, it is time to see whether virtues can be of any help to the effort of successfully rehabilitating a (refined) concept of double morality.

Virtue theory's contribution to double morality's reconstruction

It seems to me that, despite its inefficiencies, virtue theory has three major ideas to offer related to the refined concept of double morality. Two of them come directly from Aristotle, and I shall discuss them trying to be as much as possible in accordance with him. This implies that the

[33] Robert Veatch 'Character Formation in Professional Education: A Word of Caution' *Advances in Bioethics* **10** (2006), 33.
[34] *Ibid.*, 37-38.

element of practical wisdom is constantly present, even when I do not explicitly refer to it; for the notion of virtues without practical wisdom, as established moral traits, takes us back to the rigid role morality which the god of Medicine dictated, hence to the rejected concept of double morality. But, first, I shall discuss a simpler issue, the one of focusing on the agent rather than his action, and what this could mean for the refined notion of double morality.

a) Agent-focused ethics

It was noted earlier that the theory of double morality was focused on the physician's actions, and not on the physician himself. The ideal physician's role morality dictated actions rather than exemplifying an ideal personality for the physician. The same must be true for common morality, as moral thinking since Christianity's coming has been focused on actions, rules, and laws.[35] The spirit in which common morality functions is captured completely in the Ten Commandments for instance, being a list of actions which people should or should not do. We have seen that the physician has sometimes to go against common morality. Since I mentioned the Ten Commandments, let me use the most well-known one, the Sixth Commandment, as an example: 'Thou shalt not kill.'[36] The physician may be required to violate this rule – the lawfulness of it is irrelevant in the present discussion – and it was suggested that, according to the theory of double morality, he simply moves to another moral level, where common morality is no longer an issue.

Let us forget about that theory and consider a different scenario: what if the Commandment was not 'Thou shalt not kill,' but rather 'Thou shalt not be a killer'? I think that there is an important difference here. Physician-assisted suicide, for instance, can now be seen under a new light and not simply as a deviation from common morality. Of the physician who assists a suicide, one may say: 'he has killed, but he is not a killer.' Virtue ethics says that people are not what they have done,

[35] Rachels, *op. cit.*, p. 175.
[36] Exodus, 20: 13, Deuteronomy, 5: 17.

but rather that they do things according to what they are. But this does not mean that the physician is a killer and that in accordance with this quality he killed. The act of killing which he committed obviously had a different motivation. He did not act from the vice of being a killer, but from the virtue of being benevolent, sympathetic, and rational. It is obvious then that virtue ethics is of great value when we talk about morally problematic actions, because it shifts our attention from the action itself and we are able to consider its whole context. As Becker remarks, there are people whose behaviour is consistently good, and whom we still will not call, in any unreserved sense, 'good people', just as there are people whose behaviour is consistently bad, but who exhibit an accurate self-perception which makes us unable to call them 'bad people'.[37] If we judge them only by the acts they have done, our judgment misses this crucial detail. Also, we disregard the agent's intentions, which is another important consideration; because, as Adam Smith notes in the *Theory of Moral Sentiments*, 'that the world judges by the event, and not by the design, has been in all ages the complaint, and is the great discouragement of virtue.'[38] And this remark is relevant in the sense that our physician's design was not simply to kill a human being, regardless of the event which actually took place.

However, such an approach is not sufficient for a reconstruction of the theory of double morality, because it can have other implications. To put it simply, it implies that the virtuous physician can do whatever he pleases, as long as he has the practical wisdom to keep in touch with medicine's ends. The physician's morality can become an endless succession of moral exceptions, and if exceptions exist then any behaviour might become possible.[39] The physician is not a killer, but he is allowed to kill when he must; he is not a liar, but he is allowed to lie when he thinks it is appropriate; and the list of exceptions goes on. There is a profound lack of consistency here, and it bedevils the satisfactory explanation of virtues. This is why we need to examine how it is possible

[37] Becker, *op. cit.*, at 113.
[38] Adam Smith, *The Theory of Moral Sentiments* [edited by D. D. Raphael and A. L. Macfie] (Oxford: Oxford University Press, 1976, first published in 1761) pp. 104-5.
[39] Adrian Rogers, 'The restoration of medical ethics' *Journal of Medical Ethics* **10** (1984), 120.

for these exceptions to be so frequent; and whether, in the end, these are not exceptions in reality, simply because there are neither rules in the theory of virtue nor rules about how to break rules.[40] The case may be simply that what constitutes virtue differs from one person to another.

b) Against universality

When I discussed the foundations of double morality in Chapter 3, I noted the 'variable good' of which Aristotle speaks in the *Nicomachean Ethics*. Virtues are not the same for everyone, but they depend on the role which one holds. This view conflicts with the notion of 'naked virtues'[41] on which an autonomous virtue theory could be based – that is, virtues which qualify as such without a context – and, therefore, it implies perhaps that Aristotle, the philosopher who comes immediately to mind when discussing virtues, did not actually want to construct an autonomous moral theory based on virtues. He rather tries to associate the term 'virtue' with what is good for an individual, not what is good for all people concerned.[42] As Sherman notes, Aristotle shows scepticism about the possibility of codifying moral experience, and he places emphasis on the particularity of moral situations for the individual.[43] Now the important question is whether for Aristotle a characteristic social role suffices to render someone individual. An interpretation of his writings can lead to two possibilities.

In the first place, he does not seem to speak of specific persons, but rather of specific occupations – when he says, for example, that the good is one thing in one activity or sphere of expertise, and another in another.[44] An individual's social role, the role of the physician for instance, is a very important aspect of his individuality, but it is not the

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[40] Graham Reed, 'On Being Moral in Immoral Places' *Social Science & Medicine* **15** (1981), 22.
[41] Veatch, *op. cit.*
[42] Caj Standberg, 'Aristotle's Internalism in the *Nicomachean Ethics*' *The Journal of Value Inquiry* **34** (2000), 71-87.
[43] Nancy Sherman, *Making a Necessity of Virtue: Aristotle and Kant on Virtue* (New York: Cambridge University Press, 1997) p. 243.
[44] Aristotle, *Nicomachean Ethics* [translated by Christopher Rowe] (New York: Oxford University Press, 2002) 1097a, p. 100.

only one; if we disregard the other aspects, we go back to the profession's servants, the god of Medicine, and the role morality which was rejected. Of course, one has to keep in mind that the ancient Greek state which provided Aristotle's background was very different from modern societies. It was a small aristocratic moral community, where agreement about judgments of character was relatively easy.[45] Ancient Greek states had a remarkable homogeneity, as well as a profound chauvinism; it is therefore to be expected that in these communities social roles were the basic means by which people could be morally seen as individuals, because their moral values were the same in every other respect.

Based on a similar idea, the concept of role morality was developed, and then rejected as part of the failed double morality theory; so it will not do for the refined concept of double morality. To avoid mistakes of the past, our attention has to be focused on the individual physician and not on the profession as a whole. Kant's universal virtues, even if they are confined to separate universes – like medicine's universe – are not useful in this context. There is a need for individual virtues, which Aristotle had realised but could not properly analyse, in my view, because he had a different perception of individuality than the one we have. He was right in turning against Plato's – and, without knowing it, Kant's – universality, but individuality definable in professional contexts is as far as he went, and this is not good enough for reconstructing double morality. However, Aristotle developed another idea which can lead to a more interesting interpretation of his account of individuality.

c) The moving mean

We have seen that, for Aristotle, practical wisdom is a necessary ingredient for the moral recipe of virtues to be successful; this means that the individual has to be engaged in active thinking through which he

[45] Schneewind, *op. cit.*, p. 200.

understands the value of virtues himself; that is, personal moral awareness. Even if the physician knows which the virtues of the good physician are, this does not mean that he may simply employ them thoughtlessly; rather, he has to use this knowledge to construct his own personal virtues. This seems to be in accordance with the refined theory of double morality which I am trying to construct; for it clearly says that there are not universal virtues which should be prescribed for every physician, but rather personal virtues.

Now Aristotle believed that one's practical wisdom was actually one's ability to find the 'golden mean' in every given situation, which is 'the sort of thing that neither goes to excess nor is deficient – and this is not one thing, nor is it the same for all.'[46] He uses the widely acknowledged virtue of courage as an example, and notes that too much is foolishness, while too little is cowardice; but the intermediate shows moral excellence. And he admits that it is very difficult to find this intermediate, for reasons which have to do with the correct dosage: 'there are many ways of going astray ... whereas there is only one way of getting it right.'[47] The intermediate is not stable, but it moves depending on the person concerned and the situation in which he is engaged; therefore, virtues are not fixed moral traits, but rather flexible personal characteristics, which the individual has to realise constantly, and which he must internalise on his own. And in order to do this, he has to find out where exactly they are situated between the two excesses of a situation. Thus Aristotle manages, in the end, to move from universality to individuality, as each person, regardless of his social role, has to find his own intermediate, which constitutes virtue for him.

The quest for the intermediate can give a new meaning and a new direction to the theory of double morality. Consider again the layperson and his common morality, and the pure physician and his role morality; these are going to be the two excesses, as the layperson's personality contains absolutely no medical traits, while the pure physician's

[46] Aristotle, *Nicomachean Ethics* [translated by Christopher Rowe] (New York: Oxford University Press, 2002) 1106a, p. 116.
[47] *Ibid.*, 1106b, p. 117.

personality contains only medical traits. The individual physician does not need to switch from one personality to the other and its corresponding moralities according to the situation, like it was supposed in the failed double morality theory; he rather has to find the mean between the two extremes, the personal virtue which would be appropriate in the given situation. He does not have to temporarily abandon either his common or his role morality, but rather to combine them, in different proportions each time. There will be cases where a bigger dose of the physician's morality will be required, and other cases where he will need more of the layperson's moral ingredients. Whatever the case is, both moralities shall be present; they do not function at different levels anymore, and the presence of one does not require the absence of the other. The two cultures, lay and professional, constantly interact within the individual. Therefore, double morality comes to signify a new entity, which is flexible, and which is made by combining role and common morality in an effort to find the virtue, and achieve the perfect moral balance in a given situation. Thus understood, virtue is always a struggle, and never a settled principle.

The concept of virtue and the secession from virtue ethics

The focus on the agent rather than his actions, the rejection of universal principles, and the concept of the moving mean constitute a good start for double morality's reconstruction, but we should keep in mind that a theory of virtue is not a panacea, nor does it fully express the kind of ethics which I think that the new theory of double morality should call for. I do not mean, of course, that virtue ethics is ineffective in general; as I mentioned earlier, it is a very useful tool as a supplementary theory. But if we stick to a pure theory of virtue, there can be various misunderstandings mainly related to the theory of virtue's tradition.

Allow me to explain. As we have seen, what is useful for the reconstruction of double morality is the use of virtues which are a) agent-based, b) not the same for everyone, and c) not stable but flexible, expressed as a constantly moving mean between two extremes.

However, the profound lack of attention which virtue ethics received in the past, and possibly still receives in the present, has obstructed its detailed analysis and exploration. Therefore, it is not at all certain that I am in accordance with virtue ethics when I talk about virtues which are individual and flexible; perhaps a proper virtue theory demands virtues to be fixed and universal. My conclusions come from my personal interpretation of virtue theories, or they may be the product of personal preference for some modern virtue ethicists.

Indeed, it seems that, traditionally, virtues are not regarded as flexible; their content has to remain the same, and context is the only thing which changes. Private vices may be turned to public virtues as Bernard Mandeville explains in *The Fable of the Bees*,[48] a work by which he managed to turn almost everyone of his age against him. I also turn against him, because a vice cannot be turned to virtue by simply changing the context from private to public; the content, that is, the essence of this moral trait which is called a virtue, has to be changed before it can become a vice. Let me give another example: Philippa Foot says that a virtue like courage can be used by a man who is ready to pursue bad ends, but then, in him, courage is not a virtue.[49] I am not saying that her approach is wrong; she is probably a better virtue ethicist than me. But what I have come to understand as virtues does not agree with her account, which looks like Mandeville's in reverse; it is not a matter of context, but rather of content.

Therefore, I shall be using the term 'virtue' from now on as I have understood it, but not the term 'virtue ethics'. It could be misleading, it could be at odds with the history of philosophy, and it could also be a threat to the consistency of the thesis, as it would require an extensive analysis of modern trends in virtue ethics. Besides, 'defending virtue theory against all possible, or even likely, criticisms of it would be a

[48] Bernard Mandeville, *The Fable of the Bees* (Harmondsworth: Penguin Classics, 1989, first published in 1724) p. 371.
[49] Philippa Foot 'Virtues and Vices' in Roger Crisp and Michael Slote (eds.), *Virtue Ethics* (New York: Oxford University Press, 2000) p. 175.

lifelong task.'[50] But a loose approach to the concept of virtue, without the burden of virtue ethics as a whole, shall be very effective in its implementation in the new theory of double morality. This shall become apparent in the next Chapter, where I shall explicate my view.

[50] Rosalind Hursthouse 'Virtue Theory and Abortion' *Philosophy & Public Affairs* **20** (1991), 223.

Chapter 9

PREVIOUS CASES REVISITED BY TESTING THE CONCEPT OF VIRTUE

Now that there is a new direction and a new perspective, I would like to explore for a while all the previous practical cases which were examined, under this new perspective. I shall take the concept of virtue and apply it on every example separately, in an effort to ascertain that talking in terms of virtue can be a successful way of dealing with medical ethics. Of course all that has been said in the previous Chapter about virtues have to be kept in mind; for instance, that virtues are flexible and not fixed, or individual and not universal. In general, we have to leave the traditional definition of virtue behind us if we really want the concept of virtue to work. After this Chapter is finished, and provided that the treatment of these practical examples is done without any problems, I shall be ready to describe the new theory of double morality in the final Chapter.

By revisiting the main examples, which were previously examined, but this time under the new double morality concept, I do not aim at a full explanation of the physicians' behaviour; nor do I believe that attitudes which appear to be wrong can be suddenly justified. However, as previously stated, I consider this scheme to be a justifiable prerequisite in order to deal more successfully with medical ethics.

I) Cases which supported the old double morality

It seems natural to begin with the cases which supported the failed theory of double morality and then proceed to the ones which condemned it. Having been in support of the old theory does not necessarily mean that these cases cannot be in support of a new, virtue-based theory as well; as will be seen, all that is needed is a revision and a new interpretation of them.

Issues of killing and torturing

Let me first concentrate on medical killing, that is, killing based on medical or socio-medical decisions – and not based on clearly social or political decisions, such as the execution of a criminal. The cases which were examined were physician-assisted suicide, infanticide, and allocation of scarce resources (indirectly killing the patient to whom the resources were not allocated). As already noted, the issue here is not whether the physicians' decisions were ethically right or wrong, or what my personal opinion on these decisions is; these cases are real, so this means that some physicians somehow assisted patients to commit suicide, humanely terminated the life of some infants, and were forced to play God by deciding whom to save and whom to let die when not all the patients can be saved.[1] The issue is to understand how they can do something that laypersons normally cannot do. So let me assume that these decisions are not questioned. Dr Kevorkian has to kill a patient who suffers too much. Dr Arthur has to let an infant with a prospect of a very short and very miserable life die and Dr X, who, for the argument's sake, happens to be in Pakistan after a deadly earthquake, has to indirectly kill many injured victims, just because he has to treat and save some others first. The old and failed theory of double morality claimed that they could do the killing by resorting to their role morality and by shifting the burden of responsibility to the mighty god of Medicine. By adopting a virtue-based approach, we concentrate exclusively on the individual physician's responsibility.

According to Casey, it is necessary to link the consequences of an action to such notions as role, and, hence, responsibility.[2] But there is another factor which is of importance, and that is one's character: 'our conception of the role in which a man is acting, or our assessment of his character will considerably affect what we can describe him as doing in a

[1] *Cf.* Stephen de Wijze, 'Dirty hands – doing wrong to do right' *South African Journal of Philosophy* **13** [1] (1994), 31.
[2] John Casey 'Actions and Consequences' in John Casey (ed.) *Morality and Moral Reasoning: Five Essays in Ethics* (London: Methuen & Co. Ltd., 1971) p. 177.

particular situation.'[3] But roles do not exhaust ourselves: 'Unlike the carpenters and cobblers of the *Republic* we can hardly feel that in regarding a man as an *obstetrician* we have totally defined his responsibilities in life, or totally accounted for the sorts of option that are open to him.'[4] So this means that one's character, that is, one's individuality is necessarily a part of the decision process; especially if the decision is such a difficult one, like whether to kill a human being. That is why Casey thinks that, in the end, in cases like these *our* conception of one's role and its duties does not matter so much; what governs his actions is *his* conception of his role.[5]

The latest remark implies a need for self-realisation. I think that this is in accordance with the concept of virtue we have examined. The moving mean which we are looking for, that is, the physician's personal virtue, is situated somewhere between the decision to kill (based on medical reasons) and the decision not to kill (based on common reasons). The physician goes through a very important procedure before creating a self which takes the decision to kill. The good reasons that medicine offers him to proceed with the killing interact with the dictates of common morality which forbid killing. This is a 'merging' of two separate moralities, and the 'balancing' about which we hear so often,[6] without, however, knowing how exactly it is done. This is where the personal virtue of a physician enters the scene allowing for a decision to be taken. Dr Arthur did not kill that infant simply because it was a balanced medical decision; he did it mainly because he was able to do it, in line with his personal virtues and beliefs. Dr Kevorkian did not help his patients commit suicide simply because they were suffering and he could help them; he also did it because he had made his self ready for it. By making these choices perhaps they render themselves guilty from a layperson's point of view, whether or not they have made the correct choice. But this

[3] *Ibid.*, p. 168.
[4] *Ibid.*, p. 170.
[5] *Ibid.*, p. 194.
[6] See, for example, Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* [5th edition] (New York: Oxford University Press, 2001) p. 18.

guilt, as Meira remarks, is paradoxically associated with greatness of character.[7]

The money issue

When discussing the failed theory of double morality, I remarked that there is an inherent conflict of interests between the patient and the physician as a businessman, and I also considered the possibilities of undertreatment and overtreatment, according to the patient's ability to pay. Then I claimed that, when it comes to profit, a physician needs to forget Medicine's higher values for a while, especially if he works as an employee. This was the old double morality's view, which aimed at keeping the science of Medicine spotless, and separated from the business of Medicine; otherwise, if money were a constant source of speculation for the physician, Medicine would become like other jobs.[8] I can now say that this view was wrong.

A very important remark on which I would like to focus comes from Minogue:

> Physicians who view themselves as having ethical duties only to the patient are at odds with the new world of medicine.[9]

Exactly. The market forces cannot be ignored; 'they must be dealt with – but they must not be succumbed to.'[10] The real world of medicine has changed, just like the rest of the world; idealists need to realise this. There is no point in pretending that profit is unimportant, or that the patient's benefit is above anything else. Higher values which can be instantly forgotten for profit's sake cannot survive as higher values, and they need to be modified. The physician needs to merge his role morality with his common morality and stop feeling uneasiness about getting paid

[7] Ariel Meira, 'Tragic Conflict and Greatness of Character' *Philosophy and Literature* **26** [2] (2002), 261.
[8] Carl Elliott 'Disillusioned Doctors' *Advances in Bioethics* **10** (2006), 92.
[9] Brendan Minogue, 'The *Two* Fundamental Duties of the Physician' *Academic Medicine* **75** [5] (2000), 442.
[10] Howard Gardner 'Compromised Work' *Daedalus* **134** [3] (2005), 51.

for helping people and saving lives. Furthermore, if physicians do not care about money, perhaps there is a danger of submitting to what Shaw has described as 'recklessness': for example, 'they recommend wintering in Egypt or at Davos to people who cannot afford to go to Cornwall ... [this makes] one wonder whether it is possible for a man to go through a medical training and retain a spark of common sense.'[11] Medicine is a science, but it is also a business at the same time, and these two capacities cannot be distinct if we want to be in touch with reality. Physicians can go on strike and be ethically justified if they have fair demands; if the strike is humanely organised, they do not need to justify themselves more than any other trade union needs to. As for the possibilities of undertreatment and overtreatment, these are some clearly negative aspects of medicine as a business, and there should be a constant effort to avoid them. But however negative they may be, they regularly take place in every other business area, so there is no guarantee that medicine shall ever be absolutely free from them. The blame may be put on some specific individual physicians, or on some governments' health policies; nevertheless, it is still an aspect of medicine, and there is no point in denying it by shamming its separation from medicine.

Bearing these remarks in mind, I believe that a theory based on a concept of virtue is the best approach we can adopt in order to describe the merging of role and common morality which has to be done within the physician. There is the need for an individual virtue, one that allows the physician to exercise his vocation by controlling the financial aspect of the procedure at the same time – this virtue can also be used in a corporate setting, as argued by Moore.[12] A simple virtue such as altruism or generosity would fail, since it does not take notice of medicine's material reality. On the other hand, a clearly practical virtue such as, for example, a talent for business, would be useless on its own, since we acknowledge that the medical profession is something more than just an

[11] George Bernard Shaw, *The Doctor's Dilemma – Preface on Doctors* (Harmondsworth: Penguin Books, 1966, first published in 1911) p. 33.
[12] Geoff Moore 'Corporate Character: Modern Virtue Ethics and the Virtuous Corporation' *Business Ethics Quarterly* **15 [4]** (2005), 661.

occupation. What we need is a virtue to combine both altruistic and business-oriented traits, however paradoxical this may sound. This virtue has to be based on Aristotle's 'moving mean' concept, and it certainly cannot come into fruition without practical wisdom. Surely, the combination is not always successful, and the virtue could go astray, resulting in an individual physician who behaves more like a businessman and less like a doctor. But this is a matter of practical wisdom and learning through experience, and it can be fixed; if not, it is a matter of greed and bad education, and this constitutes a whole new – and irrelevant – discussion.

For fairness, I should acknowledge that, just as there are individual physicians who behave more like businessmen and less like physicians, so there are those who have the ability to keep the enterprising spirit of medicine away from their practice. Let us say that there is a physician somewhere who treats people for free, perhaps he works in Africa for Medecins Sans Frontieres (MSF), for example. How does the new, virtue-based theory would explain that? Experiencing the need for many material benefits is probably an issue of common morality. If a physician's common morality does not give any priority to money, then, by combining it with his role morality, he can become an MSF physician who treats patients in Africa for free. Our world is not normally like this. 'Generation X is making a cool appraisal of the costs and benefits of a medical career.'[13] So these MSF physicians in Africa are the ones in front of whom we should stand surprised, and not the ones who try to make their profession profitable. No matter what some idealists seem to believe, medicine is a business – and a very tough one, as Todd's remark recognises: 'every physician-patient encounter is a conflict of interest.'[14]

[13] Roger Jones, 'Declining altruism in medicine' (Editorial) *British Medical Journal* **324** (2002), 624.
[14] James Todd, 'Professionalism at Its Worst' (Editorial) *JAMA* **266** [23] (1991), 3338.

It is unnecessary to note that common morality demands that people generally tell the truth, and that deception requires special reasons. Without actually lying, physicians engage themselves in deceitful practices quite often for some undoubtedly good special reasons which have to do with the patient's well-being and, therefore, their role morality justifies this attitude. So physicians are allowed – by the god of Medicine – to be dishonest if this is what, to their judgment, is best for the patient (due to the recently augmented call for autonomy, deception does not go as unchallenged as it used to, but we assume that it still exists as a general option). This means not only that physicians' deception is to be expected by other people, but mainly that physicians can easily justify it to themselves. When lying one feels uneasy, but not when lying in a professional context, especially if role morality shows that there is no problem with that. This was a good explanation of how it is possible for the same individual to act honestly in general, and dishonestly when a professional need arises, and without having any conflicts of conscience, just by using the standard form of double morality. But this was severely criticised as *amoral*. So what would a virtue-based theory have to say on this issue?

Once again we have to keep in mind that this refined concept promotes agent-focused ethics. The focus on the action itself comes after the focus on the agent's profile. And this profile is constantly under development, in the individual's continuing effort to find, no longer the ideal physician, but rather, one's personal, ideal self. Lying or telling the truth does not have to be judged separately as to whether it is right or wrong, but only as an authentic manifestation of an instant self. Honesty and dishonesty as dispositions do not matter. The physician who lies does not have to be considered as an honest person who deviates and tells a lie when he has to, but as a person who consciously becomes a liar and then, to be consistent with himself, lies. In my view, this is how one can deceive without feeling remorse; neither by mentioning good reasons to justify his action, nor by changing moralities and allowing

himself to deceive in a professional context, but by being consistent with the self that he has become. And in order to consciously become a liar the physician has to go through a very complicated procedure of virtue creation where role and common moral traits come together, in order to let the individual physician deceive his patient.

Can this be right? Traditionally, we know that honesty is a virtue, and dishonesty a vice. Can the concept of virtue be so plastic that such a traditional vice as dishonesty can be admitted to the 'virtues-only' members club? I believe that it is possible, provided that we refer solely to role-defined virtues. We have seen that the traditional virtue of courage can be used both for good and for bad ends, and that this is one of the main problems of virtue ethics;[15] the same happens with honesty. And it is honesty's failure to be morally correct under all circumstances that forces us to accept dishonesty as a role-defined virtue, if it is of assistance to the medical profession. But it is important to note that the role alone cannot sanctify the newly created virtue of dishonesty; it is the person behind the role who has to take this decision, and claim full responsibility.

Before moving on, an obvious objection which I should consider is the one of whether becoming a liar for an instant is not the same as lying. To be sure, some people shall not be able to find any difference. But those for whom authenticity plays an important role in their life can certainly differentiate these two situations. When someone performs an action which does not express his true self, then, no matter whether this action is good or bad, this person is not authentic. This can be done; people step out of their selves and behave in inauthentic ways. But we cannot say that stepping out of a self is the same as creating a new self. It is true that the self is not something stable and that it constantly changes, but there must be some successive stages: from A to B to C and then maybe back to B. But this succession cannot be found when one steps out of one's self and moves from A to C and then back from C to A, omitting the intermediary stage B. So when a physician lies it can

[15] Greg Pence 'Virtue Theory' in Peter Singer (ed.), *A Companion to Ethics* (Oxford: Blackwell Publishers, 1993) p. 255.

mean either that he has become a liar, at least instantly, or that he steps out of his self and lies – in a similar way as to what the old theory of double morality claimed. But it is only in the former case that the physician acts fully consciously, consistently, and authentically.

II) Cases which questioned the old double morality

The next group of examples are those problematic ones, where some suspicions about the old double morality's effectiveness came up for the first time – and, of course, its ineffectiveness was later confirmed. I believe, though, that under the light of virtue these issues appear to be less problematic. So let me reconsider them to see whether this is correct.

Issues of etiquette and abstinence

As I put it (very crudely) in the previous discussion, medical etiquette means that a physician wears a professional mask at work, which he is able to take off when it is no longer necessary. He needs to have a smooth manner in front of his patients for example, and this is totally justified. The patient may not trust his physician if he sees anything that he does not expect or that he dislikes about him, and so an acceptable professional behaviour has been created, which the physicians have the ability to turn on and off. Then I suggested that this ability works too well, which partly accounts for the physicians' well-known problems of addiction to drugs or alcohol. But since the old double morality was a failure this does not look like being the case anymore. It is more probable that role and common morality get mixed, and that sometimes the demands of a role cannot suppress some common desires. This is why physicians are now more tolerant with regards to their colleagues' various modes of self-expression, without entirely accepting all of them.[16]

[16] Mary Catherine Beach and Somnath Saha, 'Free to be you and me? Balancing Professionalism, Culture, and Self-expression' (editorial) *Journal of General Internal Medicine* **20** [3] (2005), 312-3.

Often a golden mean can be found; we then have spotless professional physicians, or maybe unique professionalisms which individuals create for themselves by maintaining control of their common desires and by making their patients accept their physicians' individualities. But sometimes, a more anti-professional self is created. This misfortune needs also to be accepted. 'We are asking too much of the medical profession if we look at the quite ordinary mortals who fill its ranks ...'[17] Perhaps physicians are not quite ordinary, but rather special and peculiar mortals; however, they remain mortals nevertheless.

This seems to be a problem in the case of boundary violations as well. There are many reasons for which it could be immoral for a physician to have sexual relationships with his patients, but one of them is that 'a boundary violation can seriously harm the profession by showing that it is not meeting its obligations.'[18] These professional deviations cannot be avoided, and sexual desires cannot always be managed. So perhaps more authenticity is what is required; each physician has to sufficiently separate his self from his colleagues and from medicine in general, and the public needs to understand this instead of projecting a physician's behaviour to every member of the medical profession. And in order for this to be achieved, the need for individually constructed virtues is evident. Thus, in a different context, Bernard Williams notes:

> One area in which *difference* of character directly plays a role in the concept of moral individuality is that of personal relations ... Differences of character give substance to the idea that individuals are not inter-substitutable ...[19]

Physicians vary in their character, just like everyone else. When it comes to personal relations, even when they constitute a boundary violation, we cannot ignore the fact that individuals are not inter-substitutable. This is why I talked about the possibility of a more personalised practice of

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[17] Donald Gould, *The Medical Mafia* (London: Sphere Books, 1985) p. 268.
[18] Cherrie Galletly, 'Crossing Professional Boundaries in Medicine: The Slippery Slope to Patient Sexual Exploitation' *Medical Journal of Australia* **181** [7] (2004), 381.
[19] Bernard Williams, *Moral Luck* (Cambridge: Cambridge University Press, 1981) p. 15.

medicine for every physician, and a more personalised professionalism to come with it. This shall give physicians more freedom and, if we assume that most of them are not 'evil' so as to take advantage of it, this freedom shall allow them to make their decisions more ethical, by encouraging them to reflect seriously on difficult issues such as feelings of personal affinity with a patient.[20] But I have to remark that by 'making their decisions more ethical' I do not mean that these decisions shall necessarily be the right ones; 'more ethical' is used here in the sense of a more intense reflection, which results in greater moral activity. And whatever the outcome of this reflection, and whatever decisions a physician may be led to, personal moral activity is preferable to ready-made guidelines and prohibitions, which, albeit perhaps safe, are also narrow. In my view, one cannot achieve moral excellence without taking some risks.

Religious issues

Earlier, in trying to understand the paradox of the religious physician, I suggested double morality as an explanation; then I admitted that it was a bad explanation and postponed the discussion of this paradox. Using the concept of virtue as discussed thus far, the discussion can now proceed. But first, in order to support my view more effectively, I shall briefly describe how a modern medical miracle takes place officially, and how physicians are related to it.

The Congregation for the Causes of Saints of the Vatican retains a pool of over sixty physicians who are resident in Rome as the Congregation's *Consulta Medica*, and who are called upon to investigate alleged 'miracle cures'. Panels of five meet to render recommendations about particular cases. After the investigation, each panel member renders a decision about the cure. It is either 'natural' or 'inexplicable'.[21] Although the role of these physicians ends there, without proclaiming

[20] W. Spiegel, T. Colella, P. Lupton, 'Private or intimate relations between doctor and patient : is zero tolerance warranted ?' *Journal of Medical Ethics* **31** (2005), 27-28.
[21] William Stempsey, 'Miracles and the limits of medical knowledge' *Medicine, Health Care and Philosophy* **5** (2002), 4.

that a miracle has taken place, their thoughts about the case do not. There is the view that when some phenomenon cannot be explained, physicians do not presume that some spirit is uniquely acting to cause the phenomenon, and that, rather, they simply presume that they do not have all the facts, and that if all the facts were available, the event would be explainable according to science.[22] So the non-religious physician of the *Consulta Medica* would think that it is not a real miracle, but something to be explained in the future, just as many of the inexplicable cures of only a few years ago are now well explained. But the fact that he agrees to contribute with his knowledge to the process and actually become part of the miracle, means that he allows religion to have its way until science is able to explain the currently inexplicable. The religious physician's opinion on such a miracle cannot differ much. In my view, it is only a matter of how confident an individual is as to whether a scientific explanation shall be provided in the future or not.

Miracles have not much to do with ethics, but they provide the background which allows us to understand the paradox of the religious physician. Medical and religious moral values constantly interact, far from being entirely separated as the old theory of double morality suggested. The interaction starts from the point where the medical ethic first invades the life of a religious person, perhaps at medical school, or maybe later on. The reverse procedure is highly improbable, but it could also take place, if a non-religious physician suddenly decided to become religious for whatever reason. Still, even before this particular interaction between medical and religious morality starts, neither the former nor the latter is pure, as there are various influences in someone's life apart from medicine and religion; but this is irrelevant for the time being. The point is to emphasise once again the active merging of role and common moral elements, which create a never-ending internal conflict and a 'flexible' morality, based on personal judgment.

Quite simply, this means that the paradox of the religious physician cannot be solved. The existence of the *Consulta Medica*, and

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[22] *Ibid.*

the way it functions show clearly that even physicians who are *owned* by a religion can be full of doubt and internal conflict without hoping that they will ever find a definite answer to their questions and an explanation of the miracles. The case of miracles shows that medicine as a science conflicts with religion in such a way that physicians cannot do anything but wait. At the heart of the issue is the struggle between faiths – religious faith (as commonly understood, where to ask for proof is to miss the point), and faith in science to produce proofs (eventually). For the religious physician, both faiths are important and, no matter what non-religious or non-scientific minds may think, both are taken into account, even if this makes the situation far more complicated.

The concept of virtue enters the discussion once religious issues start influencing the physician's performance. When it comes to that, the situation is even more complex, as our concern is not exhausted in the physician's spiritual status, but is also extended to the patient's health. These cases are not as few as one might suspect. It seems easy to state that the virtuous physician should remain religiously neutral, clearly avoiding any conflict between medicine and religion. As Hall and Curlin note though, it is impossible to be neutral regarding religious issues; secularism, contrary to appearances, also makes specific claims.[23] But Hall and Curlin do not consider this to be a problem. They see it, rather, as an 'opportunity for physicians to be self-conscious about their values so that they can enter into the complex human interactions of clinical medicine without the false pretence of "objectivity" or "neutrality" regarding systems of meaning and value.'[24] This is exactly what a virtue-based theory (but without any firm and rigid virtues) would support: a personal point of view which leads to self-consciousness; and, of course, the ascertainment that every belief is subject to change. Perhaps all miracles shall be scientifically explained in the future, and every religion shall be rendered obsolete along with their moralities. But for the time being, physicians, like everyone else, have to respect and give

[23] Daniel Hall and Farr Curlin, 'Can Physicians' Care Be Neutral Regarding Religion?' *Academic Medicine* **79** (2004), 677-679.
[24] *Ibid.*, at 679.

consideration, not only to their patients' belief systems and values, where modern medical literature places the emphasis,[25] but also and mainly to their own.

Issues of caring

As opposed to a layperson's 'natural caring', which can be either too much or too little depending on one's disposition, physicians adopt a certain 'professional caring' which has to be reasonable and free from 'the pathology of empathy and compassion'[26] so as to best serve medicine's purpose. But the previous discussion on caring showed that this is not always the case. Firstly, a physician may fail to develop the required 'professional caring' and cultivate a certain cynicism instead (which I take to mean 'indifference'), or even a kind of dark humour. And, secondly, a physician may not be able to move from professional to natural caring, and vice versa, as the cases of patients who happen to be the physician's friends or relatives clearly indicate. This inability can be linked to difficulties with boundaries in medical practice,[27] but these difficulties do not necessarily constitute a problem.

The new approach which I am testing in this section does not favour the existence of a pure professional caring. Each physician is unique, so each physician's caring is situated at a different, personal level, which constitutes a caring virtue tailored to the needs of the individual physician. Furthermore, there is the view that 'a fully virtuous person is supposed to act with ease and with no need to battle his inclinations,'[28] but this is not easily defended. I think it is better if we are able to see care as a virtue on its own, not clearly natural, but, in Aristotelian terms, one harnessed by reason.[29] If professional caring

[25] See, for example, Gregory Schneider, 'Ethical Decision Making for Christian Physicians: Inspiration from Saint Ignatius of Loyola' *The National Catholic Bioethics Quarterly* **3** [4] (2003), 673-680.
[26] Ermanno Bencivenga, 'Kant's Sadism' *Philosophy and Literature* **20** [1] (1996), 42.
[27] Derek Puddester, 'Staying human in the medical family: the unique role of doctor-parents' *Medical Journal of Australia* **181** [7] (2004), 395-398.
[28] Karen Stohr 'Virtue Ethics and Kant's Cold-Hearted Benefactor' *The Journal of Value Inquiry* **36** (2002), 192.
[29] Raja Halwani 'Care Ethics and Virtue Ethics' *Hypatia* **18** [3] (2003), 168.

corresponds to role morality, and natural caring corresponds to common morality, then it is by a mixture of these two ways of caring that a physician's real virtue of care is developed. There is no level of it which is considered to be appropriate for a professional, and it is certainly unnatural for a physician to provide the same standards of caring for all his patients. Cynicism and dark humour (which imply low levels of caring) are totally acceptable as individual characteristics of individual physicians, as long as they do not diminish the quality of *care* (as opposed to the quality of *caring*) which the patients receive. A caring physician is often desirable, but he is not necessarily a good one. On the other hand, a dark-humoured physician sounds bad and causes uneasiness, but he may be an excellent one. As Misch notes:

> There is no single right answer in art; many different techniques and approaches have yielded great works. Is not the same true of the professional or humanistic physician?[30]

Therefore, such individual characteristics must not be frustrated in the name of an uncertain professionalism. And these characteristics survive only in the fusion between role and common morality, and not when one tries to by-pass either of them. It is professional morality that needs to be adapted to every individual physician, and thus become a personal morality, and not the opposite, where the physician would end up losing his authentic self. And this can happen only if caring relationships are subjected to a regulative role of reason to ensure their moral desirability,[31] thus resulting in personal caring virtues lying in a mean, with the mean relative to the individual. I think that this conclusion favours even more the concept of 'personalised professionalism' which is based on independent, individual virtues.

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[30] Donald Misch, 'Evaluating Physicians' Professionalism and Humanism: The Case for Humanism "Connoisseurs"' *Academic Medicine* 77 [6] (2002), 491.
[31] Halwani, *Op. Cit.*, at 175.

III) Cases which condemned the old double morality

Finally, there are the cases which utterly baffled the old double morality's theory and revealed the concept's most basic weaknesses. These issues all involve very complex situations, and certainly a detailed exploration of them is beyond my scope. However, it is sufficient for my purposes to provide a reappraisal based on the concept of virtue, without any attempt to analyse in depth the issues at hand.

Issues of confidentiality

We saw that in the health care area there is a duty of confidentiality and a strong presumption in favour of it, regarding both patients' and the medical profession's secrets. We also saw that society imposes new duties and considerations on physicians, who are often confused as to whether they should disclose a secret to a third party or not. In other words, there is now a *relative duty* of confidentiality, which is, however, more difficult to state and to teach, and which places a greater moral burden on physicians.[32] The term 'relative duty' is perfectly in line with the concept of virtue as explained in the previous Chapter. It means that the individual physician has to adapt his professionalism and his general behaviour to each situation's peculiarity, that a 'relative' virtue has to be constructed instead of using 'naked' or 'absolute' virtues, and that a personal decision has to be found instead of following a rule. But it has to be a real decision; this means that it has to represent a clear solution to a specific moral problem, even if there is no absolute certainty about the rightness of the solution.

For example, if Prosenjit Poddar's psychiatrist had made a real decision, he would have chosen either to protect Tatiana Tarasoff by revealing to the police exactly what his patient had told him, or to respect his duty of confidentiality and say nothing at all. But, as we saw in Chapter 6, he chose to do something in between, and the consequences

[32] Richard H. S. Tur, 'Medical Confidentiality and Disclosure: Moral Conscience and Legal Constraints' *Journal of Applied Philosophy* **15** [1] (1998), 16.

were bad. Let us suppose that the psychiatrist was upset when he learned what had happened; this is understandable, since he tried to do something from his part, and it would be understandable if he had chosen to be more actively involved and protect her himself. But what if he had chosen not to mention anything to anyone? Probably the consequences would not have been so bad for him. Because this would mean that his conscientious and personal moral solution should have been confidentiality and silence; so his remorse afterwards would have been only about a probably bad, but clearly personal and real decision, and not about his indecisiveness, or his inability to provide protection.

Then of course, there is the issue of whistleblowing, which requires separate attention. From a virtue-based point of view, the established medical tradition not to blow the whistle on colleagues clashes with some fundamental medical virtues such as conscience, honesty, integrity, and justice. Bolsin et al. seem to believe that physicians should unquestionably consider medical virtues before medical tradition, and they propose that 'virtue ethics provides a strong ethical basis for whistleblowing in health care because it provides a compelling theoretical justification for doctors to report and expose unethical practices.'[33] The problem with this remark is that we are not looking for a 'justification'; we want to explain decisions, not to justify them. I render traditional virtue ethics and the effort to make a list of universally accepted professional virtues responsible for this. It is much more rewarding to deal with each case separately, creating virtues in the procedure instead of just using ready-made ones.

If we rely on an uncertain concept of virtue, we render our decisions more difficult as we accept that there are simultaneously both role and common influences in the individual physician's moral world. And virtue can then be seen as the moving mean between role and common morality. But this should not be taken to imply that the point of virtue should necessarily lie between these two influences. Sometimes it is perhaps better to be on one side rather than the other – in other

[33] S. Bolsin, T. Faunce, J. Oakley 'Practical virtue ethics : healthcare whistleblowing and portable digital technology' *Journal of Medical Ethics* **31** (2005), 612-618, at 615.

words, the moving mean can be found very close to role morality and very far from common morality, or vice versa. But first, before deciding, both moralities should be consciously taken into account. In this way, they both make a contribution, even if sometimes the moving mean goes to extremes, making the decision seem to be based on exclusively one morality.

Defensive issues

There is not much to say about the issue of defensive medicine using a concept of virtue. We have seen that it was an oversimplification to explain that physicians resort to their common morality when they tend to think legally before thinking medically. Once again, we need to understand that their role is 'disturbed', and therefore legal considerations exist at the same time with medical ones and their common morality constantly interacts with their role morality. This interaction results neither in clearly medical, nor in clearly legalistic decisions, but in personal decisions. The individual physician acts upon considering every aspect of a medical case, even aspects which have nothing to do with proper medical practice. Defensive medicine remains a problem of course, and relying on virtues does not offer any kind of solution. However, the description it provides as to how the physician's morality functions is in accordance with the way in which defensive medicine arises. To practise defensive medicine or not is a personal decision, at which the individual physician arrives through a procedure of interaction between medical and common considerations; in the end, it depends on where one places one's moving mean, and, thus, one's virtue.

One very good example to support this view is provided by Stewart, in an article which considers what a suspended doctor should do when his actions could save one's life, if he comes across an accident

and an injured motorist, for instance.[34] He concludes that the duty of care still exists, whether one is suspended or not, but also that this duty is not derived exclusively from one's role morality, but mainly from 'the fact that he is a compassionate human being.'[35] As I have previously noted, the physician cannot turn his role on and off. He is a physician all the time, but without losing the characteristics of the layperson beyond the physician. A suspended physician is still a physician, and not simply a layperson. His decision as to whether he should help or not a person whose life is in danger stems from his personal virtue; that is, the fusion between his role and his common morality, which creates a clearly personal moral point of view.

The issue of the physician's illness

Finally, this is a case which moves away from moral issues and deals exclusively with roles. It was noted that, under the old regime, the role of the physician is so powerful that the physician *becomes* the role, and that, therefore, it is very difficult to be a pure patient when he falls ill – resulting in comparatively poor health outcomes.[36] He is neither simply a physician nor simply a patient, but a physician/patient; and this proves that there are no double roles, but only mixed ones. This statement agrees with the concept of virtue which was described, where it is clear that the physician and the layperson co-exist within the same individual, with their moralities not separated, but constantly interacting with each other. A sick physician cannot suspend his medical identity for as long as his sickness lasts and become exactly like the sick layperson. At every point he has a unique personality, which certainly retains the role of the physician, but in which various other elements are added, like the element of sickness. Of course, every individual patient is special, but it is normal to expect that the physician/patient shall be an even more

[34] J. A. D. Stewart, 'What should a suspended doctor do when his actions could save a patient's life?' *Postgraduate Medical Journal* **79** (2003), 204-5.
[35] *Ibid.*, at 205.
[36] Margaret Kay, Geoffrey Mitchell and Christopher Del Mar, 'Doctors do not adequately look after their own physical health' *Medical Journal of Australia* **181** [7] (2004), 368-370.

special kind of patient. Instead of denying it by trying to 'leave his Aesculapian authority in the waiting room,'[37] or denying the illness, the physician should better accept both the illness and the fact that he is a physician and try to make the best out of this peculiar situation. Shaw has remarked that the most tragic thing in the world is a sick doctor: 'it's like a bald-headed man trying to sell a hair restorer.'[38] Well, it may be tragic, but it is also natural; and furthermore, maybe the physician who experiences personal sickness as a physician/patient, rather than simply as a patient, gains valuable knowledge to use effectively for the good of his patients.

Conclusion

Thus I have discussed all the previous cases again, with a refined concept of virtue in mind. The underlying notion in all of them was that the physician has to strive to create personal virtues, which, put together, comprise an ideal self. Perhaps this approach is somehow utopian; in line with Kierkegaard, one could say that the average physician 'finds it too hazardous to be himself and far easier and safer to be like the others, to become a copy, a number, a mass man.'[39] Or perhaps this approach is just one among many others which a physician could adopt, without any of them being the best or the correct one. These objections are acceptable. But still I think that no matter how utopian it may be, this somewhat unstable concept of virtue has something to offer in the field of medicine. Based on this kind of virtue, and judging that it deals successfully with all the practical examples mentioned, I shall describe the new theory of double morality in the next and final Chapter.

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[37] Humphry Osmond, Miriam Siegler, 'Doctors as Patients' *The Practitioner* **218** (1977), 838.
[38] George Bernard Shaw, *The Doctor's Dilemma* (Harmondsworth: Penguin Books, 1966, first published in 1911) p. 110.
[39] Soren Kierkegaard, *The Sickness Unto Death* [edited and translated by Howard V. Hong and Edna H. Hong] (Princeton: Princeton University Press, 1980, first published in 1849) p. 34.

Chapter 10

A NEW APPROACH

Now that the previous cases have been revised and offered us a new insight, it is time to develop the idea of the *free* physician. There shall not be any specific moral rules which oblige him to behave in an 'appropriate' medical way; there shall not be a god of Medicine telling him what to do, or an ideal physician whom he should emulate; and there shall not be any kind of schizophrenic double personality in his life, or any system to take his personal identity away from him. But there shall be the construction of an individual self, its realisation and its application in any problems which come up; a more personalised professionalism, in other words. And this means that the physician shall be taking decisions based on his own professionalism, and not by trying to adapt it to particular situations. As the concept of virtue shows, constructing an individual, ideal self is by no means an easy task, and the following discussion shall confirm this. But one cannot simply deny the freedom that the construction of an individual self offers so easily, just because there are difficulties. As Sartre reminds us, 'man is condemned to be free.'[1] Bearing this in mind, I shall therefore start by describing the new theory of double morality, which values this freedom above all else. Nietzsche notes that the devil is the oldest friend of knowledge;[2] so it shall be shown that what Medicine needs is perhaps a devil rather than a god, a free spirit which encourages doubt rather than faith and obedience.

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[1] Jean-Paul Sartre 'Existentialism and Humanism' [translated by Philip Mairet] in Stephen Priest (ed.) *Jean-Paul Sartre: Basic Writings* (London: Routledge, 2001) p. 32.
[2] Friedrich Nietzsche, *Beyond Good and Evil* [translated by Marion Faber] (Oxford: Oxford University Press, 1998, first published in 1886) p. 66.

I) The new theory of double morality

The failed theory of double morality assumed that the physician can have two distinct personalities and two distinct moralities, and choose, probably unconsciously, which one to use according to the circumstances. We have now seen that, apart from some very special cases, this is impossible. There is indeed the physician's role as an abstract idea, but it is very unusual to see it manifested in its pure form in real life situations; this is why I concluded that the physician's role is 'disturbed' – and it has always been, since medicine and physicians necessarily belong to society[3] and cannot exist in isolation. From the concept of the physician's disturbed role, and in light of the ideas which the concept of virtue had to offer, a new theory of double morality shall emerge.

The immense culture of medicine, the devotion which this profession demands of its professionals, and all the other reasons which have been given in order to explain what makes physicians so special, admittedly create a morality exclusive to the physician. But since the physician is at the same time a layperson – according to the definition of layperson provided in Chapter 1 of this thesis, that is, in the sense that he surely has non-medical aspects in his life – then the layperson's morality has also to be present. So both role and common morality are present, but not separated as the old theory of double morality assumed; they exist as ingredients which are constantly mixed together to create a new morality which suits the circumstances. The physician's and the layperson's personalities are not distinct; there is only one personality for each individual, which combines elements from both the physician and the layperson. And this individual's morality can also be called 'double morality' since it is a combination of common and role morality.

A couple of very simple illustrations could show very crudely what I mean. The old and failed theory would be represented like this:

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[3] David Greaves, *The Healing Tradition: Reviving the Soul of Western Medicine* (Oxon: Radcliffe Publishing, 2004) p. 131.

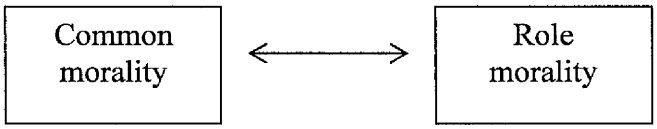

Figure 1.

We see that both moralities exist at the same time and that one is able to move from one to the other, leaving both of them intact. So double morality here does not have anything to do with a new morality; it just describes the alteration between these two moralities. And we have already seen that this was an oversimplification which could not survive as a concept. The new and refined double morality which I want to support would be represented as follows:

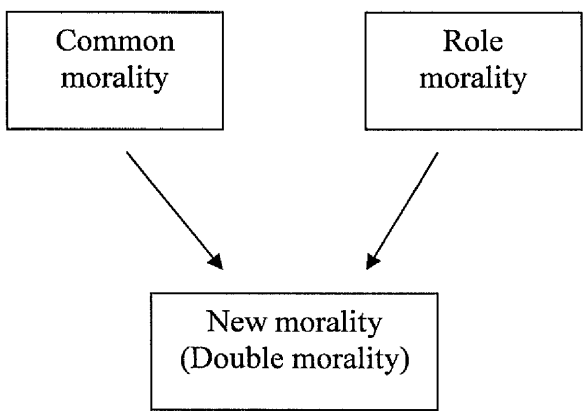

Figure 2.

Having this last illustration in mind, I shall now explain and analyse this refined concept of double morality, which also constitutes the base of what I believe to be a good way of dealing with medical ethics; and this means that I shall be far more enthusiastic about defending it than I was with regards to the failed scheme of double morality.

Double morality as a 'moving mean'

Common and role morality are not separated but they merge with each other, creating a new, double morality. We cannot say that this merge takes place suddenly, or at any specific time. This blending is a continuous process, in line with Aristotle's explanation of the 'moving mean'. But then how does it happen and what exactly is this new double morality which arises?

The physician's role morality is constantly under development, as the hidden curriculum is present throughout his entire career. On the other hand, I assumed in Chapter 1 that one's common morality is only a groundwork on which a personal morality is based and that it evolved throughout one's entire life (unless, perhaps, one lives in complete isolation). Now we have seen that it is very difficult indeed, almost impossible, for the physician to be a pure physician, with no lay characteristics within him. It does not happen, not even for a very short period, because the physician's role is influenced by society, and that is because, after all, it belongs to society. Therefore, from the moment that medical role morality also appears in one's life, side by side with common morality, it starts interacting with it, or, better, with the evolution of the groundwork of common morality which, for reasons of simplicity, I shall be referring to also as common morality from now on. So both role and common morality are under continuous development. It is thus obvious that these two ingredients are not stable, and the same should be expected of the final product, the physician's double morality.

This unstable double morality is like a struggle, as medical and lay moral elements try to prevail whenever there is a conflict between them. Moral rules, principles, virtues, guidelines, or whatever other forms in which morality manifests itself, they all exist at the same time; among all these moral ingredients, there is a balance to be reached (a successful moral recipe), which depends on the given situation and the particular individual physician whose morality we are interested in. The point of balance is reached when the physician uses the correct moral

ingredients in the correct doses, and achieves a result with the least possible moral conflict. However, we cannot pretend that there is not a moral conflict here; 'those who argue that any role eliminates moral conflict have a major case to make.'[4] And we should not try to avoid it in the way the failed double morality scheme did, just by changing moralities, for, as I concluded earlier on, that approach was in fact *amoral*. There is always the possibility of moral conflict; but in the negotiation of the point of balance an individual can construct a real professional character,[5] and finding ways to deal with it instead of hiding from it is where ethics streams from. As Baker and Emanuel remark, regarding the pioneering work of Thomas Percival, medical ethics was inspired by outrage.[6] This kind of outrage cannot exist without conflict.

Consider again Aristotle's search for the golden mean, the intermediate between two excesses which is always moving – and which is 'relative to us', which means that 'it is not one thing, nor is it the same for all ...'[7] We can imagine that role morality is on one edge, and common morality is on the other. The refined concept of double morality refers to their combination, in different proportions in each case. There will be cases where a bigger dose of the physician's morality will be required and other cases where more lay moral ingredients shall be needed. Whatever the case is, the important thing is that both these moralities shall be present. A physician can never forget, not even for an instant, what medicine has made out of him; but he cannot forget or forfeit his life beyond medicine either. His moral status is in between, closer maybe to one edge or another depending on the situation, but never exactly on one edge, where the other edge would be abandoned. If a physician tries to keep this concept of double morality in mind, he can achieve better moral results in his professional role and in his

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[4] Judith Andre, 'Role Morality as a Complex Instance of Ordinary Morality' *American Philosophical Quarterly* **28** [1] (1991), 79.
[5] David Stern, 'The Development of Professional Character in Medical Students' *The Hastings Center Report* **30** [4] (1999), S26-S29.
[6] Robert Baker & Linda Emanuel, 'The Efficacy of Professional Ethics: The AMA Code of Ethics in Historical and Current Perspective' *Hastings Center Report* **30** [4] (2000), S13.
[7] Aristotle, *Nicomachean Ethics* [translated by Christopher Rowe] (New York: Oxford University Press, 2002) 1106a, p. 116.

personal role. But there is a price to pay; one has to be much more morally active, exactly in the way described earlier referring to existential thought. And it is beyond doubt that this intensive moral activity entails many difficulties for any individual.

Double morality as the physician's individuality

So how can we expect of physicians to agree on what is the correct proportion of role morality and of common morality in each case? I am not referring exclusively to medical cases, but cases from every aspect of their lives. How can they know where to find the unstable golden mean and thus decide which yields morally acceptable conduct? This is a difficult question but perhaps there is no need for a definite answer, if we attribute to each physician's individuality its proper value. As Hume remarks, private virtues are more arbitrary than the public and social, but less liable to doubt and controversy.[8]

Moral dilemmas rarely have one correct answer. There is no need for absolute consensus when a decision has to be taken, otherwise nothing could ever be decided as there are always people who disagree, in more than one way. The god of Medicine demanded from everyone acceptance of his view as the correct one, and this was one of the reasons why we concluded that it had failed as a concept. The new scheme of double morality does not presuppose that there is only one way of dealing with a moral problem – the ideal physician's way – but rather, that every physician should find a correct answer for himself, and by looking into himself. Thus the answer gains intrinsic value, because 'intrinsic value is a matter of an individual's intrinsic properties and completely independent of what good or bad it can do for persons.'[9] And if the answer provided by this self-inquiry does not seem absolutely correct, it is very hard to prove that a different answer would be more

[8] David Hume, *Enquiries concerning human understanding and concerning the principles of morals* [3rd edition] (New York: Oxford University Press, 1988, first published in 1777) p. 242.
[9] M. Bernstein, 'Intrinsic Value' *Philosophical Studies* **102** (2001), 332.

correct; and this is because one can never be sure as to what the good is. In G. E. Moore's words:

> If I am asked 'What is good?' my answer is that good is good, and that is the end of the matter. Or if I am asked 'How is good to be defined?' my answer is that it cannot be defined, and that is all I have to say about it. But disappointing as these answers may appear, they are of the very last importance.[10]

And the reason they are of the very last importance is that every individual can think on his own, and decide on what is good, by-passing the need for definition. This is a cardinal difference between the old and the new theory of double morality: both are somehow situational, but while the old theory claims that we know what is good and what the correct answer is according to the situation, the new one prefers a merge of potentially good and potentially bad behaviours,[11] with the hope that perhaps the answer which will be yielded by this merge shall be the correct one. But even if it is not, no one will surely know. 'The virtuous agent, who possesses practical wisdom, will know the right reasons for action and will behave accordingly. However, the reasons he gives for his behaviour will be unconvincing to a non-virtuous agent.'[12] An individualistic approach has the advantage of being incontestable – if it is not beyond reason of course. Taking this into account, Baldwin modifies Moore's view as follows:

> Good is not definable in terms which permit a person to determine whether something is good without engaging in ethical judgment.[13]

So the physician who chooses a clearly personal view, after serious reflection, and based on both his role and his common morality, finds himself in the highest moral position. In general, there are higher

[10] G. E. Moore, *Principia Ethica* [revised edition] (Cambridge: Cambridge University Press, 1993, first published in 1903) p. 58.
[11] The term 'potentially' is used in the sense that a behaviour may be good or may be bad, but there is no way to judge it.
[12] Peter Allmark, 'An argument for the use of Aristoetelian method in bioethics' *Medicine, Health Care and Philosophy* **9** (2006), 73.
[13] Thomas Baldwin, 'The Indefinability of Good' *The Journal of Value Inquiry* **37** (2003), 327.

authorities than any individual of course, but when it comes to ethics the highest authority is one's self.

To be sure, this kind of individuality can be bad when it is applied to science as a whole, so this is why I have to make clear that I am referring to the moral part of medicine and not to its scientific part, which is very far from my area of knowledge. Also, I am not arguing that every physician should do whatever they like without offering any reasons; individuality has to be reasonable. This roughly means that, when the physician has pondered over an issue and reached a personal decision, for which he is able to present decent reasons, there is no need for any advice or any confirmation of the decision's rightness by third parties. Then of course, lack of knowledge can destroy this heroic figure of the physician with the highly personal and subjective morality. He might have decided something important and after a while his thoughts might have turned to a different direction, proving that he was wrong in his decision. But this is part of the procedure of self-knowledge and of the uncertainty which characterises it. Every decision is unstable and every morality is momentary, as the individual is constantly enriched with new knowledge, thoughts and experiences – in other words, Aristotle's practical wisdom. As Kierkegaard would put it, the individual thinker is continually striving, but this does not mean that in a finite sense he has a goal toward which he is striving, where he would be finished when he reached it; 'no, he is striving infinitely, is continually in the process of becoming ...'[14]

But we cannot expect physicians to act like Kierkegaard or like any other obscure and tormented philosopher. Some things have to remain stable at an individual level, or else the practice of medicine would perhaps lose its basis and its meaning. There has to be a goal. The problem is that many physicians do not know what this goal is, nor can they ever find out unless they acquire a certain personal awareness. Medicine as a profession does not have a definite goal or purpose; each physician has to find this out individually for himself. It can be something simple, such as to save a life or to reduce suffering, or something

[14] Soren Kierkegaard, *Concluding Unscientific Postscript to* Philosophical Fragments [translated by Howard Hong and Edna Hong] (Princeton: Princeton University Press, 1992) p. 91.

grandiose, such as to make an important discovery. Whatever it is, Medicine is the physician's instrument, helping him to reach his goal, and not the opposite, where the physician becomes a servant.

The other problem is that this personal awareness is subject to change anytime, according to one's practical wisdom. This can be quite painful, but it can certainly have better results: not only at a theoretical level, but sometimes even at a scientific one, as Novack and al would seem to recognise:

> Because physicians use themselves as instruments of diagnosis and therapy, personal awareness can help them to 'calibrate their instruments,' using themselves more effectively in these capacities.[15]

Good has to be invented all the time, not only because every medical case is unique, but also because every physician is unique, and furthermore, unique at any given time. One case could be treated differently by the same physician if it could be identically repeated in the future, even if the physician made absolutely no ethical mistake the first time. Physicians, like everyone else, have personalities and moralities which constantly change. So even if an ethical problem stays the same, its solution is never ready, based on a previous one; it has to be found again. There are no universal or everlasting solutions, only individual and instant ones. Does this mean that the new theory of double morality has nothing concrete to suggest, apart from a constant search within the individual? Perhaps so; but this is in no way unethical, but only too difficult; what it asks for is continuous moral development in the sense of a never-ending struggle. Thus understood, perhaps this individuality which double morality demands favours morality more than any concrete moral theory does.

Nevertheless, one may be forgiven for believing this is not always the case; we often encounter the phenomenon of routinization, which transforms one's moral world by shrinking it and leaving many moral

[15] Dennis Novack, Anthony Suchman, William Clark, Ronald Epstein, Eva Najberg, Craig Kaplan ,'Calibrating the Physician: Personal Awareness and Effective Patient Care' *JAMA* **278** [6] (1997), 502.

issues out of the question, just because one gets used to problematic situations.[16] And this is exactly why physicians need to be morally evolving all the time, even if this is much more difficult for them compared to routinization.

Double morality as a 'personalised professionalism'

I think that, up to this point, the more controversial concept that has emerged is the one of 'personalised professionalism', as opposed to my definition of professionalism offered in Chapter 1 as the physician's role morality. In line with the importance placed on individuality, a personalised professionalism can be expected to stress the need for a physician to separate himself sufficiently from a) other physicians, and b) Medicine's past. Kierkegaard believes that Socrates' highly individualistic phrase 'know thyself' can designate subjectivity, but that it also means 'separate yourself from the other'.[17] How can this happen, while allowing us still to argue that one belongs to a specific profession, rather than that the physician becomes a free agent, totally unaware of established professional practices?

By 'sufficient separation' I do not mean that one has to cut all ties with the medical world as we know it. This would be too much. It means, though, that a physician should acquire a certain level of authenticity. One does not have to be extravagant or eccentric in order to be authentic; nor does the physician necessarily need peculiar abilities or a great talent. One just needs to use one's abilities in a unique, authentic way. This is also what Howard Gardner supports, when he stresses the need for '... a realization that the profession does not have to be accepted the way that it is today; as a human agent, a person can work

[16] Daniel Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics* (Chicago: The University of Chicago Press, 1996) pp. 58-9.
[17] Soren Kierkegaard, *The Concept of Irony (with continual reference to Socrates)* [edited and translated by Howard Hong and Edna Hong] (Princeton: Princeton University Press, 1989) p. 177.

towards changing that domain.'[18] There has to be a unique way to practise medicine for any individual physician, one that leaves both the physician and the patient satisfied. The search for this way, and its constant re-evaluation constitute the core of the concept of personalised professionalism. Each individual physician should be personally and actively involved when it comes to moral decisions. In this way, he is able to render these decisions his own, even if they concur with similar decisions made by other physicians.

In my view, the most important obstruction to a physician's authenticity is Medicine's past. It is true that medicine has a great tradition and a very important culture; a glorious past, to put it differently. Medicine has offered immensely valuable services to humanity allowing people to lead longer and happier lives, and I think that there is no need to recite all the ways in which it has achieved that. Despite the attacks which physicians have had to face in recent years (caused mainly by lawyers), the vague notion that – to put it very crudely and unsophisticatedly – 'medicine has saved the world' still exists. For example, at the Nobel Foundation's Centennial Speech, Harold Varmus remarked that medicine has dramatically affected life expectancy and quality of health, and that the Foundation has always rewarded the ones who have made those discoveries for the benefit of mankind.[19] This notion certainly affects the image of modern physicians, and by that I do not mean the image that laypersons keep in their minds about physicians, but mainly the image that physicians have about themselves. To be sure, medical history is very important, and every physician should be aware of it; however, there is a common misconception regarding the way this history is used by modern physicians.

> Inheriting a tradition is not the same as commemorating it; indeed, it is rather the opposite. You come into possession of an

[18] Howard Gardner 'The Ethical Responsibilities of Professionals' *Good Work Project Report Series*, Number 2, 1998 (updated 2001), p. 9, available from http://pzweb.harvard.edu/eBookstore/PDFs/GoodWork2.pdf, accessed 14/10/2007.
[19] Harold Varmus 'Nobel Foundation's Centennial Speech, 2001' *Memorial Sloan-Kettering Cancer Center*, World Wide Web, (www.mskcc.org/mskcc/html/6285.cfm), accessed November 7, 2005.

> inheritance by taking it over and giving it a new opening in the future, not by tagging along behind it and taking your orientation from its past.[20]

Sartre has mentioned the example of a person who flies on a plane and exclaims that 'man is magnificent'[21] – assuming in this way that *any* man can consider himself honoured by achievements that are peculiar to *some* men. I cannot help but think of a different example. Picture the following image: a modern Greek drinks his ice coffee and reads his newspaper at the foot of Acropolis; and, as he turns his eyes to look at the temple of the Parthenon, he is filled with pride at the thought that the Greeks constructed this magnificent monument. This is a tragic misconception, and it directly condemns this modern Greek to inauthenticity, for he is using history and tradition in a completely wrong way. He is not inspired by the Parthenon; otherwise he would want to make something equally great of his own. He does not, he prefers to drink his coffee and read his newspaper. His pride rests with the past, so he offers his self to a vague notion of Greek ancestors by saying: 'It was us, Greeks, who made this monument.' Hence because he uses it in the wrong way, his culture causes the loss of his authenticity. The past has to teach us, not to guide us. When used correctly, it constitutes Aristotle's practical wisdom; otherwise it is inauthenticity.

A modern physician can find himself in a similar position. It is true that he represents a science which has offered many advantages to humankind, but he must not let this glorious past blind him and give him a false impression of himself. In order to be authentic, he must start from scratch. Medicine's past exists, but only as a reference, to give him the practical wisdom that he needs. The individual physician must not consider himself part of it. Each one has to create a medicine of his own, a personal medicine in the sense of professionalism, sufficiently separated from the past. By that I do not mean of course that every physician should have his very own methods or make his own

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[20] Jonathan Ree, *Heidegger* (London: Phoenix, 1998), p. 13.
[21] Jean-Paul Sartre 'Existentialism and Humanism' [translated by Philip Mairet] in Stephen Priest (ed.) *Jean-Paul Sartre: Basic Writings* (London: Routledge, 2001) p. 45.

discoveries, or that he is not allowed to use the experience of the past; learning from the past is necessary, as it constitutes practical wisdom. But this is as far as one should go. If an authentic self is what is best for any physician – or any one in general, but our focus here is on physicians – then pride and arrogance streaming from the profession's previously created status are not welcome. One should be proud only of one's own deeds.

This is not as simple as it may sound. One has to keep in mind that physicians form a very homogenised group, and, therefore, it is natural for a physician's good deeds – or bad deeds, for that matter – to be reflected upon other physicians. To many individual physicians it is not at all clear that they should be careful to be sufficiently separated from others, and never to rest on what has already been done by others. A simple piece of evidence to support this is the medical 'we', which is used by almost everyone entering the medical profession.[22] But the new double morality can help overcome these tendencies.

The god of Medicine demanded of every individual physician that he emulate the ideal physician, whenever such a need appeared, meaning that one should be entirely guided by role morality and medicine's history and culture. This perception resulted in inauthenticity. The refined concept of double morality which aims at merging role morality with common morality constitutes a step in the direction of the physician's authenticity and, thus, personalised professionalism. It admits that role morality is still there, but never on its own. Lay moral traits are continuously combined with medical ones, in an effort to achieve not an *ideal physician* anymore, but an *ideal self* – one who happens to be a physician. There is no personal element which is left outside the moral procedure; everything must be taken into account. There is a kind of 'moral democracy' as every moral trait deserves some attention by the agent. In other words, by viewing himself as a whole, by rejecting the concept of a 'split self,'[23] and by constantly using his entire

[22] Michael Hardimon 'Role Obligations' *The Journal of Philosophy* **91** (7) 1994, 357.
[23] William Dunning, 'Post-Modernism and the Construct of the Divisible Self' *British Journal of Aesthetics* **33** [2] (1993), 136.

personality instead of the traits which are more appropriate according to different situations, the individual physician approaches his authentic self.

Is that necessary? Why is authenticity, as separation from others, so important? I cannot hope to answer to this question with great success. However, I do see a necessity for authenticity in general:

> Various writers have pictured the emergence over two centuries of authenticity as a new ideal for human living ... an ideal that can save us from the nihilisms which threaten us following the self-destruction of what people once regarded as their highest values.[24]

Thus, there is no reason why this tendency should not be expected in the field of health care, especially if we consider that it is a field where important human values are regularly under serious threat. Of course, the main concern in recent years has been the patient's, and not the physician's individuality. Medical writers have stressed to physicians the importance of seeing every patient as an individual and not merely as a case, and constantly pointed out to them that the patient's personality should not be excluded by the concept of disease.[25] Again and again, we are reminded of our unmet need for a Medicine that can engage patients as persons, and respect their autonomy; it has been a very popular issue, and 'the philosophical flagship of modern bioethics.'[26] On the other hand, nobody has seemed to care very much about the individuality of the other person in the therapeutic relationship, that is, the physician. The thought may have been that there is no need to worry about that, as the physician has always been in a stronger position of power than the patient – indeed, this can be seen to be a chief source of the enthusiasm for patient autonomy. In any case, whatever the reason, some of medicine's biggest problems could be avoided, or eased at the very least, if there were an effort to treat physicians as individuals in the same

[24] M. A. B. Degenhardt, 'Should Philosophy Express the Self?' *Journal of Philosophy of Education* **37** [1] (2003), 42.
[25] Walter Burger, 'The relation between medical education and the medical profession's world view' *Medicine, Health Care and Philosophy* **4** (2001), 81.
[26] Jonathan Moreno, 'Bioethics after the Terror' *American Journal of Bioethics* **2** [1] (2002), 62.

way that patients are apparently keen to be treated. Patients are persons, we are told. So are physicians, but people tend to forget it. The new double morality, which is focused on the physician's entire personality reminds us about that.

Role and agent focused schemes

I hope that the big difference between the two theories of double morality has become clear by now. No theory was focused on actions; but, while the failed scheme of double morality can be described as 'role-focused ethics', the refined scheme is clearly 'agent-focused'; the interest lies in one's self. 'An entire self must be completely made over as an enterprising individual.'[27] And this is in line with the opinion of some medical educators, namely that we need to 'minimize ethics as quandary solver; maximize ethics as character builder.'[28] But let me repeat that the morally active agent can be very unstable. Therefore, the self we are interested in can never be taken for granted; it is a *self in flux*, as noted earlier. Szasz notes that:

> People often say that this or that person has not yet found himself. But the self is not something one finds; it is something one creates.[29]

But this process of creation has to be continuous. It is also necessary to create an *authentic self*. So what the new double morality dictates, based on the concepts of 'the moving mean', the physician's individuality, and the 'personalised professionalism' is roughly an *authentic self in flux* for every physician. 'As professionals, we may not be fully connected to our lives,' says Rachel Remen.[30] This may be true, but it has to be

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[27] Erica McWilliam, 'Against Professional Development' *Educational Philosophy and Theory* **34** [3] (2002), 291.
[28] Jack Coulehan, Peter Williams, Van McCrary, and Catherine Belling, 'The Best Lack All Conviction: Biomedical Ethics, Professionalism, and Social Responsibility' *Cambridge Quarterly of Healthcare Ethics* **12** (2003), 29.
[29] Thomas Szasz, *The Second Sin* (London: Routledge & Kegan Paul, 1974) p. 49.
[30] Rachel Remen, 'Recapturing the soul of medicine' *Western Journal of Medicine* **174** (2001), 5.

confronted. Would that be good for the patient and the therapeutic relationship, or could it add further problems? In what follows I shall defend the new theory of double morality and the concept of virtue on which it is based as well as I can.

II) In Support of the New Theory

In the beginning of this final section, I shall present the conclusions which can be drawn from the previous discussion of the theory. Then I shall consider three main objections to what I have been saying, and try to provide answers to them. Finally, I shall make an effort to sum up the new theory of double morality and support it with some concluding remarks.

Double Morality's Conclusions

In the first section of this Chapter, I suggested that the new theory of double morality is not role-focused, but clearly agent-focused, shifting the emphasis to the individual physician. Based on the concept of virtue which was examined previously it proposes an *authentic self in flux* for every physician. But this conclusion was quite general and vague; therefore, in what follows, and keeping in mind the practical examples which were revisited in the previous Chapter, I shall provide a list of conclusions which briefly pinpoint this thesis's main ideas.

a) Authentic acts are instant demonstrations of the physician's instant self

As I have already stated, the theory of double morality is not much of a moral theory, because it does not propose solutions to moral dilemmas, or suggestions about what is right and wrong. Thus, it does not judge the physician's actions – at least not directly – but rather each individual physician's character. One could argue that this is exactly what virtue theory does, since it considers which character traits count as virtues as

opposed to vices, and what constitutes good character as opposed to bad. But the difference is that the theory of double morality is not primarily concerned with the character's goodness; first of all, because good is not the same for everyone, and, most importantly, because it sees character as something which is constantly changing, like a series of successive instant selves. And in this context, what matters most is the authenticity of one's character, and its ability to perform authentic acts. So, in order to be authentic, the action which one takes at any given point, demonstrates one's character at that point, that is, one's instant self at that point. But this observation is not complete unless we examine how these 'instant selves' work – otherwise, one's character could become completely incoherent.

b) Authenticity requires an ordered succession of instant selves

An authentic action expresses one's instant self, but this self has to be reached through an ordered succession of selves. If one's self moves from stage A to stage C, there has to be a stage B in between; if not, it means that the agent has stepped out of his character's course, and behaved in inauthentic ways. This is so because one cannot have knowledge of C if one does not know B first. If this leap takes place, it is safe to assume that one is merely imitative.

c) Medicine has to turn against fake idealism

The real world of medicine has changed, and there is no point in trying to deny this if one is not willing to make the sacrifices which idealism requires. If, for example, a physician is willing to work for free, and he actually does, then he is a true idealist, and there is nothing wrong about that. But if a physician just dreams of a better medicine (more humane, more unselfish, more life-saving, etc.) without actually believing in it, then this physician is pretending – above all to himself. A glance at the real world of medicine, and at the mortal physicians who work there, suffices to convince us that, most of the time, idealistic demands do harm rather

than good. The shift of the emphasis from the institution of medicine to the individual physician leaves much less space for idealism, because it increases each individual's self-knowledge, thus presenting to him a more realistic image of himself and of his relation to his profession.

d) Personalised professionalisms are needed, even if they look anti-professional

In the beginning of the thesis, professionalism was described as role morality; thus understood, it refers to commonly accepted ways of behaviour, which are achieved by compromising some personal views and desires. The theory of double morality claims that individual characteristics must not be frustrated in the name of professionalism; instead it proposes that the active merging of role and common morality should create a personalised professionalism for each individual physician. Even if this strikes us at first as completely anti-professional, it is in fact reasonable when we consider that, first, we should care as well for the physician's, and not only for the patient's autonomy, and, second, that each physician has to sufficiently separate himself from his colleagues and from medicine in general. It is professional morality that needs to be adapted to every individual physician, and thus become a personal morality, and not the opposite, where the physician would end up losing his authentic self.

e) Internal conflict is desirable, even if it makes situations more complicated

Conflict sounds like bad news, but internal conflict is quite different. The interaction which constantly takes place between role and common morality certainly results in internal conflict. This is not to be viewed as a problem, but merely as a difficulty, which leads to increased moral awareness. It may also lead to moral dead-ends, away from any real solutions to practical problems. But for the physician, this procedure is of extreme moral value, as it provides a level of self-consciousness which

cannot be reached without conflict and the brainstorming that goes along with it.

f) The fusion of moralities does not necessarily mean intermediate solutions

We have seen that the constant interaction which takes place between role and common morality creates a 'moving mean' for the physician. This is not to imply that moral solutions have to be reached after mutual role and common compromises – otherwise I would have referred simply to a 'mean' and not to a 'moving mean'. The fusion of moralities presupposes that the physician's entire self has to participate in a moral procedure, and not just his professional or his lay side. Therefore, as I suggested earlier, the role of the physician is not 'pure', but 'disturbed' to a certain extent. But this is irrelevant to where one places his moving mean. Role and common elements interact, and all have to be taken into account, but when it comes to decisions, one can choose a rather one-sided, or extreme, course of action, if one thinks that it is for the best.

Three possible objections

Some views seem great in a theoretical context, but they can be quite meaningless if they cannot stand up to, put simply, a 'real-life situation' test. The theory of double morality may be interesting, but can it face a practical challenge? I shall now consider three possible objections mainly related to practical applications of this new approach. Many more objections could be raised, but, in my view, these are the most important ones, which require direct anticipation.

a) Is not the 'ideal self' idealistic?

The merging of role and common morality aims at an 'ideal self'. This self is difficult to achieve, and the physician may not want to pursue it. But even if there is a will, it is probably very hard for anyone to actually

achieve it. Stack asserts that it can never be fully realized, and therefore, there is an inevitable asymptotic relationship between what one is, and what one ought to be.[31] We have encountered a similar problem when discussing the 'ideal physician,' but there is a very important difference here: the concept of the ideal physician referred to a universal ethic, while the concept of the ideal self of a physician refers to a clearly personal ethic. The impossibility of the first case can be very disappointing, as it imposes a role-model which cannot be reached. However, the impossibility of the second case is not the same; 'professional institutions are not supposed to make physicians into saints.'[32] The ideal self is subjective and what one 'ought to be' cannot be defined – and even if it could, it would need constant redefinition, as its active evolution has been repeatedly noted. Therefore, some might want to say that the ideal self is a goal which does not have intrinsic value, since it cannot be reached; but the moral procedure, which one goes through for this impossible goal's sake, is of great value on its own.

b) Is the concept of virtue compatible with professional practice?

Virtue may sound good as a philosophical element, but perhaps it cannot have any value in the medical profession.

> Practitioners are generally not interested in meta-ethical debate and they can understandably become exasperated when someone tries to 'sell' virtue ethics by quoting the definition of paradigm character and failing to translate this into something that can be recognized as relating in a clear way to their lives and work.[33]

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[31] George Stack, *Kierkegaard's Existential Ethics* (Alabama: The University of Alabama Press, 1977) p. 119.
[32] Stephen Latham 'Medical Professionalism: A Parsonian View' *The Mount Sinai Journal of Medicine* **69** [6] (2002, 368.
[33] Ann Marie Begley 'Practising Virtue: A challenge to the view that a virtue centred approach to ethics lacks practical content' *Nursing Ethics* **12** [6] (2005), 626.

In other words, people, particularly those with little experience, need guidelines[34] which the development of one's personal virtue is not able to provide.

However, virtues can generate virtue-rules. Even though they are not as simple and easy to grasp as guidelines, they can be used in a professional setting. Within the virtue perspective the individual is engaged in a dynamic process of moral development, and the example of virtuous people is crucial to this development.[35] Physicians need to have proper educators, especially in the 'hidden curriculum' sector. 'Virtue theory emphasizes the influence of character on the individual, yet reveals that a virtuous character can be a disposition acquired through training, such as medical training.'[36] If this is true, why should the concept of virtue be incompatible with professional practice?

The problem is that the concept of virtue we have in mind is rather individualistic. 'Professionalism is a structurally stabilizing, morally protective force in society'[37] and, therefore, some people would find it quite incompatible with concepts like 'moving mean', constant search, and instant morality. However, this possibility depends on the aspects of individuality which one chooses to emphasise. I believe that the way I referred to it describes it as open-mindedness and flexibility, qualities which are absolutely compatible with professionalism, and even vital in order for a profession to survive. I think that the objection to individuality finds its way only if one ignores its other aspects and relates it to non-commitment. But being open-minded should not be confused with being uncommitted to anything at all.[38] One can hold a firm view and at the same time have an open mind about this view; and this does not happen only because situations are changing, but mainly because one's self is changing as well.

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[34] *Ibid.*, at 627.
[35] *Ibid.*, at 630.
[36] Erica Zarkovich and R.E.G. Upshur 'The Virtues of Evidence' *Theoretical Medicine* **23** (2002). 405.
[37] M. K. Wynia, S. R. Latham, A. C. Kao, J. W. Berg, L. L. Emanuel, 'Medical professionalism in society' *New England Journal of Medicine* **341** [21] (1999), 1612.
[38] Derek Sellman, 'Open-mindedness: a virtue for professional practice' *Nursing Philosophy* **4** (2003), 19.

Hughes notes this fact when she refers to medical students, and she wonders: 'If we seek to identify the personal characteristics we want in a medical student, can we have any confidence that they tell us anything about future personality or adjustment?'[39] But this is a more general question, concerning every individual, and at every stage of their lives. According to Nagel, the question whether the same self is preserved under all conditions is open,[40] while Parfit finds indefensible the view that our identity is determinate[41] (*Reasons and Persons* is full of arguments as to why he holds this belief). If our identity is not determinate, we cannot be certain that our instant firm views shall remain firm. But on the other hand, this does not mean that we cannot be committed to anything. A physician can be very committed to certain professional values for as long as these values are acceptable by the physician's *self in flux*. When they are no longer acceptable, new values, perhaps better ones, shall replace those that have become outmoded. Professionalism is indeed a stabilising and morally protective force in society, but professional values are subject to change for every open-minded individual.

c) Is 'personalised professionalism' possible?

Earlier, I mentioned the need for unique and personalised professionalisms to be adapted to individual physicians, instead of physicians being adapted to a universal professionalism. I also explained that even if what is correct cannot be defined and accepted by everyone, it does not matter as long as one's individuality is used effectively – which means that the physician should be able to present decent reasons in support of his decisions and actions, and thus prove that he went through a moral procedure before deciding about a particular issue. These views are risky, and the obvious objection is that this kind of

[39] Patricia Hughes, 'Can we improve on how we select medical students?' *Journal of the Royal Society of Medicine* **95** [1] (2002), 19.
[40] Thomas Nagel, *Mortal Questions* (Cambridge: Cambridge University Press, 1979) pp. 199-200.
[41] Derek Parfit, *Reasons and Persons* (Oxford: Oxford University Press, 1984) p. 239.

professionalism cannot be real as it fails to protect the patient, because what the patient needs to be protected from is exactly this individuality of every physician.

What seems to be the problem here is that we cannot easily leave the traditional concept of professionalism behind, the one that takes it to be the same as 'role morality'. This view has also troubled David Wilkins, the Director of the Program on the Legal Profession at Harvard Law School. In trying to understand how to redefine 'professionalism' more effectively, he organised an intensive course involving both law students and medical students entitled 'Ethical Dilemmas in Clinical Practice: Physicians and Lawyers in Dialogue.'[42] The overall effect of this effort was to shift the focus away from the norms and practices of particular professionals in favour of a more general examination of moral duties, making it clear that no group should be exempt from the demands of ordinary morality simply because they occupy a particular social role.[43] On the other hand, 'although common morality stands as the ultimate check on any assertion of professional ethics, it does not define the normative stance of professionals.'[44] Lawyers, just like physicians, are more than ordinary citizens. These remarks are perfectly in line with the theory of double morality, which demands a constant combination of role morality with common morality.

Besides, I need to say again that in a therapeutic relationship there has been a pressing demand to treat the patient as an autonomous individual, while the physician became increasingly stereotyped and lost much of his autonomy. Second, I believe that, even when a concrete professionalism and a spotless professional exist, they do not ensure that the patient shall be treated in the best possible way. Sometimes, a highly personal and perhaps anti-professional response (like, for instance, having a sexual relationship with a patient) can function better than confining mutual desires, but being professionally on the safe side.

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[42] A complete analysis of this course can be found in David Wilkins 'Redefining the "Professional" in Professional Ethics: An Interdisciplinary Approach to Teaching Professionalism' *Law and Contemporary Problems* **58** [3/4] (1995), 241-258.
[43] *Ibid.*, at 244.
[44] *Ibid.*, at 249.

Mackie says that morality may well need to be in part remade,[45] and, accordingly, professionalism may well need to be challenged all the time. This can be done only if it is to be adapted to one's entire – and individualistic – personality. 'One should be *morally* good, a good man ... If a good professional must be a bad man, then it is immoral to be a good professional.'[46]

Concluding remarks

As we have seen, the new approach offers an alternative point of view in many bioethical issues. This point of view often seems complicated and it renders discussions on morality more difficult. Sartre states:

> You are free, therefore, to choose – that is to say, invent. No rule of general morality can show you what you ought to do: no signs are vouchsafed in this world.[47]

Without any signs, one can easily get lost. But we should note that, even if rules of morality cannot show what to do and one is left to invent, it is very probable that one can come to the same rules through one's personal creation. So it is not as if a physician has to invent something entirely new and original; the results of his creation can be exactly the same as a set of rules of his role morality. But the difference is that, when he finds these rules on his own, they have intrinsic moral value in addition.[48] Therefore, when a rule comes from within it has much greater value, even if it is only an instant rule. And in my view, this greater value can justify the difficulties of the new approach of double morality.

The focus is on the individual physician and the ideal self which he should continuously try to approach, because 'it is in the self and not

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[45] J. L. Mackie, *Ethics: Inventing Right and Wrong* (Harmondsworth: Penguin Books, 1977) p. 123.
[46] Arthur Isak Applbaum, *Ethics for Adversaries: The Morality of Roles in Public and Professional Life* (Princeton, New Jersey: Princeton University Press, 1999) p. 40.
[47] Jean-Paul Sartre 'Existentialism and Humanism' [translated by Philip Mairet] in Stephen Priest (ed.) *Jean-Paul Sartre: Basic Writings* (London: Routledge, 2001) p. 34.
[48] Denise Tarlier, 'Beyond Caring: the moral and ethical bases of responsive nurse-patient relationships' *Nursing Philosophy* **5** (2004), 235.

in social roles or practices that moral agency has to be located.'[49] In order to try to achieve this, it is necessary to unify the physician and the layperson, the role and the common morality. Fosdick notes that the central criterion of successful personal living is somehow to pass from mere 'multiple selves' into the poise, balance and cohesion of a unified personality,[50] and MacIntyre adds that 'role and personality must be fused.'[51] It is only in this way that physicians should be able to fully explore different aspects of their lives and 'develop personally as interesting and interested individuals'[52] instead of moral chameleons who adapt to fit roles. If they cannot unify their medical roles and their lay personalities, all the dangers and the disadvantages of the old theory of double morality shall be present, hazarding the individual physician and his personal moral development.

Mary Warnock describes something very similar to double morality when she mentions the concept of *private morality*:

> When I speak of private morality ... I mean a morality grounded in a mixture of principle and sentiment, from whatever source these come, which together give rise to an imperative for the person who experiences the mixture.[53]

The 'principle' which she talks about can refer to role morality, while the 'sentiment' can be equivalent to common morality, expressed as an inherent moral instinct. It is clear, however, that her theory is also focused on individual persons, who experience the mixture. And this inevitably leads to a perception of ethics as a personal moral procedure: ethics is not 'the history of moral codes or the application of universal

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[49] Sartre, *op. cit.*, p. 32.
[50] Harry Emerson Fosdick, *On Being a Real Person* (London: Student Christian Movement Press, 1943) p. 38.
[51] Alasdair MacIntyre, *After Virtue: a study in moral theory* [2nd edition] (London: Duckworth, 1985) p. 29.
[52] Sarah Elise Finlay, Monica Fawzy, 'Becoming a Doctor' *Journal of Medical Ethics: Medical Humanities* **27** [2] (2001), 92.
[53] Mary Warnock, *An Intelligent Person's Guide to Ethics* (London: Duckworth, 1998) p. 23.

moral imperatives; ethics takes on the idea of a flow, movement, the idea of a work of the self on the self.'[54]

The views expressed in this chapter about the new theory of double morality are not unchallengeable. However, I believe that, as a theory, it offers a different angle in medical ethics, laying emphasis on some issues that have been much neglected, or even forgotten. The creation of a unique self and a unique moral identity is important, but it does not appear to have a direct *practical* value; therefore, it is often taken for granted, or not discussed at all, as clearly practical issues are more urgent and require immediate attention. But some important issues are often neglected for the sake of urgent ones, and priorities related to personal moral development are difficult to set.

> People for the most part fail to see that they are self-creating beings ... In our day-to-day existence, we tend to drift along into the public ways of acting, doing what 'one' does, and we assume that our lives are justified so long as we are conforming to the norms and conventions accepted in our social world.[55]

I hope that this is not the case. There certainly is an institutional dimension to morality, but the fact that an individual occupies a social role is never in and of itself a morally significant fact. As the leading figure of Harvard's 'Good Work Project', Howard Gardner, states: 'Greater mindfulness about our responsibilities has become a necessity if we are to pass on to our progeny a world that is worth inhabiting.'[56]

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[54] Adrienne Chambon & Allan Irving, '"They Give Reason a Responsibility Which It Simply Can't Bear": Ethics, Care of the Self, and Caring Knowledge' *Journal of Medical Humanities* **24** [3/4] (2003), 267.
[55] Charles Guignon & Derk Pereboom (eds.), *Existentialism: Basic Writings* (Indianapolis: Hackett, 1995) p. xxxi.
[56] Gardner, *op. cit.*, p. 13.

EPILOGUE

I believe that, on the pretext of double morality, I have made a quite extensive discussion of some issues of medical ethics. Double morality is a troubled concept as we have seen; it started with a direction that was proven to be wrong, it was based on uncertain presumptions, and it received many attacks which pointed out its weaknesses. However, when some failed notions were removed, the new approach that was adopted resulted in a refined concept of double morality, which I find to be worthwhile. A physician's morality and a layman's morality are, in a great extent, prefixed and probably rigid. Double morality combines them and offers new perspectives in this way. When viewed as a continuous blending of two separate – separate, but not separated – moralities, which takes place within every physician individually, double morality gains some value. It shifts the emphasis from medicine as an institution to the physician as an individual, and it creates 'personalised professionalisms' thus protecting both the patient's and the physician's autonomy.

Perhaps such an approach is necessary in the field of medical ethics. Hafferty and Franks make a very interesting point in the following passage:

> ... there is a valid and operationally viable distinction between 'good doctors' and doctors who 'do good', between ethical physicians and physicians who act ethically; and ultimately between an ethics that exists independent of its practitioners and external to the problem at hand (and thus can be characterized as something that can be *applied*) and an ethics that functions as an integral part of the physician's identity.[1]

In the above passage lies the big difference between the failed concept of double morality which I discussed in the beginning of this thesis, and

[1] Frederic Hafferty and Ronald Franks, 'The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education' *Academic Medicine* **69** [11] (1994), 864.

the refined concept of double morality, the development of which occupied the last chapter. The god of Medicine existed independent of physicians, and created a role morality to which they had to adapt themselves; without this god however, every individual physician can use this role morality in whatever way he thinks better, by combining it with his common morality, and thus creating an integral morality of his own identity. In other words, the old double morality does not work because it is based on the presumption that rights and wrongs in health care can be objectively defined and universally acknowledged, while the new double morality is less ambitious, and, therefore, more effective. It encourages every physician to be constantly aware and more active when it comes to moral reflection. It suggests that one cannot be based on the profession's collective ways of thinking and moral rules, because 'without reflecting one's own thinking patterns a "bad" epistemology is established.'[2]

Are these remarks of any practical value and use? I daresay they are not, at least not directly. The refined concept of double morality can be interpreted as instigation to more thinking before acting from the part of health care professionals. This could be seen as quite useful; however, it is not at all certain that this thinking results in any practical solutions to moral problems, or even in different appreciations of specific situations. To be sure, it may result in a 'good doctor', but not in a 'doctor who does good'. Besides, if we accept that moral dilemmas rarely have satisfactory solutions, it is certain that the more one thinks about them, the more confused one gets. Therefore, the notion of goodness becomes extremely fragile and the physician starts resembling heroes of tragedies, always trapped in moral uncertainty.[3] It seems that, by focusing on the individual, the refined concept of double morality seeks to add problems and difficulties rather than reduce them.

However, I believe that I have sufficiently stressed the importance of individuality, and explained why it should be preferable as a moral

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[2] Walter Burger, 'The relation between medical education and the medical profession's world view' *Medicine, Health Care and Philosophy* **4** (2001), 80.

[3] See, for example, Martha Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy* (Cambridge: Cambridge University Press, 1986) p. 25.

attitude despite its difficulties. Double morality as a tool can help the physician to achieve his individuality. It does not offer any guidance or solutions to moral problems, but it potentially leads the physician to his ideal self. In so doing, it forms him in such a way so as to find his personal solutions to moral problems, and work as a master of medicine instead of its servant. In my view, the physician deals more effectively with his profession as a consistent personality than he does when he tries to keep his professional and his personal self separated. Medicine is an integral part of every physician's life. But every physician's personality should also be an integral part of his practice of medicine. The outcome of this blending can never be certain or safe; but this is in line with the medical tradition. Throughout the years, medicine has never been either certain or safe.

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