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TECHNIQUES AND PERSONS: HABERMASIAN REFLECTIONS ON MEDICAL ETHICS

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Introduction

In a recent article in *Human Studies,* Richard M. Zaner (1984:71-90) has argued that the tasks of medical ethics have failed to achieve clear definition despite the generous quantity of contributions to the field. This failure has prompted several individuals who are directly acquainted with medical ethics to wonder if it really serves any useful purpose at all. Zaner (1984:77) refers to knowledgeable doctors who "are deeply skeptical about the supposed fruits of the two-decade-long attempt at serious flirtation between medicine and philosophy". While remaining fully aware of these frustrations, Zaner (1984: 80-85) then proceeds to sketch some "significant 'clues' " for a "clinical ethics" in medicine. We would like to follow a few of these "clues" to medical ethics by situating them within a more comprehensive framework. We develop this framework out of some ideas of Jurgen Habermas (1970) and Karl Jaspers (1963a and 1963b). This framework, once erected, will permit us to return to Zaner's more specific recommendations and evaluate their relevance and importance.

2. The elusive problem of medical ethics

Zaner describes the emergence of the unprecedented medical problems that prompted doctors to seek greater comprehension of the ethical issues involved. Zaner (1984: 72-73) writes that "Not only was it increasingly possible to maintain patients who only a few years before would have died, ...but the horizons of life's beginnings (the double helix of DNA, genetic research) and ceasings (CNS, whole brain) were becoming increasingly understood, and perforce redefined". Thanks to important scientific discoveries, these topics were becoming "increasingly understood", but this increased understanding disclosed, in Zaner's apt terms, the hitherto unknown "horizons" of life's beginnings and ceasings. Like horizons, birth and death were now perceived a~ spread out and continuous. They were not discrete events; they were gradual processes. They were not qualitative disjunctions; they were matters of degree.

If these are the reasons doctors call upon philosophers for assistance, we can readily understand why physicians (and most philosophers too) remain baffled. With these problems they confront a sub-class of those novel ethical perplexities that arise from advances in science and technology. Hans Jonas' recent book, *The Imperative of Responsibility: In Search of an Ethics for the Technological Age* (1984), treats these new problems from a comprehensive point of view. Traditional ethic.11 systems, according to Jonas, fail to furnish the principles and concepts we need today in order to decide how to employ our far- reaching technological powers.

But Zaner immediately refers to other difficulties which, we suggest, fall into a different area. He mentions the fact that patients feel "dehumanized" by modern health care centers and new technologies. Increasing specialization fragments "the whole person." Doctors know much about "diseases" and "organ systems" but little about "persons". Zaner (1984:73) himself hints at the differences involved in issues such as these when he notes that large demands made on the physician's "technical competence" leave scant time for the same physican to reflect on moral issues, religious values, or sensitive caring.

These topics, then, do not raise questions regarding new ethical principles needed for the use of new technologies. The questions here rather center upon *the insufficiency of technology and "technical competence" as such* in the treatment of human beings. Medical care, in other words, includes more than *technical knowledge.* It even includes more than the proper ethical guidance of technical knowledge. And it is this' 'more than the technical' , that philosophers are supposed to introduce into medical practice.

3. **Technical action in medicine**

We would like to approach this topic of the "more than the technical" in medical practice by adopting some notions from Jurgen Habermas (1970:91-94). Habermas distinguishes between *purposive-rational action and communicative action.* For the sake of simplicity in terminology we shall substitute the adjective' 'technical' , for Habermas' more cumbersome qualifier "purposive-rational"
(zweckrational). But in addition to this change of labels, we shall also feel free to modify and extend Habermas' concept for our own purposes. We shall argue that physicians tend to view their practice as involving primarily technical action and thus tend to overlook the communicative interaction also embedded in clinical work. The task of the philosopher in medicine, then, consists in explicating the clinical role of communicative interaction and in showing its essential connection with technical activities.

Technical expertise is based upon empirical scientific research. This expertise permits the physician to select the means which is most likely to achieve a desired end. Technical expertise must then draw upon scientific predictions. For the physician must know which interventions in the patient's present condition are most likely to lead to a more desirable future state. Technical activities are attempts to influence and manipulate the patient's present condition with a view to altering it for the better.

Since technical procedures aim at creating "a more desirable future", they are inherently governed by *values.* Indeed, each technical activity, we might say, obtains its direction and aim from the value or values it seeks to realize. Valued goals, in other words, are a *sine qua non* of technical actions. In the case of medicine, these valued goals should always be the promotion of health and the amelioration of illness.
Edmund D. Pellegrino has distinguished the values which govern technical intervention in patients' lives from other values. Pellegrino calls these values peculiar to medical intervention, "the bio-medical good". He (1983:570) characterizes this "good" as follows:

> This is the good which a medical intervention can offer by modifying the natural history of disease in a particular patient. The good can be cure, prevention, or containment of disease, amelioration of symptoms, or prolongation of life. It is the good aimed at by the doctor's craftsmanship and the result of scientifically correct decisions about what can be done, and how to carry it out safely, competently, and with minimum discomfort.

The realization of such valued ends, however, requires the *mastery* and *control* of means (Habermas, 1970:92-93). Medical techniques must, therefore, exercise power over the circumstances adversely affecting the patient's life. In order to improve the patient's health, the physician must control certain aspects of the patient's life. Because it exercises mastery and power over the patient's plight, technical action tends to treat the medically relevant aspects of the patient as "objects" (Jaspers, 1963a: 168-191). We do not mean by this that technical–scientific approaches reduce human beings to inorganic things. We rather mean that techniques inevitably treat the conditions of health and illness as causal processes whose direction and outcome can be influenced by scientific intervention. Such "objectification" contains at least two main steps.
(l)Objectification through scientific concepts. The patient's difficulty is *conceptualized* in scientific terms. Through such conceptualization the physician can apprehend the patient's problem as a causal entity. Without scientific concepts the physician could never know how to diagnose and treat the patient. Such conceptualization, however, also abstracts from all those aspects of the person which the scientific terms fail to express. In other words, scientific conceptualization tends to focus upon those aspects of the patient's life which can be expressed by these concepts. (2) *Objectification through technical control.* The physician *acts on* the patient in accordance with the chosen scientific terms. The doctor intervenes in the patient's life, influencing and manipulating aspects of it. The patient becomes an entity to be controlled for a particular purpose. Such objectification tends to reduce the patient to an item of manipulation.

We can now appreciate Habermas' advance beyond Jaspers' notion of causal explanation *(Erklaeren)* in medicine. Jaspers (1963b: 451-462) recognizes only objectification through scientific concepts. For Jaspers, such objectification always occurs whenever we conceive human processes in terms of cause and effect; i.e., this objectification occurs whenever we seek causal explanations of human events. Jaspers, however, does not proceed from this important insight to an account of technical action or of objectification through technical control. Habermas, on the other hand, focuses precisely on technical action. Drawing on Habermas, then, we can notice how technical action necessarily affects the *entirety* of the patient's life while scientific conceptualization must objectify only a *part* of it. For example, when confronted with a particular neoplasm, the physician conceptualizes *a lesion* in an organ or tissue but medicates or operates on the *patient.* Ultimately therefore, in the technical activities of medicine the "whole human being" is necessarily objectified. Accordingly, human beings are "objectified" by technical action because they are treated as beings to be acted upon in accordance with a plan primarily devised by the physician. Furthermore, the patient only secondarily decides what will happen to him or her. For it is primarily the doctor who conceptually defines and actively influences those aspects of the patient's life that pertain to health and illness. Through the process of objectification the patient relinquishes at least apart of his or her autonomy. The physician who wields the techniques assumes greater autonomy and perogative than the patient to whom they are applied. Hence technical action creates an *inequality* between patient and physician: technical expertise accords a predominance to the physician's knowledge and activities.

Without specifically calling it 'inequality', Zaner (1984:84-85) has characterized the superior power and knowledge of the physician which is necessarily involved in the use of medical techniques:

> ...all power to do and to know lies on the side of the healers, not the patient (even if the patient 'knows' about these sorts of things, while a patient he/she often is unable to think about them, forgets them, and in any case is regularly encouraged in multiple ways to ignore such knowledge). The more grievously ill a patient, the greater is the imbalance, and the more exposed to others' actions, judgments, and decisions. Even though they 'want' to 'do the right thing' for me, I am nevertheless within their world, not my own, within their range of power-to-act. ..

Pellegrino (1982-159), however, has explicitly referred to the "inequality" between patient and physician,

> The ill person is condemned to a relationship of inequality with the professed healer, for the healer professes to possess precisely what the patient lacks -the knowledge and power to heal.

This objectification of the patient can also be noted in the language appropriate to technical action. The speech of technical action is scientific. But it is not simply the fact that this language is scientific that objectifies the patient. The patient is objectified through the fact that in technical speech the patient can be reduced to the being *referred to or designated by* the words and sentences. Technical-scientific language does not aim at communication between doctor and patient. The patient is not someone who speaks this language and thereby expresses his or her discomfort and distress. It is the *physician* who categorizes the patient's suffering in scientific terms. And in this scientific categorization the patient is not respondent but rather referent. Although physicians may communicate with one another in technical terms, the patient need not participate in such discussions. As a possibly unhealthy organism, the patient is the object of technical speech just as he or she is the object and not the agent of technical procedures.

The practice of medicine today tends to be shaped by an ambition to remain as scientific as possible. Indeed, physicians sometimes believe that their special usefulness to patients extends only as far as their technical expertise. Medical schools, organizations, and journals reinforce this belief by concentrating almost exclusively on infusing medicine with scientific knowledge and skills. The ideal doctor, it seems, is the perfect scientific technician. From a sociological point of view, we might say that medicine as a cultural institution is attempting to "the legitimate" itself to society at large by displaying its indisputably *scientific* credentials.

4. Communicative interaction in medicine

Drawing on Habermas (1970:92-94) and incorporating Jaspers' (1973b:302-363) notions of understanding *(Verstehen)* and communication, we shall now develop our own distinction between technical practice and communicative action. In communicative interaction with physicians, patients express their concerns and ideas. Through such communication patients present themselves as persons; i.e., communication permits patients to disclose far more aspects of their lives to physicians than can be apprehended through scientific concepts (Jaspers, 1963a: 175-177). Patients are directly given to doctors as *more than* "organ systems" or "diseased organisms".

Through communication, then, physicians can encounter more values in their patients' lives than the value of health. The goals guiding technical intervention in the lives of patients, namely, the promotion of health and the treating of illness, are not the sole values of their lives. Cultural, "moral, religious, political, economic, and aesthetic values, as well as tie' with families, friends, and colleagues, are the primary values animating the lives of patients.

Pellegrino (1983: 570) has maintained that in clinical practice the "bio-medical good" must harmonize with these additional values of patients:

> A biomedically good decision is one that is scientifically correct but it is not automatically a good decision from the patient's point of view. It must be placed within the context of the patient's life situation and his value system.

And Zaner (1984:83) provides a kind of list of the non-technical "social values" that pervade the lives of patients and in this way influence medical treatment:

> a patient's values, character, occupation, etc., the family and/or intimates and their respective biographical situations; the social and/or religious community within which the patient lives, along with their values, etc. (1 think, for instance, of how the latter can impact medical recommendations for blood transfusion, treatment of cancer, and the like).

Only by listening to and communicating with patients can doctors directly experience these many additional values as conditioning and contextualizing the specifically medical values which their technical actions seek to actualize (Reiser and Rosen, 1984).

Because it situates technical action within a larger human context, communicative interaction is shaped not by scientific terms and predictions but rather by cultural codes, social norms, and learned expectations (Habermas, 1970:92-93). These codes, norms, and expectations arise not from scientific theorizing but rather from pre- scientific social participation in everyday life. The language involved in communication is not the technical vocabulary of science but rather ordinary vernacular speech. In communicative action patients are active participants and agents. Patients are. not simply the referents designated by words and sentences. The ideas and intentions of patients rather shape the conversations as much as the ideas and intentions of doctors do. Patients thus share an *equality* of agency and responsibility with doctors. No person's knowledge and choices carry more import than do those of other participants. In interaction with the physicians, therefore, patients remain *subjects.* Once again, in using the term "subject" we do not mean that the patient is regarded as human rather than as some sub-human thing. We rather intend to express two related notions. (1) The patient's life is experienced by the doctor as more than whatever scientific concepts can capture (Jaspers, 1963a: 168-191). And (2) the patient is not simply an item to be controlled but is an autonomous source of speech and action. Through communication the patient is experienced by the physician as a free agent whose intentions and wishes must be respected.

Pellegrino (1983:571) has emphasized the importance of the physician's respect for the "moral agency" of the patient. He distinguishes "the good of the patient as a person " from the "bio- medical good" we mentioned with regard to technical medicine. This "good of the patient as a person" is equivalent to respect for the patient as a subject or for what Pellegrino calls the patient's "moral agency". According to Pellegrino (1982:161), "the patient must be assisted, to the extent he wishes, to make conscious choices and thus to act as a human person rather than become the object of technical manipulation".

Modern health science centers with their powerful technologies are organized around technical action (Zaner, 1984:73). Treating patients exclusively from this technical point of view, however, will indeed objectify and "dehumanize" them. Such centers and technologies can be "humanized" only if the patient is also approached as a free subject or "moral agent" through communicative interaction. Similarly, the increasing specialization that is required for technical expertise fragments "the whole person" of the patient into "diseases" and "organ systems" because "the whole person" can be encountered only through communicative interaction.

Habermas' distinction between communicative and technical action is based upon an ambiguity that permeates human existence. Jaspers (1970) has shown how human beings are necessarily both objects and subjects. Humans exist as objects in the world in relationship with other objects. Human beings are, consequently, affected and shaped by these other mundane entities. Because humans are integral parts of this world-whole, they, like other mundane realities, can be treated as objects of causal explanation and technical action. On the other hand, human beings are subjects who experience the world and choose to act upon it. Humans are not simply parts of a causal nexus but are also autonomous agents who can affect and influence this nexus. This ambiguity implies that humans are both the objects of technical control and the subjects of communication and social action. Modern medicine should confront patients as *both* objects and subjects. For medicine should consist of *both* technical action and communicative interaction. Neither can be sacrificed to the other. Patients must be approached as objects because the goals which physicians value and seek to achieve are the promotion of health and the amelioration of disease in their patients, and these goals can be most effectively achieved through scientific techniques. Applying such techniques, however, runs the risk of reducing the patient to an unfree object defined by the physician's concepts and controlled by the physician's technical will. Consequently, the patient should also be approached as the autonomous subject of communicative action: the values peculiar to medicine should be situated within and influenced by the other values animating the patient's existence. Nevertheless, if the patient is to receive medical treatment, his or her own choices must conform to the superior technical expertise of the physician. Thus, on the one hand, an inequality between doctor and patient must exist; but, on the other hand, so must equality. As we have argued elsewhere, the communicative activities of the lifeworld are the basis of all medical knowledge and practice (Schwartz and Wiggins, 1985). Therefore, communicative interaction must always serve as the *basic* tie between doctor and patient. The inequality of technical expertise can find its rightful place only within this more basic context. As long as communicative interaction remains decisive, the patient can defer to the superior expertise of the physician. Equality and inequality thus reach some kind of tension and balance. Medical ethics arises, we believe, because of the need to define clearly this peculiar tension and balance.

5. Following Zaner's clues

We believe that Zaner's "clues" to a "clinical ethics" significantly illuminate these complex moral connections between technical and communicative action in medicine. Zaner's (1984: 80-89) principle insights, we think, resituate the goals of medical techniques within the more encompassing evaluative contexts of communication.

Zaner (1984 81-83) sees technical procedures as conditioned by a "covenant" between the "dyad" of doctor and patient. The term "covenant" connotes a mutual agreement between doctor and patient. Pellegrino approaches Zaner's notion of a covenant when he speaks of the physician's implicit "promise of help" which responds to the "expectations" of the patient. Such a "promise" Pellegrino finds in the very concept of the physician's "profession" -what he calls the doctor's "act of profession". Pellegrino (1982:160) says of the doctor, "He promises that he has authentic knowledge and skill - competence; that he will put them at the service of the patient, will act in the patient's best interest". Pellegrino (983:572) even claims that this basic promise is "the source of (the physician's) ethical obligations".

Zaner maintains that the covenant is structured by norms which define and circumscribe the relationship. The most fundamental of these norms, according to Zaner, consists in the physician's commitment " to act on behalf of the patient" or "to act on behalf of the patient's 'best interest"'. This "fundamental moral commitment " by the physician Zaner calls "caring". We suggest that Zaner is here referring primarily to the values peculiar to medical techniques: the goals of promoting health and ameliorating illness. The fact that the physician's care aims at such technical goals becomes clear from Zaner's own phraseology: as if he were simply restating what it means to "act on behalf of the patient", i.e., to "care" for the patient, Zaner (1984:82) continues,

> ...doing whatever is reasonable to relieve the patient's *present* condition (pain medication, surgery, etc.), and to act with the patient's best interest as governing actions designed to enable, from the range of possible futures for this patient, the *future* which is agreed upon as preferable (cure disease, insure successful pregnancy, etc.).

This instrumental creation of the future out of the present, i.e., this acting on present conditions with the intention of bringing about a desired future condition, is precisely technical action.

Now such technical intervention in the lives of patients requires that patients *trust* that this intervention will serve their "best interests" (Zaner, 1984:82). In the covenant between doctors and patients, the attitude of care in physicians must be reciprocated by an attitude of trust on the part of patients. Trust is required because patients must transfer at least apart G, the control over their lives to doctors. Relinquishing important segments of their autonomy, patients submit to the knowledge and designs of other persons, physicians. Patients, in other words, agree to be objectified by doctors on the condition that such objectification serve solely as a means toward the ends of promoting their health and alleviating their suffering.

6. **Medical ethics and the lifeworld**

We submit that this care and trust which must structure technical medicine finds its basis in pre-technical social life (Schwartz and Wiggins, 1985). When people interact with one another in the everyday 1ifeworld,* they must, at least to some degree, trust that their actions will not harm one another. In ordinary life I trust that whatever other people do their actions will not prohibit me from performing my own activities in accordance with my own valued ends. This everyday trust that the other person's activities will not harm oneself takes on a special form when it moves to the level of medical treatment. In ordinary life I trust that the other person's actions will not interfere with mine in unexpected or inconvenient ways. Medical treatment, however, consists precisely in such interference. Consequently, I, as a patient, must trust that such intervention in my life by someone else will ultimately serve my own purpose *in accordance with my overall values.* I trust, in other words, that my basic values will be respected by the physician who otherwise interferes with aspects of my life. The values peculiar to technical medicine must thus be qualified by the other, non- technical values that permeate the patient's existence. Or, to phrase it in other terms, the ends governing the use of medical techniques should be situated within and shaped by the more fundamental context of the patient's communicative life. And the reason for doing this lies partially in the fact that the trust the patient accords the doctor's activities has its basis in the pre-medical trust the patient already accords to other "well-meaning" people in the communicative lifeworld.

7. Conclusion

By analyzing Zaner's notion of trust, we have sought to show how the technical actions of the physician presuppose the values already operative in the patient's existence at the more fundamental level of communicative interaction. A similar analysis of the physician's *care* for patients would disclose how it also presupposes our capacity to care for other people in distress in the everyday lifeworld. Because medical values simply develop further values already operating in pre-medical, ordinary life, they present neither the physician nor the patient with entirely novel and unfamiliar moral issues. Such moral problems are "always already" familiar. And yet they are familiar only to some vague degree or other. They remain to a certain extent “unfamiliar", "uncanny", and "unintelligible". This moral strangeness arises from the peculiarity of medical techniques and the difference of such techniques from everyday undertakings.

Medical ethics, as we have said, has the special task of explicating this connection between moral familiarity and moral strangeness. In other words, medical ethics has the task of reconciling the peculiar values of medical techniques with the more ordinary values of communicative interaction. This task requires the philosopher to trace the genesis of medical techniques out of the everyday lifeworld (Schwartz and Wiggins, 1985). Only such agenesis can show us how scientific medicine develops beyond the lifeworld while always remaining deeply dependent upon it. Thus the values of medicine too presuppose the values of everyday life while nevertheless moving beyond them.

* In this article we assign to the term "lifeworld" *(Lebenswelt)* a meaning broad enough to encompass both its phenomenological and Habermasian uses (Husserl, 1970:121-189; Habermas, 1971:301-317). For us, the concept "lifeworld" signifies the realm of everyday social interaction and practical projects (Schwartz and Wiggins, 1985:340-341). It is the world as we experience it in a pre-scientific manner. Hence it is the domain of ordinary perception, action, and natural speech.

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