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Technical expertise as an ethical form: towards an ethics of distance

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Author's abstract

The present article proceeds from the observation that the therapeutic relationship is basically unequal. This inequality essentially concerns the respective situation of the patient and his or her doctor vis-à-vis medical knowledge. A strict professionalism guarantees that this inequality remains factual and without essential value. Yet, if both partners unreflectively allow affectivity excessively to intrude into their relationship, their behaviour may then be inspired by subconscious, rather than rational, motives. In that case, the unverifiable allegations of philanthropy or paternalism may be used to rationalise a kind of 'medical sadism' which attempts to justify the will to humiliate the patient by means of the constraints inherent in medical care. The concept of ethical form *is introduced as a non-verbal criterion of ethical reliability. It is mainly a way of training the will through the application of rationally justified rules of behaviour. In this context, it is suggested that an effort to remain constantly within the limits of professionalism represents a method of training for the achievement of some degree of ethical credibility in the therapeutic relationship. In the long term, such abstinence could constitute a sort of catharsis, and thereby help to reveal the non-rational motives in medical behaviour. Contrary to the belief prevailing in modern society, the established limits of medical knowledge are not so broad. The application of these limits would probably be the best method of preventing emotions from interfering undesirably in the therapeutic relationship.*

The current protests against 'medical power' tend to contrast medical technology with the ability to communicate. Sometimes, the former is regarded as a possible source of contempt for the patients. The purpose of this paper is to suggest, in direct opposition to the prevailing trend, that the process of development of an optimally technical approach could ensure an ethical basis for the practice of medicine.

Let me begin with two observations which could probably be documented without too much trouble, but will be stated rather dogmatically, as simple premises. The first is that the dispenser and the recipient of medical care are engaged in a fundamentally *unequal* relationship. In a world which regards disease as a regression and death as the ultimate evil, how can these two individuals relate as equal? The patient maybe suffers incomprehension; is physically, mentally or psychically diminished; experiences pain or anticipates it. As E D Pellegrino writes, the patient 'suffers what is nothing less than an ontological assault' (1). The physician is said to know; is required to exercise a competence; is not suffering; and is entitled to prescribe, forbid, touch, penetrate – even mutilate. As a result of this basic inequality, the patient is 'forced to place himself under the power of another person' and is in 'a state of wounded humanity'. No honest approach to medical ethics can disregard this problem.

Let me make the second observation, before surveying the consequences of the first: Western medicine is violent and thus offensive for the patient. The word 'violent' is not aimed at giving unnecessary offence: it means only that quite often, medicine is a potential source of harm – or pain. Giving an injection, the most trivial medical event, is a considerable corporal aggression – having regard especially to the usual norms of non-violence which prevail in social behaviour today, at least theoretically. As to tests referred to as 'non-invasive', their pathogenicity is often suspected – or even known: x-rays are the archetypal illustration of this, but present debate over ultrasonography shows that nothing can safely be assumed safe (2). Is it necessary even to mention drugs, with their inexorable side-effects (3)?

It is useful to emphasise that, up till now, my remarks have not been value judgements: I have not said that the patient's inferior status is shocking or regrettable (or, on the contrary, desirable); nor have I criticised the current state of the art in therapeutics. But if the reader may agree with the statement that the therapeutic relationship is inferiorising and violent, then he will not find as ethically unacceptable the suggestion that the primary justification for a medical act should unquestionably be the patient's request: the doctor should act when requested to do so. The obvious corollary: the therapeutic relationship – which is incompatible with 'unwounded humanity' (ie: the normal equality characterising a genuine human

Key words

Doctor – patient relationship;

relationship) – should be confined within stringent limits.

A first objection to the foregoing might be the following: if a request from the patient is necessary before any medical intervention, what would happen if a patient were unable to express his will? In my opinion such an objection will impress only those who refuse to face the ramifications of what I am trying to deal with, namely the medicalisation of society. Finding an isolated comatose accident victim is a real event but a specious dilemma. Which of us, finding a person unconscious and wounded, would think that *this* particular person would certainly be opposed to any medical or surgical action being taken on his behalf? If the issue of the medicalisation of society were only a matter of deciding whether a doctor can intervene when someone is temporarily physically prevented from expressing his will, there would be no problem at all (of course, I am less inclined to be so serene about psychiatric cases, when a subject is judged – by whom? – to be irresponsible).

A second possible objection suggests itself: what is to be done if the patient makes an excessive, or unacceptable demand? I have not claimed that the patient's desires should govern the therapeutic relationship, but merely that a request is a necessary pre-condition for establishing a relationship. A doctor is in no way bound to submit to the desiderata of the person consulting him. His professionalism and his personal ethics may guide him to reject an inappropriate demand. The familiar claim that he must sympathise with a person's suffering is not relevant here (and is perhaps a justification for maintaining an unequal relationship). There is much suffering that cannot be dealth with medically: what kind of privilege could the doctor claim? Faced with it, he is like everybody else: he does not know what to do. . . . In fact, is it not a bit comforting to pretend that a patient's demand has to be met, thereby assuming that it *can* be met? Does admitting the limitation of one's knowledge not further the limitation of one's power as well? From which I conclude that declining to take medical action may be a more clear-minded gesture of humility than a sign of inhumanity, as is suggested by improper propaganda.

Some may object that my diatribe is out of step with modern medical practice. The time is past when doctors were content to be technicians; what we actually need is an all-embracing attitude in medicine with a holistic view of the individual as a physical, psychological, social being, etc. Thus, from then on, the inquiry will advance in three stages. Firstly, what are the scientific and moral objections to 'holistic' medicine? Secondly, what kind of limits may the patient-physician interaction be bound to? Thirdly, what are the philosophical value and implications of the proposed limitation?

1. Against 'holistic' medicine

Who could claim that modern medical interventionism has set for itself any limits in number, space or time? It is necessary to insist upon the quasi-religious role of contemporary medicine which tries to cure the psychic or somatic manifestations of a protean world-weariness: with what success? To talk about the sacrosanct preventive medicine, which tends to transform everybody into a potential patient: in accordance with which universal ethics or philosophy of life? And what can be said about the innumerable areas which are seized by a medicine which claims to dictate dietary, recreational or sexual behaviour? In the name of which kind of validated and justified knowledge? So, across numerous rifts in the hippocratic paths, we approach a situation of greater intrusion, more medicalisation, and, thus, more inferiorisation.

Incidentally, I want to point out that it does not follow from denying that the patient is a spontaneous source of demand that he can be said to be treated against his wishes. In effect, between the extremes of spontaneous demand and actual constraint, there is the middle ground of plain consent. Thus, the point is to examine the nature of the offer. Consider the many remedies that are 'offered' by fringe medicine for overweight, impotence or cancer. Few doctors would disagree that they raise thorny ethical questions. But consider now whether the countless offerings with which *academic* medicine increasingly affects our lives have greater credibility. Exactly what scientific grounds underlie the large-scale medical enterprises I mentioned above? So what does it mean to say that a demand is 'spontaneous', if the person requiring treatment has, by a *cultural mystification*, been encouraged to develop false expectations? What is the impact of the constant incitement to expectation which results from exaggerated claims about the depth and reach of medical knowledge? Surely one who demands treatment consents to it; but if the patient has been misled into overconfidence, there can be no informed consent.

Thus, the cases against contemporary medical interventionism could clearly be developed on pure scientific grounds. The issue at stake is that of the validation of medical knowledge. For example, there is a striking contrast between the amount or frequency of nutritional recommendations or prescriptions on the one hand, and the huge scientific uncertainties which persist concerning even elementary mechanisms or consequences of obesity, on the other (4). And, for obvious linguistic reasons I prefer to spare my reader a diatribe against sexology – even on pure scientific grounds. . . . When scientific papers show that our diagnoses may be false as often as in 50 per cent of cases (5), or when researchers may ask whether we are losing the war against cancer (6), we should return to an attitude of professional humility and expend our energy on improving our technical procedures rather than aiming at more intrusion into the lives of people. ... When one reads that if a young man chooses to avoid the severe nausea associated with the

chemotherapy aimed at curing his testicular cancer, this may require the physician's 'coercing the patient to complete the therapy' (7), the first question should not be: has the physician the right to coerce someone who is a free moral agent (which is, of course, a very good question) (8)? But: is it possible to coerce somebody to complete a therapy which has not proved its efficacy in 100 per cent of cases? . . . The ramifications of this question of validation, however, are of philosophical importance: the current trend in medicine is too 'total' not to risk becoming totalitarian. One cannot help shuddering when one hears a 'progressive' doctor insisting that she cannot treat a patient unless she knows *everything* about him (9). Again, what authority, what validated science give her the right to force patients through a confessional? How has she achieved the spiritual perfection which will guarantee her patients and herself that she will always find her place in this relation of glaring inequality? Which criteria will she use to distinguish her technical requirements from personal needs to ensure her superiority?

To sum up, 'holistic' seems a nice word to characterise a model where the doctor is envisaged as a priest, while actual scientific failures of contemporary medicine are discreetly swept out. It is undeniably true that this model of the doctor-patient relationship tends toward paternalism – that is a sort of complacence with the patient's inferiority. Sadism – in the Freudian sense – being, in the last analysis, the refusal or inability to treat others as equals, I consider paternalism as no less than a special form of medical sadism. It is a fact of observation that some physicians who are undoubtedly loved by their patients, have major difficulties in their human relationships as soon as they are in an extra-professional situation. Indeed, it costs more than some kind words, more than a nice condescension, to have a satisfactory relationshp with a spouse, a child, a colleague or any kind of person who is not in a situation of objective inferiority. . . . Medicine, however, should not be a place for solving the doctor's problem of interpersonal relations: we should decline any libidinal benefits from an exceedingly unequal relationship. The degree of dissimulation or rationalisation which every human unwittingly deploys in order to justify (*a posteriori*) his behaviour makes it important to find better criteria than our good faith or honour to provide a sounder basis for professional conduct.

Of course, it is not claimed that the *subconscious* and the *rational* are necessarily opposed; but when reason commits itself to justify actions inspired by subconscious motives, it makes *rationalisations*, ie perversions of reason. What after all, is that 'conscientiousness' behind which we take refuge whenever faced with a hard problem? Naturally, none of us would recognise a need to be needed or claim to experience pleasure of advantage in weakness of others – or in their confession. Yet, who is sure to be completely insensible to the gratitude, expectancy or simply the docility of a patient? Thus, how can the solicitude of a physician for another human being be that of a respectful adult, and not an expression of affective immaturity? We need a measure of confidence in our benevolent allegations – an *ethical form*.

2. Limits of the patient-physician interaction

I have followed two apparently disparate lines of thought. First, I have evoked the patient and his suffering in the therapeutic relationship; then, I have gone on to question the reliability of medical knowledge – especially its relevance and its significance. The two problems are intimately intricated, and of primary importance for a professional ethics.

In medicine, as mentioned above, technical necessities result in a situation based on an inequality of knowledge and a violence of procedures. *This inequality and this violence – factual in themselves – create optimal conditions for a drift of the therapeutic relationship into a situation of medical sadism.* Sadism begins when mutual or unilateral pleasure (perhaps subconscious) tends to prolong or aggravate the constraints of medical care beyond the limits which can be justified by pure technical or scientific considerations. Thus, the fundamental question of medical ethics is, in my opinion: how to prevent an inequality of fact from becoming a moral (or essential) inequality?

In a country like France, it is difficult to be a 'progressive' doctor today without acknowledging some degree of discipleship in respect of Balint (10,11). A number of our contemporaries are confident that a Balintian approach enables them to avoid the pitfalls of medical power.

Apart from whatever reservations Balint's thinking might itself elicit, one may question how and why it has become fashionable. In the mundane realm of everyday life, there is no self-contained idea of static validity: any evaluation of philosophical or other creative work needs to be dynamic – in this case, historically based. What was the impact of Balint's ideas at the time of their publication? I do not presume to make a definitive analysis, but there can be no doubt that the post-war period was a time of great enthusiasm for technology and that Balint's work, focusing as it did on the irrational tenor of a one-to-one relationship, ran counter to the current opinion that chemistry and pharmacology promised remedies for the major ills of humanity. Balint can therefore be said to have led at the time a protest movement.

And today? I do not think that Balint's ideas, locked in a remote historical setting, have kept their potential for generating critical questions. In conformity with a classic outcome in 'l'histoire des mentalités' (when identical ideas may be applied to opposite purposes according to the cultural context), I believe on the contrary that these ideas may now emerge from the cracks in today's medical power to prepare for that of tomorrow. Indeed, our environment has changed in the last forty years: the dominating way of thinking is

no longer submitted to a triumphant technology. Therapeutic research is stagnating; as a sign of the times, demographers wonder whether the decline of the rate of mortality may be coming to an end (12). Unable to provide new technological answers which people have understandably come to expect, medicine is side-tracking the problems. Far from admitting its (perhaps transient) incompetence, it is turning to the Psychic or even the Spiritual. What a transformation this is! Here I am not seeking to revive the ancient dichotomy of mind and body. I am simply observing that our academic medical training is based on the body, and that transferring one's attention to the mind after reaching an impasse with the body is covering up one form of ignorance with another. In this strategy, the theories of Balint (which amazingly circumvent the question of the psychological training of physicians) furnish a formidable weapon. Therefore, I see no evidence of any progress being made in this psychological drift: where is the dissident threat, this time, in these once unorthodox ideas? Their most evident potential now is to preserve medical power by masking its failures.

In contrast, all the great minds of medicine have perceived the asymmetry and risk inherent in the therapeutic relationship, and have made a point of mapping out the boundaries of their art sharply. Hippocrates, the very first master of Western physicians, springs to mind. His strict prohibition of sexual relations within the care relationship is well known, but perhaps, more understandable in the light of some current trends in medicine. In an age with different social structures or magical practices, the sexual privilege which the dispenser of care exercised over his patient or entourage may have seemed less egregious than we think. Why should Hippocrates expressly have required of his disciples that they renounce this perhaps common privilege? Precisely because the medical care relationship that Hippocrates has initiated is by nature so inferiorising that, without sternly imposing limits on our gestures, we could not prevent the victim of our position from devolving to a state of non-being. And what fulfilment could we gain from relations created and accomplished by subjugation? Would we not degenerate into symbolic assassins? A reference to the great Freud is equally inevitable – even independently of the sharp insight that psychoanalysis gives to the real nature of an unequal relation between two persons. Freud's prohibition of sex within the care relationship is also well known, though less attention has been given to his determination to eliminate physical examination from the psychoanalytic encounter (a wise precaution, sometimes ignored by child therapists: would violence to children be a lesser evil in our society?). Why this freudian exclusion of any gesture involving the body? Freud – who always acknowledged the legitimacy of self-analysis for his disciples – was sufficiently aware of the suffering of analysis to appreciate, with his deep medical genius, that the patient's necessary abandon had somehow to be limited. The 'fundamental rule of analysis', by requiring mental obedience, necessarily excludes the physical docility which is generally expected in any other medical situation. Establishing the analytic relationship depends also on this unwritten contract: the patient cannot become 'the thing' of the doctor, since he is assured inviolable protection of bodily privacy.

The end result is that a patient cannot be asked to surrender both psychically and physically: one or the other must be chosen. Power over body and soul is precisely the province of God alone 'who fathoms the loins and the hearts'. It is not here a question of religious belief: the point I want to raise is why some modern prescriptions tend to transpose to a social relationship what the collective imagination has for a long time seen as the reason and power of divinity. For us simple mortals, the acquisition of human maturity seems manifested by the ability to attain cognisance of the other as an integral being who remains at a certain distance. The divine prerogative that those who make a profession of treating illness claim, could correspond to overestimation or emotional immaturity more than to great charity. If it is necessary to choose in a medicine traditionally oriented towards the care of the body, the sexual chastity which is usually required for the physicians could *represent* a prototype and training – a paradigm – for a more complex form of reserve: an emotional and intellectual chastity. And the fundamental question of medical ethics becomes: how to establish with precision the *distance* to which a patient is entitled in order to feel respected and recognised?

The extent of our scientific knowledge or technical power provides us with an upper bound of what can be done with a patient. In medicine it is probably not acceptable to do whatever is technically possible; but it is surely immoral to aggravate the constraints of medical care beyond what is scientifically justified. By carefully delineating the area of possible relationships with patients – as the domain of reliable validated knowledge – and by appreciating the patient's autonomy and his right to privacy, we could set clear limits beyond which we would agree not to go. By restraining ourselves, and possibly by diverting the disastrous request of a patient in perdition, we might convince ourselves that two beings remain separated by an unencroachable gap. Coming to grips with the irreducibility of others means accepting that the patient is not a site for the crystallization of egoistic fantasies but is a whole 'object' in the psychoanalytic sense, and end-in-himself in a Kantian sense.

3. Discussion

The present paper is nothing more than a suggestion for further reflection; it does not claim to solve every problem of medical ethics. One evident difficulty lies in my proposition of reappraising the concept of technical expertise, which is basically imprecise: in medicine, there is no consensus on what is scientifically

validated, and what is not. The present debate over carcinogenicity of oestrogens is a paradigm of this sort of difficulty (13,14,15): is the corpus of knowledge about the pill sufficient to subject millions of women to a risk perfectly known – or not?

Nevertheless, continuously reassessing, objectively and uncomplacently, the breadth of his validated knowledge in order to determine to what extent he can and should respond to a patient's requirements represents for the physician a challenging exercise in ethics. More: an ethical training. Let us call *form* a means for training the will towards the progressive acquisition of a certain spiritual state: a precise and well delimited performance to be engaged repetitively, similar to those which have been constantly called for by philosophers (like Epictetus or some mystics) more concerned with action than with talk in ethics. Even before Freud instituted the 'era of suspicion', it has always been known that words are not adequate proof of the authenticity of moral feelings. In ethics, forms are required by the necessity of a shift from the subjectivity of verbal allegations towards more objectivity: one is not moral alone. . .

As guarantors for the content, ethical forms are twofold: in medicine, for example, they concern the two partners of a transaction, namely the patient and his doctor. *For the patient* the definition of an area of validated knowledge and the certitude that interaction with the physician will not go beyond these limits, is a kind of protection. The objectivity of the process lies in particular in the fact that the physician could be questioned about the practical consequences of his actions and that – possibly – his answers could be checked. It is one thing to ask a woman about her sexual life (as priests did in the past – at least in Latin countries (16) . . .); it would be another to explain to her with some degree of precision what kind of influence her answer will have on her treatment. . . . But ethical forms are also a guarantee *for the physician* himself. Indeed, many papers on medical ethics seem to consider that inappropriate moral actions will harm the patient only. From a moral standpoint however, a physician may be essentially damaged by his ethical errors. To lack intellectual or moral chastity with patients, to be content with their objective inferiority, is to prevent oneself from acquiring more humanity and maturity: that is to stagnate in one's innate sadism.

Of course, the technical model proposed here has potential dangers: that of a dehumanisation of medicine, for example. But even in the present state of the art, this risk exists already. If I had to be treated by a sadistic physician, I would prefer to be in a situation severely restricted on scientific ground rather than left to his free will, as would be the case now.

Moreover, it is not true that technicality necessarily implies a dehumanisation of medicine. On the contrary, excessive intrusion in the life of people is likely to fit with bad science. For my part, I perfectly agree with A R Feinstein that good science (or technique) could permit a re-humanisation of medicine, for example by restoring attention to crucial, but 'soft' clinical data, which can be managed today with reasonable rigour and standardisation (17,18). Henceforth, the challenge for a physician is to be human as a technician (or a scientist), not as a priest. . .

A major objection against any paper like this one could be that scepticism about the possibility of philosophical medical ethics which was ironically outlined by R Gillon: 'it's all too subjective' (19). Firstly, despite its subjectivity, an ethical reflexion furthers rigorous analysis of the issues at stake; this analysis may be of interest even for those who reject its ethical presuppositions.

Secondly, I would like to emphasise that modern medical interventionism itself is by no means morally neutral. Two of its moral prejudices are easily recognisable:

– a view of illness as fundamentally bad, and of death as the ultimate evil.

– a strong positivism, characterised by a good deal of optimism about the breadth, significance and reliability of medical knowledge.

Thus we have to convince ourselves that questioning modern medicine on moral grounds does not represent an (out-of-date) fight of Philosophy against Science: simply a confrontation between an explicit and an implicit ethics. Thirdly, it is illusory to believe – as Pellegrino does – that it is possible to propose a professional ethic 'prior to (. . .) a fairly wide range of value system', ie independently of any philosophical commitment. We have not one ethic as physicians, another as parents, another as believers or atheists, another as citizens, and so on. We have, or we have not an ethic, and as Seneca remarks somewhere in his Letters, the best criterion for a moral philosophy is the ability of its followers to live accordingly in a constant, consistent and convincing way. For a professional ethics, to have a general philosophical derivation is not a flaw, but the hallmark of a high standard – and a prerequisite for internal consistency.

In medicine, technical necessities impose an inequality of skill and a violence of procedures; as such, they may act as rationalisations of a medical sadism. The natural dynamics of unequal situations is a spontaneous tendency towards worsening.

It is illusory or presumptuous to believe to be possible the assessment of the genuine motivations of a person: allegations of moral sincerity are essentially irrefutable. That does not mean, however, that relational transactions are confined to a savage confrontation of subjectivities, since subjectivity expresses itself by the means of social acts which can be tested or subjected to some kind of verification. One major ethical duty of social life should be to make as objective as possible the subjective content on which social acts are founded, in such a way that others could have some indication of the authenticity of the motives.

A shift like this could be named a *process of objectivation;* an *ethical form* is the process of objectivation of a moral subjectivity. The aim of social life is not to believe (or to make others believe) any kind of subjective allegations; it is rather to ask for (and to give) as many proofs of authenticity as possible.

Too often, in medicine, the concept of *trust* is perverted – and acts as a means of alienation: it is not the duty of a patient to take the physician's word for it. As there is no possibility of checking the doctor's sincerity, it is useful and even necessary to assess the reliability of the technical necessities governing his action. As an ethical form, the concept of technical expertise needs to be reappraised: if medical prestige has the value of Science in modern society as its main origin, then it should be normal to question most of the medical attitudes on scientific grounds.

From then on, the risk of seeing the patient's objective inequality transformed into a humiliating situation would decrease – if not vanish. It is important, in effect, to remark that inequality is not, in itself, negative. For people (physicians included), an illness can be an important spiritual experience: that of the limitation of one's autonomy, for which the help of another human being may be required. Inescapable as it is, this request may be a positive experience of self-knowledge which depends on a firm definition of the respective roles and mutual distances.

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